

A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 14 January 2021 at 9.30 am via Microsoft Teams

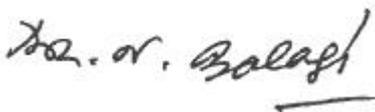
**AGENDA
(Public)**

Item	Session	GB Requested to	Enclosure Lead	Time
1	House Keeping	Information	Nick Balac	9.30 am
2	Apologies	Note		9.30 am
3	Quoracy	Note		9.30 am
4	Patient Story	Note	Jayne Sivakumar	9.35 am 10 mins
5	Declarations of Interest relevant to the agenda	Assurance	GB/Pu 21/01/05 Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	GB/Pu 21/01/06 Kirsty Waknell	9.50 am 10 mins
7	Questions from the Public	Information	Verbal Kirsty Waknell	10.00 am 5 mins
8	Minutes of the meeting held on 12 November 2020	Approval	GB/Pu 21/01/08 Nick Balac	10.05 am 5 mins
9	Matters Arising Report	Note	GB/Pu 21/01/09 Nick Balac	10.10 am 5 mins
	Strategy			
10	Chief Officer's Report	Information	GB/Pu 21/01/10 Chris Edwards	10.15am 10 mins
11	Covid-19 Response and Phase 3 Recovery update	Approval & Assurance	GB/Pu 21/01/11 Jamie Wike	10.25am 10 mins
12	Home First - A New Model for Intermediate Care	Approval	GB/Pu 21/01/12 Jayne Sivakumar	10.35am 10 mins

13	Cancer Assurance Report	Assurance	GB/Pu 21/01/13 Jamie Wike Siobhan Lendzionowski	10.45am 10 mins	
14	Integrated Care at Barnsley Place Assurance Report	Assurance	GB/Pu 21/01/14 Jeremy Budd	10.55am 10 mins	
15	Maternity Assurance Report	Assurance	GB/Pu 21/01/15 Patrick Otway	11.05am 10 mins	
16	Suicide prevention and bereavement support update	Information	GB/Pu 21/01/16 Dr Mark Smith Patrick Otway	11.15am 10 mins	
Quality and Governance					
17	Quality Highlights Report	Assurance	GB/Pu 21/01/17 Jayne Sivakumar	11.25am 10 mins	
18	Covert Administration of Medicines Policy	Approval	GB/Pu 21/01/18 Jayne Sivakumar	11.35am 10 mins	
19	Risk & Governance Exception Report	Assurance	GB/Pu 21/01/19 Richard Walker	11.45am 10 mins	
20	Home Working Policy	Approval	GB/Pu 21/01/20 Richard Walker	11.55am 10 mins	
Finance and Performance					
21	Integrated Performance Report	Assurance and Information	GB/Pu 21/01/21 Roxanna Naylor Jamie Wike	12.05pm 15 mins	
Committee Reports and Minutes					
	22.1	Minutes of the Finance and Performance Committee held on 5 November 2020 and 3 December 2020	Assurance	GB/Pu 21/01/22.1 Nick Balac	12.20pm 5 mins
	22.2	Minutes of the Primary Care Commissioning on 24 September 2020	Assurance	GB/Pu 21/01/22.2 Chris Millington	
	22.3	Minutes of the Quality and Patient Safety Committee held on 22 October 2020	Assurance	GB/Pu 21/01/22.3 Jayne Sivakumar	
	22.4	Assurance Report from the Equality and Engagement Committee held on 19 November 2020	Assurance	GB/Pu 21/01/22.4 Chris Millington	
General					
23	Reports Circulated in Advance for Noting: From the SYB ICS Health Executive Group held on 10 November 2020	Information & Assurance	Nick Balac	12.25pm 5 mins	

	<ul style="list-style-type: none"> • SYB ICS CEO Report (marked enc B) From the SYB ICS Health Executive Group held on 8 December 2020 • SYB ICS CEO Report (marked Enc B) 			
24	<p>Reflection on how well the meeting's business has been conducted:</p> <ul style="list-style-type: none"> • Conduct of meetings • Any areas for additional assurance • Any training needs identified 	Assurance	Nick Balac	12.30pm
25	<p>Date and Time of the Next Meeting:</p> <p>Thursday 11 March 2021 at 09.30 am Via Microsoft Teams</p>			12.35pm Close

Signed



Dr Nick Balac – Chairman

Exclusion of the Public:

The CCG Governing Body should consider the following resolution:

“That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted - publicity on which would be prejudicial to the public interest”

Section 1 (2) Public Bodies (Admission to meetings) Act 1960

GOVERNING BODY

14 January 2021

Declarations of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR							
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input type="checkbox"/>
2.	PURPOSE							
	To foresee any potential conflicts of interests relevant to the agenda.							
3.	REPORT OF							
	Executive / Clinical Lead	Name	Designation					
		Richard Walker	Head of Governance & Assurance					
	Author	Paige Dawson	Governance, Risk & Assurance Facilitator					
4.	SUMMARY OF PREVIOUS GOVERNANCE							
	The matters raised in this paper have been subject to prior consideration in the following forums:							
	Group / Committee	Date	Outcome					
	N/A							
5.	EXECUTIVE SUMMARY							
	<p>Conflicts of interest are defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.</p> <p>The table below details what interests must be declared:</p>							

	Type	Description
	Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
	Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
	Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
	Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.
	<p>Appendix A to this report details all Governing Body Members' current declared interests to update and to enable the Chair and Members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict.</p> <p>Members should also declare if they have received any Gifts, Hospitality or Sponsorship.</p>	
6.	THE GOVERNING BODY IS ASKED TO:	
	<ul style="list-style-type: none"> Note the contents of this report and declare if Members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship. 	
7.	APPENDICES / LINKS TO FURTHER INFORMATION	
	<ul style="list-style-type: none"> Appendix A – Governing Body Members Declaration of Interest Report 	

Agenda time allocation for report:	5 minutes
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PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act		
	Management of conflicts of interest (s14O)	<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)
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		Y
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA
3.4	Improving quality (s14R, s14S)		
	Has a Quality Impact Assessment (QIA) been completed if relevant?		NA
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?		NA

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

NHS Barnsley Clinical Commissioning Group Register of Interests

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Group's Constitution the Clinical Commissioning Group's Accountable Officer will be informed of any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated as a minimum on an annual basis.

Register: Governing Body

Name	Current position (s) held in the CCG	Declared Interest
Adebowale Adekunle	GP Governing Body Member	<ul style="list-style-type: none"> • GP Partner at Wombwell Chapelfields Medical Centre
		<ul style="list-style-type: none"> • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG • Clinical sessions with Local Care Direct Wakefield • Clinical sessions at IHeart • Member of the British Medical Association • Member Medical Protection Society

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

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

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

Name	Current position (s) held in the CCG	Declared Interest
		<ul style="list-style-type: none"> The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		<ul style="list-style-type: none"> Shareholder in GSK 3A Honorary Senior Lecturer Wife has a position as a Consultant Breast Surgeon with Leeds Hospital Trust.
Chris Millington	Lay Member	<ul style="list-style-type: none"> Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 2018) Partner Governor Barnsley Hospital NHS Foundation Trust (since 6 February 2019)
Roxanna Naylor	Chief Finance Officer	<ul style="list-style-type: none"> Partner works at NHS Leeds Clinical Commissioning Group.
Mike Simms	Secondary Care Clinician	<ul style="list-style-type: none"> Provider of Corporate and Private healthcare and delivering some NHS Contracts.
Mark Smith	GP Governing Body Member	<ul style="list-style-type: none"> Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles.
		<ul style="list-style-type: none"> Director of Janark Medical Ltd Practice is a Member of Barnsley Healthcare Federation which may provide services to Barnsley CCG

Name	Current position (s) held in the CCG	Declared Interest
Jayne Sivakumar	Chief Nurse	<ul style="list-style-type: none"> • Director of RJS Healthcare Ltd – a healthcare company which receives referrals from healthcare organisations.
		<ul style="list-style-type: none"> • Husband is a Consultant Surgeon at the Mid Yorkshire Hospital NHS Foundation Trust.

In attendance:

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

Governing Body

14 January 2021

Patient and Public Involvement Activity Report

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR												
	<table border="1" style="width: 100%;"> <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"/>					
2. PURPOSE												
	<p>This report outlines the patient and public involvement activity we have carried out to help inform commissioning decisions and service development.</p>											
3. REPORT OF												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 20%;"></th> <th style="width: 30%;">Name</th> <th style="width: 50%;">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										
4. SUMMARY OF PREVIOUS GOVERNANCE												
	<p>Notification of the annual assessment rating has been noted at the following CCG committee.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 60%;">Group / Committee</th> <th style="width: 20%;">Date</th> <th style="width: 20%;">Outcome</th> </tr> </thead> <tbody> <tr> <td>CCG engagement and equality committee</td> <td>03/12/2020</td> <td>Noted</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	CCG engagement and equality committee	03/12/2020	Noted			
Group / Committee	Date	Outcome										
CCG engagement and equality committee	03/12/2020	Noted										
5. EXECUTIVE SUMMARY												
	<p>Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have a statutory duty to involve the public in commissioning (section 14Z2). In addition to meeting statutory responsibilities, effective patient and public participation helps CCGs to commission services that meet the needs of local communities and tackle health inequalities.</p> <p>NHS England assesses how well each CCG has discharged its public involvement duty (section 14Z2). As a result of this, Barnsley CCG has received the top rating Green Star for 2019/20.</p>											
6. THE COMMITTEE IS ASKED TO:												
	<ul style="list-style-type: none"> • Note the positive annual assessment rating. 											

	<ul style="list-style-type: none">• Note the progress of local involvement activity.
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Agenda time allocation for report:	10 minutes
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PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	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>
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T) ✓
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U) ✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V) ✓
	Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1) ✓
	Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2) ✓
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		Y
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

PART 2 – DETAILED REPORT

INTRODUCTION/ BACKGROUND INFORMATION	
1	<p>Compliance with statutory guidance on patient and public participation in commissioning health and care: the NHS Oversight Framework Patient and Community Engagement Indicator</p> <p>Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have a statutory duty to involve the public in commissioning (section 14Z2). In addition to meeting statutory responsibilities, effective patient and public participation helps CCGs to commission services that meet the needs of local communities and tackle health inequalities.</p> <p>NHS England has a legal duty (section 14Z16) to assess how well each CCG has discharged its public involvement duty (section 14Z2), as well as a commitment to supporting continuous improvement in public participation. A robust, and improvement focused, process of national assessment has been now been carried out for 2019/20 to reach final RAGG* ratings and scores for individual CCGs.</p> <p>The final RAGG* rating and score for 2019/20 Barnsley CCG, following the national assessment and moderation process has now been received and is rated at the top rating of Green Star.</p>
2	<p>Held monthly Barnsley Patient Council via Zoom on 2nd December</p> <p>10 attendees took part in an hour long meeting and we dedicated the last meeting of 2020 to feeding back to members about all the information we have been collecting and collating in relation to what people are telling us particularly in relation to their experiences of life during the pandemic and how this information is being used to inform discussions and decision making.</p> <p>The CCG engagement manager delivered a presentation to members about this work and discussed and captured member’s experiences and challenges which will be fed back into the weekly intelligence reporting referenced below.</p>
3	<p>Healthwatch Barnsley Survey</p> <p>The CCG and other partners have been working with Healthwatch Barnsley to inform their next local survey designed to gather insight and feedback from local people about their experiences of life during the pandemic.</p> <p>The survey is to be promoted by all partners working across the borough and will run until the end of January and can be accessed here</p> <p>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 results will be available in February 2020.</p>

<p>4</p>	<p>Barnsley Hospital – Developing a new Paediatric Emergency Department and assessment Unit</p> <p>Barnsley Hospital is in the process of developing a new Paediatric Emergency Department and assessment Unit. They have been engaging with our Barnsley children and young people throughout this process and the CCG have been involved in supporting this. Barnsley Hospital has set up a private Facebook group for their service users and the Barnsley population to help make decisions on final design, environment, communication and signage and information concepts.</p>
<p>5</p>	<p>Barnsley BAME Mothers Maternity Survey</p> <p>Working in partnership Barnsley Maternity Services, Maternity Voices Partnership, the CCG and the Barnsley Together Forum have launched a survey and are inviting feedback from any Black, Asian or Minority Ethnic (BAME) parents who have had a baby in the Barnsley area in the last year, or will soon have a baby here.</p> <p>COVID-19 has magnified the importance of pregnant women from the BAME community communities seeking help early when they have symptoms of COVID-19. Women from BAME communities are up to eight times more likely to be hospitalised due to COVID infection. We want to hear about their experiences of maternity care before and during this pandemic.</p>
<p>6</p>	<p>Insight and Intelligence Reporting</p> <p>As highlighted previously, engagement and experience leads from the CCGs in South Yorkshire and Bassetlaw continue to meet on a monthly basis. This group has interdependencies with the communications; intelligence; and workforce cells and links into the wider Barnsley silver health and social care tactical group.</p> <p>The CCG engagement team provide summary updates from the findings of national, regional and local engagement activities that feed into the weekly borough wide intelligence reports prepared by colleagues working within the intelligence cell and circulated across the local system via the weekly surveillance reporting to cell and workstream leads.</p> <p>The most recent feedback we have shared is the feedback received in relation to the Barnsley carers survey 2020 which will be used to inform the new carers strategy for Barnsley and also the latest results to the Barnsley children and young people emotional health and wellbeing survey which is repeated every 4-6 weeks and led by the public health team at Barnsley Council.</p>

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 12 November 2020, 9.30 am in the Boardroom at Hilder House 49/51 Gawber Road, Barnsley S75 2PY.

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 (from minute ref GB/Pu 20/11/05)
Dr Hussain Kadarsha	Member
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning
Roxanna Naylor	Chief Finance Officer
Mike Simms	Secondary Care Clinician
Jayne Sivakumar	Chief Nurse
Dr Mark Smith	Member

IN ATTENDANCE

Lucy Barker	Senior Programme & Performance - Sheffield CCG (for Minute reference GB/Pu 20/11/14 only)
Jeremy Budd	Director of Strategic Commissioning and Partnerships
Jane Howcroft	Programme & Performance Assurance - Sheffield CCG (for Minute reference GB/Pu 20/11/14 only)
David Lautman	Lead Commissioning and Transformation Manager (For minute ref GB/Pu 20/11/11 only)
Kay Morgan	Governance and Assurance Manager (Minutes)
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance
Jamie Wike	Chief Operating Officer

APOLOGIES

Dr Jamie MacInnes	Member
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The Chairman welcomed members of the public to the Governing Body meeting.

Agenda Item		Action	Deadline
GB/Pu 20/11/01	HOUSEKEEPING		
	Members noted the etiquette for meetings held via Microsoft Teams.		
GB/Pu 20/11/02	QUORACY		
	The meeting was declared quorate.		

Agenda Item		Action	Deadline
GB/Pu 20/11/03	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA		
	The Governing Body considered the Declarations of Interests Report. No other new declarations were received		
GB/Pu 20/11/04	PATIENT STORY		
	The Chief Nurse introduced the patient story reflecting the experiences of a son whose mother is diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and involvement of family as carers. It was noted that the Patient Story links to the Governing Body agenda item 12, BREATHE in the Community Service, a new service for people with respiratory conditions bringing care closer to home.		
	<p>The following comments were received from Governing Body Members in respect of the Patient Story.</p> <ul style="list-style-type: none"> • The new BREATHE service is focussed on managing a patient's condition at home and trying to prevent avoidable admissions. • A diagnosis of COPD can have a severe impact on a patient. In addition to physical health services the BREATHE specification includes mental health support for patients with long term conditions. • Bringing care closer to home and empowering patients, family and carers, alleviates stress on patients, family and carers for example reducing the need to travel and attend hospital appointments. <p>The Chairman concluded discussing advising that the new BREATHE Service will improve the existing service provision.</p>		
	The Governing Body noted the Patient Story.		
GB/Pu 20/11/05	PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT		
	The Head of Communications and Engagement presented the Patient and Public Involvement Activity Report, which detailed the engagement activity to support a respiratory service for Barnsley Adults and feedback received from people who have had Covid-19 to help plan rehabilitation		

Agenda Item		Action	Deadline
	services.		
	<p>At the request of the Lay Member for Patient and Public Engagement & Primary Care Commissioning and for Members of the Public the following explanation was provided in respect of the BEATHE Acronym, 'The <u>B</u>arnsley <u>R</u>espiratory <u>A</u>ssessment and <u>T</u>HERapy (BREATHE) in the Community Service'</p> <p>The Chairman advised that on diagnosis of Chronic Obstructive Pulmonary Disease (COPD), patients may also require psychological support. It was clarified that the new BREATHE Community service is a service for patients with all facets of respiratory disease and included psychological support and also post Covid care.</p>		
	<p>The Governing Body noted the Patient and Public Involvement Activity Report and progress and feedback from local involvement activity.</p>		
<p>GB/Pu 20/11/06</p>	<p>QUESTIONS FROM THE PUBLIC</p>		
	<p>No questions had been received from Members of the public.</p>		
<p>GB/Pu 20/11/07</p>	<p>MINUTES OF THE MEETING HELD ON 10 SEPTEMBER 2020</p>		
	<p>The minutes of the Governing Body Extra Ordinary meeting held on 10 September 2020 were verified as a correct record of the proceedings.</p>		
<p>GB/Pu 20/11/08</p>	<p>MATTERS ARISING REPORT</p>		
	<p>The Governing Body considered the Matters Arising Report</p> <ul style="list-style-type: none"> Minute reference GB/Pu 19/09/13 - Mental Health Update, Suicide Prevention Plans and Minute reference GB/Pu 20/01/11 - Bereavement Services <p>The Governing Body noted that the above actions remained outstanding.</p> <p>Agreed action Dr Mark Smith and the Head of Commissioning (Mental Health) to submit a report to the next meeting of the</p>	<p>MS PO</p>	

Agenda Item		Action	Deadline
	<p>Governing Body on 14 January 2021 regarding suicide prevention plans / strategy and the bereavement / Mental health support services available in Barnsley.</p> <p>The Governing Body noted the Matters Arising Report</p>		
STRATEGY			
GB/Pu 20/11/09	CHIEF OFFICER'S REPORT		
	<p>The Chief Officer provided Governing Body with the latest information re COVID-19 NHS preparedness and response – including notification of a return to Incident Level 4. He also provided an update on changes to the CCG's executive team, clarifying roles and portfolios to enable the CCG to meet future challenges. The key adjustments were noted as:</p> <p>Jeremy Budd's title and role will become the Director of Strategic Commissioning and Partnerships</p> <ul style="list-style-type: none"> • Lead on the development and delivery of integrated care and joint commissioning in Barnsley. • Act as the place based lead for Barnsley, ensuring that Barnsley is well represented at the ICS. • Lead on strategic planning for the organisation, including a population based approach to commissioning. <p>Jamie Wike will take on the role of Chief Operating Officer</p> <p>Responsible for the day to day operational management of the CCG.</p> <ul style="list-style-type: none"> • Ensure statutory work and local policies are delivered acting as a point of escalation for staff on a day to day basis. • Lead on the development of transformational plans and operational planning. • Lead the operational planning activity to deliver NHS Constitution and other targets required by NHS England. <p>Dr Madhavi Guntamukkla has been appointed as Medical Director. Her role will be to:</p>		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> • Chair of the Quality & Patient Safety Committee. • Clinical adviser to the Primary Care Commissioning Committee. • Clinical and Executive Lead for Primary Care. • Health Inequalities Lead for the CCG. 		
	<p>The Governing Body noted:</p> <ul style="list-style-type: none"> • The letter from Letter from Professor Keith Willett, NHS National Director for Emergency Planning and Incident Response NHS England and NHS Improvement regarding the COVID-19 NHS preparedness and response – notification of return to Incident Level 4 • The update on changes to the CCGs executive team. 		
GB/Pu 20/11/10	COVID-19 RESPONSE AND PHASE 3 RECOVERY UPDATE		
	<p>The Chief Operating Officer and the Director of Strategic Commissioning and Partnerships provided the Governing Body with an update in relation to the CCG's response to the Coronavirus Disease (COVID19) outbreak and details of the reset plans developed by partners to support recovery in line with national and local priorities.</p> <p>Covid 19 Response</p> <p>The Chief Operating Officer highlighted that the local health and social care system had become more pressured since his report had been written and currently the situation in Barnsley is very challenging for all services. The Barnsley Hospital NHS Foundation Trust had declared an OPEL level 4 status. Staff absence at the Trust is very high especially amongst nursing staff and 40% of bed occupancy is for Covid positive patients. To help alleviate the situation, the hospital was placed on ambulance divert to other hospitals and in one day 103 patients were discharged from the hospital. Demand for oxygen usage is a real concern across the country, and this has been escalated to NHSE. All health and social care partners are working together across Barnsley and the SY&B system to provide mutual aid and support to each other as required.</p> <p>The general Covid 19 infection rates are beginning to reduce slightly and plateau and hopefully this will continue to improve.</p>		

Agenda Item		Action	Deadline
	<p>Phase 3 Recovery & Reset</p> <p>The Director of Strategic Commissioning and Partnerships advised that the Barnsley Place Reset Plan is a plan at a point in time and will be refreshed in January 2020. Progress against the five priorities for reset and recovery are monitored on a weekly basis and progress will be reported to the Governing Body. The partnership response to the phase 3 requirements is coordinated by the Integrated Care Partnership Group.</p> <p>The Chairman advised Members that the Recovery and Reset Plan is a detailed document, and any feedback should be provided outside of the meeting to The Director of Strategic Commissioning and Partnerships</p>	ALL	
	<p>The Chairman commented that the People of Barnsley will be interested in the deployment of the Covid Vaccine. The Chief Operating Officer highlighted that there is no confirmation of exactly when the vaccine will be available in December 2020. However in the meantime, NHSE has asked the CCG to plan for mass vaccination of the local population once the vaccine is available.</p> <p>In Barnsley the biggest proportion of vaccine will be administered by Primary Care. The defined cohorts of people to receive the vaccine has not been confirmed but it is suggested that the first cohorts will be NHS front line and other health and care workers; the care home population and staff; and the 80 or 85 plus age group population. There will also be some clinical prioritisation for people to receive the vaccine.</p> <p>Full scale population vaccination is anticipated in early Spring. Vaccines will be delivered in weekly batches of just under 1000 doses. Each person will require 2 vaccinations 21 days apart. The first dose must be at least 7 days after a flu vaccination. Patients will be observed 15 minutes after each vaccination before being allowed to leave the vaccination observation area.</p> <p>It is anticipated that a Primary Care Enhanced Services Scheme or Quality and Outcomes Framework (an annual reward and incentive programme for GP Practices) will be offered to Practices, to work with the CCG and Primary Care Network in delivery of the vaccination programme.</p>		

Agenda Item		Action	Deadline
	<p>Expressions of interest have been requested from Practices.</p> <p>The identification of suitable NHS sites to receive / store / manage vaccines and administer mass vaccinations are expected to be determined by Tuesday 17 November 2020. Only NHS sites that meet specific strict criteria will be designated as approved sites. The NHSE will confirm the approved sites by 23 November 2020.</p>		
	<p>The Chief Officer commented that the national approach for Primary Care to deliver the Covid vaccination programme is excellent news, GPs in Barnsley have a good track record of delivering mass flu vaccinations. Discussion took place. In response to questions raised it was clarified that there is extra funding for Primary Care Covid costs and a Directly Enhanced Service (DES) for the Covid vaccinations. The Local Authority are funded separately for care home costs. The detail around delivery of the vaccination programme is being progressed. The CCG's Primary Care Team is scoping the work for Practices to vaccinate care home residents. It was noted that people who have not had the seasonal flu vaccination can have the Covid Vaccination.</p> <p>The Chief Operating Officer advised that the current thinking is to have two vaccination sites within the borough coordinated by the Barnsley Healthcare Federation on behalf of Practices and supported by Practices to help with the administration of vaccines.</p> <p>Practices signed up to undertake the Covid vaccinations will work with the Primary Care Network to coordinate and deliver the vaccination programme.</p>		
	<p>The mass Covid vaccination programme is a real challenge but with support from the GP Federation, Primary Care Networks, Practices working at scale in a consolidated way, this will be achieved for the people of Barnsley.</p> <p>NHSE approved NHS premises must be used to deliver the vaccination programme. The BHF Lundwood practice based at Priory Campus could be a potential site. The vaccination of housebound people is more challenging in terms of the time required for each vaccination. The CCG will work closely with Partners (i.e. Public Health / School and Community Nurses) to ensure the Covid vaccination programme is delivered to the housebound.</p>		

Agenda Item		Action	Deadline
	<p>The Chairman concluded the discussion indicating that he hoped the Governing Body update on the Covid Vaccination Programme had provided assurance to the people of Barnsley that the CCG is forward planning to ensure the vaccines are administered in a timely and safe manner.</p>		
	<p>The Governing Body noted</p> <ul style="list-style-type: none"> • The update provided in this paper • The contents of the COVID 10 Reset Plan presented to the Governing Body. 		
<p>GB/Pu 20/11/11</p>	<p>BREATHE IN THE COMMUNITY SERVICE</p>		
	<p>The Lead Commissioning and Transformation Manager joined the meeting for this item only.</p> <p>The Director of Strategic Planning and Performance presented, an Engagement report which demonstrated how the engagement process influenced the specification for the BREATHE Service, alignment of the service to the Neighbourhood Team model and also the final BREATHE Service Specification and Key Performance Indicators.</p> <p>It was noted that the key changes in the specification will ensure the requirement for a community respiratory / out of hospital based service. The main principle being for patients to be seen and treated in the community and managed in their own homes, supporting people to stay well at home by proactive care, risk stratification of patients to pick up concerns early, and use of multi-disciplinary teams to co-ordinate specialist input.</p>		
	<p>The Chairman commented that the final BREATHE Service Specification brings to conclusion the long development on the BREATHE Service and thanked everyone involved in this work.</p>		
	<p>The Governing Body noted:</p> <ul style="list-style-type: none"> • The Engagement Report which details engagement activity undertaken and the ‘You Said, Our Response’ Report that demonstrates how the engagement process influenced the specification. • The final BREATHE Service Specification and Key 		

Agenda Item		Action	Deadline
	<p>Performance Indicators.</p> <p>The Lead Commissioning and Transformation Manager left the meeting.</p>		
QUALITY AND GOVERNANCE			
GB/Pu 20/11/12	QUALITY HIGHLIGHTS REPORT		
	<p>The Chief Nurse introduced the Quality Highlights Report to the Governing Body.</p> <p>The Governing Body noted the Quality Highlights Report for information and assurance.</p>		
GB/Pu 20/11/13	RISK AND GOVERNANCE EXCEPTION REPORT		
	<p>The Head of Governance and Assurance introduced the Risk and Governance Exception Report to the Governing Body. It was highlighted that the update and refresh of the Governing Body Assurance Framework (GBAF) had been completed. A new priority area relating to Care Homes has been added to the GBAF.</p> <p>The following minor amendments were received in respect of the Governing Body Assurance workplan/ Agenda timetable; in the Finance and Performance Section</p> <ul style="list-style-type: none"> • reference to budgets should be documented as 2021/22 Budgets and not 2020/21. • November 2021 date for the Operational and Financial Plan 20/21 to be removed <p>It was noted that the workplan will be further updated to schedule routine Assurance Reports to the Governing Body against the priority areas within the GBAF.</p>		
	<p>The Governing Body:</p> <ul style="list-style-type: none"> • Reviewed the Assurance Framework and Risk Register • Determined that all risks are being appropriately Managed • Did not identify any potential new risks or risks for removal • Noted the Finance and Performance Committee and Audit Committee TOR had been reviewed 		

Agenda Item		Action	Deadline
	<p>and no changes are proposed</p> <ul style="list-style-type: none"> • Noted that the Decommissioning Policy had been reviewed and minor changes approved by the Finance & Performance Committee • Noted the Workforce Report for Quarter 2 of 2020/21 • Received and noted the Governing Body work Plan & Agenda Timetable 2020/21 <p>Agreed Action To update the Governing Body work Plan & Agenda Timetable 2020/21 in line with comments received at the Governing Body meeting;</p> <ul style="list-style-type: none"> • reference to budgets should be documented as 2021/22 Budgets and not 2020/21. • November 2021 date for the Operational and Financial Plan 20/21 to be removed 		
FINANCE AND PERFORMANCE			
GB/Pu 20/11/14	INTEGRATED PERFORMANCE REPORT		
	<p>Performance</p> <p>The Chief Operating Officer updated the Governing Body on the latest performance against key performance indicators. The information provided continues to show the adverse impact of Covid 19 upon delivery of some NHS Constitutional standards. Governing Body noted the improvement in waiting times performance on the cancer pathways and that IAPT performance had improved although the access rate remains slightly below the target level.</p>		
	<p>Finance</p> <p>The Chief Finance Officer presented an update on the CCG's financial position and updates on financial reimbursements outstanding to 30 September 2020. The report provided details of all Covid-19 expenditure incurred and approved in line with the Governing Body delegation.</p> <p>The Chief Finance Officer highlighted that the outstanding top up required for Month 6 is £2.4m including £0.8m Covid expenditure and £1.6m non-Covid expenditure to allow the CCG to achieve a break even position. Confirmation and</p>		

Agenda Item		Action	Deadline
	<p>notification of the top up allocation is expected later in November 2020. There is however a potential risk to the CCG if the full amount is not received.</p> <p>Members noted the Covid Finance Update including costs reclaimed for September 2020 but not yet reimbursed and the Covid expenditure approved by the CCG Gold Command.</p>		
	<p>The Governing Body noted the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2020/21 • Finance update to Month 6 including Covid expenditure and expenditure approved at the CCG Gold Command in line with Governing Body delegation. 		
GB/Pu 20/11/15	FINANCIAL PLAN		
	<p>The Chief Finance Officer provided details on the CCG's Financial Plan to the Governing Body for approval. The significant unmitigated risk was highlighted, and the Governing Body was advised that there is no flexibility in the budgets. It was therefore emphasised that the CCG needed to do everything it could to deliver on its financial duties in the remainder of 2020/21 with identified efficiency plans delivering in line with targets agreed with each lead. The financial position will continue to be monitored and reported to the Governing Body.</p>		
	<p>The Governing Body noted the report and approved Appendix 1 as the budgets to be set for the CCG for Month 7-12 noting the further work to be undertaken across budgets.</p>		
COMMITTEE REPORTS AND MINUTES			
GB/Pu 20/11/16	COMMITTEE REPORTS AND MINUTES		
	<p>The Governing Body received and noted the following Committee minutes & assurance reports:</p> <ul style="list-style-type: none"> • Unadopted Minutes of the Audit Committee held on 14 October 2020 		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> Minutes of the Finance and Performance Committee held on 2 July 2020, 1 October 2020 and 15 October 2020. Assurance Report of the Primary Care Commissioning on 24 September 2020. <p>The Lay Member for Patient and Public Engagement & Primary Care Commissioning highlighted that the Chief Executive Officer, Barnsley Healthcare Federation had attended the September 2020 PCCC meeting to inform members of the support being extended into the primary care networks during the Covid Pandemic. A dedicated clinic called the blue clinic had been established at the Oaks Park Medical Centre, Kendray to treat those patients who had or were suspected of having Covid symptoms. Also, the ambitious plan to recruit 79 whole time equivalent staff covering a number of roles. The Governing Body noted the adopted minutes of the PCC Committee held on 30 January 2020, 28 May 2020 and 30 July 2020.</p> <p>At this point, the Chairman lost connection to the meeting. The Vice Chair, Lay Member for Patient and Public Engagement & Primary Care Commissioning chaired the meeting.</p> <ul style="list-style-type: none"> Minutes of the Quality and Patient Safety Committee held on 20 August 2020 Minutes of the Health and Wellbeing Board held on 8 October 2020. 		
GB/Pu 20/11/17	REPORTS CIRCULATED IN ADVANCE FOR NOTING		
	<p>The Governing Body noted the reports circulated in advance of the meeting:</p> <p>From the SYB Health Executive Group held on 8 September 2020</p> <ul style="list-style-type: none"> SYB ICS CEO Report (Enc B) Flu Planning Update (Enc B (i)) <p>From the SYB Health Executive Group held on 13 October 2020</p>		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> • SYB ICS CE Report (Enc C) 		
GB/Pu 20/11/18	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED		
	<p>The Governing Body agreed that the all papers were presented in a timely manner and the quality of papers received was good.</p> <p><i>Agreed action</i> <i>The Governing Body agreed that additional assurance is required around the Covid vaccination Programme.</i></p>	JW	
	<p>The Governing Body agreed to close the public session of the meeting and proceed to the private part of the agenda. The recording of the meeting was ceased.</p>		
GB/Pu 20/11/20	DATE AND TIME OF THE NEXT MEETING		
	Thursday 14 January 2021 at 09.30 am via Microsoft Teams		

**GOVERNING BODY
(Public session)**

**14 January 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 12 November 2020

Table 1

Minute ref	Issue	Action	Outcome/Action
GB/Pu 20/11/10	<p>COVID-19 RESPONSE AND PHASE 3 RECOVERY UPDATE</p> <p>To provide feedback on the Recovery and Reset Plan to The Director of Strategic Commissioning and Partnerships</p>	ALL	
GB/Pu 20/11/13	<p>RISK AND GOVERNANCE EXCEPTION REPORT</p> <p>To update the Governing Body work Plan & Agenda Timetable 2020/21 in line with comments received at the Governing Body meeting</p> <p>In the Finance and Performance Section</p> <ul style="list-style-type: none"> reference to budgets should be documented as 2021/22 Budgets and not 2020/21. November 2021 date for the Operational and Financial Plan 20/21 to be removed <p>Update the workplan to schedule routine assurance reports against the priority areas within the GBAF.</p>	RW & KM	Complete

GB/Pu 20/11/18	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED To provide Governing Body with additional assurance around the Covid vaccination Programme	JW	Complete – Information of the Vaccination Programme is included within the COVID Update on the 14 January 2021 agenda
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ITEMS FROM PREVIOUS MEETINGS CARRIED FORWARD TO FUTURE MEETINGS

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

Table 2

Minute Ref	Issue	Action	Outcome/Actions
GB 19/09/13	MENTAL HEALTH UPDATE To present local and South Yorkshire & Bassetlaw regional suicide prevention plans to a future meeting of the Governing Body or Developmental session.	PO	Rescheduled from 28 May 2020 to 29 October 2020. Update 12 November 2020 - Dr Mark Smith and the Head of Commissioning (Mental Health) to submit a report to the next meeting of the Governing Body on 14 January 2021 regarding suicide prevention plans / strategy and the bereavement / Mental health support services available in Barnsley. Complete - Included on the 14 January 2021 Governing Body agenda
GB 19/11/03	PATIENT STORY - YOUNG COMMISSIONERS, OASIS To consider how the voice of the young commissioners can be involved with the work of the CCG and Health and Wellbeing Board.	NB	IN PROGRESS - Under consideration Patient Council Member; considering introductions via

			her contacts.
GB 20/01/11	<p>BEREAVEMENT SERVICES</p> <p>To invite a local Authority representative to attend the Governing Body Development Session for discussion on the Bereavement support services in Barnsley.</p>	PO	<p>Rescheduled from 28 May 2020 to 29 October 2020.</p> <p>Dr Mark Smith and the Head of Commissioning (Mental Health) to submit a report to the next meeting of the Governing Body on 14 January 2021 regarding suicide prevention plans / strategy and the bereavement / Mental health support services available in Barnsley</p> <p>Complete - Included on the 14 January 2021 Governing Body agenda</p>
GB/Pu 20/09/10	<p>COVID-19 RESPONSE, RECOVERY & RESET</p> <p>To determine a named executive lead for Health Inequalities.</p>	NBa CE	<p>COMPLETE - the Medical Director is the named executive lead for Health Inequalities</p>

**GOVERNING BODY
Public Session**

14 January 2021

REPORT OF THE CHIEF OFFICER

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<table border="1"> <tr> <td><i>Decision</i></td> <td><input type="checkbox"/></td> <td><i>Approval</i></td> <td><input type="checkbox"/></td> <td><i>Assurance</i></td> <td><input type="checkbox"/></td> <td><i>Information</i></td> <td><input checked="" type="checkbox"/></td> </tr> </table>			<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>	
<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>					
2.	PURPOSE											
	<p>This report provides the Governing Body with information regarding the annual performance assessment of CCGs 2019/20 publication and the NHSE&I publication Integrating care Next steps to building strong and effective integrated care systems across England.</p>											
3.	REPORT OF											
		Name	Designation									
	Executive / Clinical Lead	Chris Edwards	Chief Officer									
	Author	Chris Edwards	Chief Officer									
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Membership Council</td> <td>09.12.2020</td> <td>To provide feedback on the NHSE&I proposals</td> </tr> <tr> <td>Governing Body Private session</td> <td>10.12.2020</td> <td>To provide feedback on the NHSE&I proposals</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Membership Council	09.12.2020	To provide feedback on the NHSE&I proposals	Governing Body Private session	10.12.2020	To provide feedback on the NHSE&I proposals
Group / Committee	Date	Outcome										
Membership Council	09.12.2020	To provide feedback on the NHSE&I proposals										
Governing Body Private session	10.12.2020	To provide feedback on the NHSE&I proposals										
5.	EXECUTIVE SUMMARY											
	<p>Annual performance assessment of CCGs 2019/20</p> <p>I am pleased to announce that Barnsley CCG has retained its 'Outstanding' rating as a CCG for a third year running. There are 191 CCGs in the country and Barnsley is 1 out of only 22 CCGs rated as outstanding.</p> <p>NHS England and Improvement assess all clinical commissioning groups across the country on how effectively they work with others to improve quality and</p>											

	<p>outcomes for local people. The rating takes into account things like the percentage of people treated, admitted or discharged from A&E within four hours, the percentage of people who receive timely treatment for cancer after being referred by their GP and the leadership and financial management of the CCG. The annual assessment is a judgement, reached by taking into account the CCG's performance over the full year and balanced against the financial management and assessment of the leadership of the CCG.</p> <p>Further information about the Annual Performance Assessment is available on the NHS and CCG websites</p> <p>Integrating care Next steps to building strong and effective integrated care systems across England</p> <p>NHS England & NHS Improvement have issued proposals for <i>Integrating Care: Next Steps to Building Strong & Effective Integrated Care Systems Across England</i>.</p> <p>The key objectives of the strategy are:</p> <ul style="list-style-type: none"> • Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care; • Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; • Developing strategic commissioning through systems with a focus on population health outcomes; • The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care. <p>The consultation time frame for the new proposals is short and views are invited by Friday 8 January 2021. It is intended that responses to the NHSE&I proposals will be co-ordinated across Barnsley Place and the South Yorkshire and Bassetlaw ICS footprint.</p>		
6.	THE GOVERNING BODY IS ASKED TO:		
	<ul style="list-style-type: none"> • Note the Report 		
7.	APPENDICES / LINKS TO FURTHER INFORMATION		
	<ul style="list-style-type: none"> • Appendix A –Integrating care Next steps to building strong and effective integrated care systems across England 		
<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">Agenda time allocation for report:</td> <td style="text-align: right;"><i>10 minutes</i></td> </tr> </table>		Agenda time allocation for report:	<i>10 minutes</i>
Agenda time allocation for report:	<i>10 minutes</i>		

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T) See 3.5
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2) See 3.6
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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



Integrating care

Next steps to building strong and effective integrated care systems across England

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Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take effect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan (2019)*, [*Breaking Down Barriers to Better Health and Care \(2019\)*](#) and *Designing ICSs in England (2019)*, and our [*recommendations to Government and Parliament for legislative change \(2019\)*](#).

1. Purpose

- 1.1. The NHS belongs to us all¹ and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.
- 1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.
- 1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:
 - improving population health and healthcare;
 - tackling unequal outcomes and access;
 - enhancing productivity and value for money; and
 - helping the NHS to support broader social and economic development.
- 1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.
- 1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.
- 1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

¹ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

- 1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.
- 1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.
- 1.9. This reflects three important observations, building on the *NHS Long Term Plan's* vision of health and care joined up locally around people's needs:
 - **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
 - **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
 - **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.
- 1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

Devolution of functions and resources



- 1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.
- 1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:
- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
 - **improvement and transformation resource** that can be used flexibly to address system priorities;
 - **operational delivery** arrangements that are based on collective accountability between partners;
 - **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
 - **emergency planning and response** to join up action at times of greatest need; and
 - the use of **digital and data** to drive system working and improved outcomes.

“Place”: an important building block for health and care integration



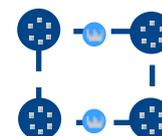
- 1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at ‘**place**.’
- 1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.
- 1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

- 2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.
- 2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:
 1. Provider collaboratives
 2. Place-based partnerships
 3. Clinical and professional leadership
 4. Governance and accountability
 5. Financial framework
 6. Data and digital
 7. Regulation and oversight
 8. How commissioning will change
- 2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

- 2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.
- 2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:
 - **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above ('vertical integration'); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

- 2.6. **All NHS provider trusts will be expected to be part of a provider collaborative.** These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.
- 2.7. This greater co-ordination between providers at scale can support:
- higher quality and more sustainable services;
 - reduction of unwarranted variation in clinical practice and outcomes;
 - reduction of health inequalities, with fair and equal access across sites;
 - better workforce planning; and
 - more effective use of resources, including clinical support and corporate services.
- 2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.
- 2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.
- 2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.
- 2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:
- deliver relevant programmes on behalf of all partners in the system;
 - agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a ‘triple aim’ duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a ‘one workforce’ strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

- 2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.
- 2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:
- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
 - to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
 - to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
 - to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.
- 2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.
- 2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

- 2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

- 2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.
- 2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

- 2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.
- 2.25. **Primary care clinical leadership** takes place through critical leadership roles including:
- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
 - Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and [NHS planning and contracting guidance for 2020/21](#), we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **‘place’ leadership** arrangements. These should consistently involve:
 - i. every locally determined ‘place’ in the system operating a partnership with joined-up decision-making arrangements for defined functions;
 - ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
 - iii. agreed joint decision-making arrangements with local government; and
 - iv. representation on the ICS board.

They may flexibly define:

- i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
 - ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
 - iii. the precise governance and decision-making arrangements that exist within each place; and
 - iv. their voting arrangements on the ICS board.
- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
 - i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
 - ii. provider collaboratives represented on the appropriate ICS board(s).

They may flexibly define:

- i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

- ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);
 - iii. the precise governance and decision-making arrangements that exist within each collaborative; and
 - iv. their voting arrangements on the ICS board.
- **individual organisation** accountability within the system governance framework. This will consistently involve:
 - i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and
 - ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

It may flexibly define:

- iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

- 2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.
- 2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.
- 2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.
- 2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

- 2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.
- 2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.
- 2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

- 2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.
- 2.40. That means that we will **create a 'single pot,'** which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.
- 2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

- 2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.
- 2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.
- 2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.
- 2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.
- 2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.
- 2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

- (1) build smart digital and data foundations
- (2) connect health and care services
- (3) use digital and data to transform care
- (4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan**. This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.
- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.
- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:
 - actionable insight for frontline teams;
 - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
 - system-wide workforce, finance, quality and performance planning;
 - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.
- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.
- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

- 2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.
- 2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.
- 2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.
- 2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

- 2.56. There are a further practical steps that we can take to support systems:
- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the “Well Led” assessment;
 - issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
 - ensuring foundation trust directors’ and governors’ duties to the public support system working.
- 2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an ‘integration index’ for use by all systems.
- 2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.
- 2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

- 2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.
- 2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority’s role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
 - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
 - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
 - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

- 2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.
- 2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.
- 2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.
- 2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

- 2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.
- 2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.
- 2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

- 2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.
- 2.72. The following principles will underpin the detailed development of the proposed arrangements:
- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.
 - ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.
 - ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'***. We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

- 3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012*) does not present a sufficiently firm foundation for system working.
- 3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill². These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.
- 3.3. Recommendations 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 remove 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 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 NHS bodies;
 - a new “**triple aim**” duty for all NHS organisations of ‘better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

- 3.4. These recommendations were strongly supported and backed across the health and social care sector³. We believe these proposals still stand.
- 3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.
- 3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.
- 3.7. Many respondents to our engagement and specifically Parliament’s Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.
- 3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory “clarity” for ICSs and the organisations within them. With an NHS Bill included in the last Queen’s Speech, we believe the opportunity is now to achieve clarity and establish a “future-proofed” legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.
- 3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

³ https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-_proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual 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.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

- 3.17. Furthermore, many may not consider this model to be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

- 3.18. In this option, ICSs would be established as NHS bodies partly by “re-purposing” CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.
- 3.19. 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 ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. 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.
- 3.20. The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.
- 3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.
- 3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. 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?

Q. 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?

Q. 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?

Q. 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?

4. Implications and next steps

- 4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.
- 4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.
- 4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.
- 4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:
 - managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
 - tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
 - using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

- 4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

- 4.6. This will be underpinned by a comprehensive support offer which includes:
- access to our national transformation programmes for outpatients and diagnostics;
 - support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
 - the data they need to drive improvement, accessed through the 'model health system';
 - the resources and guidance that they need to build improvement capability; and
 - assistance from our emergency and electivity intensive support teams (dependent on need).
- 4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then be able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.
- 4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.
- 4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.
- 4.10. The new operating environment will mean:
- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
 - the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
 - as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become 'thinner' as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

- 4.11. The 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. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.
- 4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.
- 4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.
- 4.14. ICSs need to be of sufficient size to carry out their 'at scale' activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.
- 4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.
- 4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.
- 4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

- 4.18. 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 and tackling population health.
- 4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.
- 4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.
- 4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.
- 4.22. Our commitment is:
- not to make significant changes to roles below the most senior leadership roles;
 - to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
 - offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

- 4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.
- 4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

- 4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:
- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
 - **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.
- 4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.
- 4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations.** These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.
- 4.28. Please submit your response to this address:
www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system
- 4.29. Alternatively you can also contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.
- 4.30. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

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GOVERNING BODY

14 January 2021

Covid-19 Response and Phase 3 Recovery update

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input checked="" type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input type="checkbox"/>				
2.	PURPOSE											
	<p>To provide Governing Body with an update in relation to the CCG response to the Coronavirus Disease (COVID19) pandemic and details of the reset plans developed by partners to support recovery in line with national and local priorities.</p> <p>At the Governing Body meeting on 12 November 2020, initial 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> <p>This paper also provides an update on the latest NHSE/I expectations as set out in letters published on 23 December 2020 – These letters are appended to the report.</p>											
3.	REPORT OF											
	<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 & 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										

4.	SUMMARY OF PREVIOUS GOVERNANCE						
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1" data-bbox="256 322 1474 434"> <thead> <tr> <th data-bbox="256 322 676 360">Group / Committee</th> <th data-bbox="676 322 959 360">Date</th> <th data-bbox="959 322 1474 360">Outcome</th> </tr> </thead> <tbody> <tr> <td data-bbox="256 360 676 434">Management Team</td> <td data-bbox="676 360 959 434">Weekly MT Call</td> <td data-bbox="959 360 1474 434">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					
5.	UPDATE REPORT						
5.1	<p>Introduction</p> <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 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 as cases rise there have been a number of national actions taken to try to control the spread. 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.</p> <p>Whilst it is important to recognise the continuing pressures across the health and care system as a result of sustained high levels of COVID19 related activity alongside the usual winter pressures, the CCG continues to work with local partners in Barnsley and across the South Yorkshire and Bassetlaw Integrated Care System to delivery against our local priorities and plans as described in the Barnsley COVID19 Reset Plan previously presented to Governing Body. This work will now also need to take account of the expectations set out in two letters published by NHSE/I on 23 December, the first on operational priorities for winter and 2021/22 and the second on COVID-19 Hospital discharge and recovery services. Further details are included in sections 5.3 and 5.4 of this report and copies of the letters are attached at appendix 1 and 2.</p>						
5.2	<p>Command, Control and Co-ordination Arrangements</p> <p>The command, control and co-ordination structures described to Governing Body on 30 April 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).</p> <p>Over the summer months there was a change in focus of some of these groups and the frequency adjusted to free up capacity to focus on ensuring that system and CCG priorities were delivered. This included the Barnsley wide groups being structured to ensure sufficient focus on both response and addressing issues arising and on delivering</p>						

	<p>the agreed priorities for stabilisation and recovery. During October this focus shifted towards response and ensuring the local health and care providers were able to meet the increasing demands on services. As the current rate of infection and numbers in hospital continue to rise there is an expectation that pressures across the health and care system will continue to increase and therefore the focus will continue to be on response to local pressures and responding to national expectations and requirements.</p> <p>The CCG command and control structure and clinical leadership arrangements also remain in place and in line with the above the CCG/Primary Care Silver Group will focus upon the resilience of the CCG and supporting the providers of commissioned services to maximise capacity, respond to increasing demand and manage winter pressures.</p>
5.3	<p>Operational priorities for winter and 2021/22</p> <p>On 23 December 2020, Amanda Pritchard – Chief Executive NHS Improvement and NHS Chief Operating Officer and Julian Kelly – NHS Chief Finance Officer wrote to all NHS organisations to set out the Operational priorities for the NHS for winter and 2021/22. As the NHS remains in a level 4, national incident, this letter provides direction to all organisations including commissioners and providers.</p> <p>The letter recognises the extraordinary year that was 2020, including the incredibly hard work by NHS staff to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and to restore non-urgent services that had to be paused. It sets out 3 key areas to ensure there is a collective view of critical actions for the remainder of this financial year and signal the areas that will be important in 2021/22:</p> <ul style="list-style-type: none"> • Managing the remainder of 2020/21 • Planning for 2020/21 • The 2021/22 Financial Framework <p><u>Managing the remainder of 2020/21</u></p> <p>In the context of the current surge in COVID19 infection rates and the new more transmissible variant of the virus, the challenge in managing the remainder of 2020/21 is significant and the task set out is five-fold:</p> <ol style="list-style-type: none"> A. Responding to COVID19 demand – mobilising surge capacity, utilising independent sector and other specialist capacity and maintaining rigorous infection prevention and control procedures. All systems are also expected to provide timely and equitable access to post-COVID assessment services. B. Pulling out all the stops to implement the COVID19 vaccination programme (Further information in section 5.5) C. Maximising capacity in all settings to treat non-COVID19 patients – maximising capacity in primary care by making full use of available funding including for the ‘Additional Roles Reimbursement Scheme, treating as many elective patients as possible and restoring services to as close to previous levels as possible and prioritising those who have been waiting longest, whilst maintaining cancer and urgent treatments. D. Responding to other emergency demand and managing winter pressures – focus on effective and timely safe discharge from hospital, completing flu vaccination programmes, continued development of NHS111 as the first point of triage for urgent care services and maximising community pathways for ambulance service

	<p>referrals or step up from other services.</p> <p>E. Supporting the health and wellbeing of our workforce – delivery of the priorities set out in local people plans.</p> <p><u>Planning for 2021/22</u></p> <p>Planning priorities for 2021/22 will be to continue to:</p> <ul style="list-style-type: none"> • Recover non-COVID services in a way that reduces variation in access and outcomes. • Strengthen delivery of local people plans. • Address the health inequalities that COVID19 has exposed. A key area of work will be to make further progress on reducing inequalities for people with learning disabilities or serious mental illness. • Accelerate the planned expansion of mental health services including enhanced crisis response. • Prioritise investment in primary and community care, continuing to focus on improving patient experience, increasing use of online consultations and expansion of capacity to increase GP appointments available. • Build on the development of effective partnership working at place and system level in line with plans set out in the integrated care consultation document referenced in the Chief Officers report to the Governing Body. <p><u>The 2021/22 financial framework</u></p> <p>The full financial settlement for the NHS will not be known until closer to the beginning of the new financial year once it is clearer what the impact of the vaccination programme is and what the additional direct costs of COVID19 response have been and are likely to be going forward. The letter however recognises the need to start work early to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:</p> <ul style="list-style-type: none"> • Revenue funding will be distributed at system level. Based on the CCG published allocations and the organisational Financial Recovery Fund each system would have been allocated in 2021/22. • Systems will need to calculate baseline contract values to align with these financial envelopes so there is a clear view of baseline financial flows. Guidance is expected to suggest that these be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes not on the nationally set 2020/21 block contracts. • System and organisational plans will be required for reducing COVID19 costs once we start to exit the pandemic. • System capital envelopes will be allocated on a similar national quantum and using similar distributional methodology to that introduced for 2020/21 capital planning.
<p>5.4</p>	<p>COVID-19 Hospital discharge and recovery services</p> <p>In addition to the letter described above, NHSE/I also wrote to NHS organisations to set out measures to support improvements in performance and oversight of the discharge to assess services across England with a request that the actions are prioritised by all systems. Three key areas are included:</p>

	<ol style="list-style-type: none"> 1. Using all available hospice capacity 2. Designated facilities for people who are COVID positive being discharged from hospital into a care home. 3. Strengthening leadership and oversight of discharge arrangements in acute hospitals. <p>To support the embedding of the 'home first' approach, seven actions have been identified that systems are asked to prioritise where they are not already in place. In Barnsley all of these have been implemented either prior to the COVID pandemic or as part of strengthening discharge to assess pathways over the last year.</p>
5.5	<p>COVID-19 Vaccination Programme</p> <p>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.</p> <p>At the same time the Joint Committee for Vaccination and Immunisation (JCVI) set out the priorities for roll out of the vaccine. The priority for the first phase of the vaccination programme is therefore for individuals over 80 years of age and over, care home residents and care home workers. To minimise wastage, vaccination sites have also been asked to ensure unfilled appointments are used to vaccinate healthcare workers.</p> <p>There are a number of elements to the vaccination programme, these include:</p> <ul style="list-style-type: none"> • Hospital Hubs • Large scale vaccination centres • PCN/Community Hubs • Roving vaccination teams (to vaccinate housebound, care home residents and other vulnerable groups) <p>CCG's were asked to work together at ICS level and to locally support General Practices, coming together in PCN groupings to establish the PCN community hubs at designated sites and the roving services. Hospital hubs and large scale vaccination sites are being developed and coordinated at an ICS level by a lead provider – Sheffield Teaching Hospital NHS Foundation Trust.</p> <p>The ambition of the national programme has meant that timescales for establishing arrangements and commencing vaccination have been extremely challenging however GP practices in Barnsley, coming together as one PCN have been able to meet this challenge with support from the CCG.</p> <p>In summary the timescales leading up to the first vaccine being administered in Barnsley to Herbert Barker on 15 December 2020.</p> <ul style="list-style-type: none"> • 9 November GP's asked to begin to prepare plans for the delivery of the vaccine in collaboration as PCN groupings – No detail of expected level of delivery in PC or when programme would commence. PC delivery to sit alongside regionally co-ordinated Hospital Hubs and large scale sites. • 17 November – Practices working as PCN's to submit proposed sites for vaccination with CCG's assuring the sites met set criteria by 19 November. Three Sites were proposed – Priory, Goldthorpe and Apollo Court (Dodworth) which would be able to deliver a minimum of 975 vaccines in 3.5 days

	<ul style="list-style-type: none"> • 24 November – Designated sites confirmed – For Barnsley all 3 sites were designated. • 1 December – Enhanced Service published and GP practices invited to sign up – All Barnsley practices have signed up. • 2 December – First Vaccine approved by MHRA. • 4 December – Confirmation that vaccination would be delivered in Primary Care through the designated sites from w/c 14 December 2020 with vaccine delivery for Wave 1 on 14 December, Wave 2 on 16 December, Wave 3 on 21 Dec and Wave 4 on 28 December – Barnsley had 1 site approved for wave 1 (Priory Campus) and 2 in wave 3 (Apollo Court and Goldthorpe LIFT) • 8 December – Letter re: Governance, Handling and Preparation of the vaccine • 10 Dec – Standard Operating Procedure for Vaccination in community hubs published. • 11-13 December – All kit and equipment delivered to wave 1 site. • 14 December – Vaccine arrived – must be used by 9am on 18 December. 15 December – Priory site go live – Facility all set up, 6 vaccination streams in place delivering initially 8.5 hours per day to ensure full usage of the 975 supply. • 21 December – Vaccine delivery to Wave 3 sites and commencement of delivery of vaccination on both sites in Barnsley. <p>Whilst there have been numerous challenges throughout the planning period, with support from local partners in Barnsley the Barnsley Primary Care Network was able to deliver approximately 3,000 first doses of the vaccination over a 2 week period to people aged 8 and over, care home staff and other health and care workers. This was the maximum number of vaccines available.</p> <p>On 30 December the MHRA confirmed approval of a second vaccine for use as part of the vaccination programme. With this good news also came a clear expectation that the vaccination programmes at each point of delivery would be stepped up to maximise delivery and ensure that people receive the vaccine as soon as possible with only supply being the limiting factor.</p> <p>On 31 December the next vaccine deliveries for community hub sites were confirmed with Wave 1 sites receiving vaccines from 4 January and Wave 3 sites receiving vaccines on 6 January. It is expected that supply will then become more regular and that vaccine will also be available to commence delivery in Care Homes and for housebound patients.</p>
6.	THE GOVERNING BODY IS ASKED TO:
	<ul style="list-style-type: none"> • Note the update provided in this paper including the progress in implementing the vaccination programme in Primary Care.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix 1 – Letter, Operational priorities for winter and 2021/22, 23 December 2020 • Appendix 2 - Letter COVID-19 Hospital Discharge and recovery services, 23 December 2020

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

1.	Links to Corporate Priorities, GBAF and Risk Register	
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):	
	1.1 Urgent & Emergency Care	✓
	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
2.	Links to statutory duties	
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):	
	Management of conflicts of interest (s14O)	
	Duty to promote the NHS Constitution (s14P)	✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	
	Duty as to improvement in quality of services (s14R)	
	Duty in relation to quality of primary medical services (s14S)	
	Duties as to reducing inequalities (s14T)	
	Duty to promote the involvement of each patient (s14U)	
	Duty as to patient choice (s14V)	
	Duty as to promoting integration (s14Z1)	
	Public involvement and consultation (s14Z2)	
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)	
3.1	Clinical Leadership	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	Y
	Proposals to be signed off by virtual Governing Body meeting	
3.2	Management of Conflicts of Interest (s14O)	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)	
	Have any financial implications been considered & discussed with the Finance Team?	NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	NA

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

To:

- STP and ICS Leaders
- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers
- GP practices and Primary Care Networks
- Providers of community health services
- NHS 111 providers

Skipton House
80 London Road
London
SE1 6LH

23 December 2020

CC:

- NHS Regional Directors
- Regional Incident Directors & Heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of adult social care
- Chairs of Local Resilience Forums

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

- A. Responding to Covid-19 demand
- B. Pulling out all the stops to implement the Covid-19 vaccination programme
- C. Maximising capacity in all settings to treat non-Covid-19 patients
- D. Responding to other emergency demand and managing winter pressures
- E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the [ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission](#).

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the [commissioning guidance](#).

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in [our letter of 14 December](#) there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing [£80m in new funding](#) to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's [letter](#), as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.
- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).
- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.
- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.
- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.
- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.
- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.
- Build on the development of effective **partnership working at place and system level**. Plans are set out in our [Integrating Care](#) document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,



Amanda Pritchard
Chief Executive, NHS Improvement and
NHS Chief Operating Officer



Julian Kelly
NHS Chief Financial Officer

Publications approval reference: 001599

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

To:

CEOs of NHS Trusts and Foundation Trusts
CEOs of Clinical Commissioning Groups
CEOs of Community Health Providers
CEOs of private, not-for-profit community
providers and community interest companies
Chief Executives of Councils

Cc:

NHS England and NHS Improvement Regional
Directors

23 December 2020

Dear colleague,

COVID-19 Hospital discharge and recovery services

This letter sets out measures to support improvements in the performance and oversight of the discharge to assess services across England. All systems are asked to prioritise these actions.

1. Using all available hospice capacity

Hospices have played an important part in the response to COVID-19. They provide vital care to patients of all ages through both inpatient and community provision.

The NHS should use all available hospice capacity, including re-purposing existing provision either in beds or home services, for both COVID and non-COVID patients. Hospices are required to submit data on their hospice beds and community capacity onto the National Capacity Tracker daily, including weekends and bank holidays, with non-compliance affecting funding.

Up to £125m extra funding has been made available for the period 1 November 2020 until 31 March 2021. Payments will be made by NHS England and NHS Improvement nationally, working with Hospice UK, on the basis of capacity used. CCGs should honour existing agreements and continue to pay any funding agreed with hospices – including business-as-usual and local agreements for COVID-19, both of which will be funded from resources already allocated to local systems.

2. Designated facilities for people who are COVID+ being discharged from hospital into a care home

Some systems have yet to agree designated care settings. Where that remains the case, we are asking local NHS leaders to engage with the Director of Adult Social Services (DASS) in the Local Authority and care provider organisations to explore whether NHS community hospital sites could provide a solution for that area. It would of course need to meet the infection prevention and control standards stipulated by the CQC.

To maintain existing capacity and support patient flow from acute hospitals, it is essential that local systems replace the number of beds that are used in NHS rehabilitation units for designation purposes with the comparable number of

rehabilitation beds commissioned from vacant units/beds in care homes. Therapists and other specialists would be transferred to work in the care home rehabilitation beds.

Where Council owned and operated care home beds are used as a designated facility, CCGs / LAs would commission the comparable number of beds in vacant care homes in the private sector.

The cost of the designated facilities would be met by the COVID discharge funding. Where this is not necessary because already commissioned beds are being used, the replacement care capacity commissioned can instead be charged to the COVID discharge fund.

3. Strengthening leadership and oversight of discharge arrangements in acute hospitals

[Systems that have fully implemented the 'home first' approach successfully](#) cite a range of factors that have helped their hospital and discharge teams with the discharge to assess approach. The seven actions below are key issues that each acute hospital and discharge system is asked to prioritise implementing, where they are not already in place.

Action
1. Clinical champions are identified in each trust to support the implementation of the discharge to assess approach.
2. As early as possible, daily ward rounds/reviews are undertaken, including the comprehensive use of the reasons to reside criteria.
3. Achieve 100% data completeness of discharge and daily patient information, by no later than 31 January 2021.
4. Instil the culture and processes of 'home first' ethos across hospital wards and discharge teams- fully implementing the hospital discharge guidance . This includes continuing to discharge people using 'without prejudice' funding arrangements between health and social care.
5. Maintain the Government policy on the choice of care home at the point of discharge.
6. Maximise the number of support packages of care and rehabilitation at home using the £588m COVID discharge funding.
7. Set improvement targets (from November baseline) for each acute hospital site: <ul style="list-style-type: none">➤ for 14+ and 21+ length of stay categories;➤ % of people not meeting the 'reasons to reside criteria', discharged each day by 5pm

The actions above will be overseen by leads at a system and regional level, who will support discharge systems to learn from and adopt best practice approaches over the remainder of the winter period.

Yours faithfully



Matthew Winn
NHS England and NHS Improvement



Dr Cliff Mann
NHS England and NHS Improvement

GOVERNING BODY

14 January 2021

Home First - A New Model for Intermediate Care

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR																	
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>															
		<input checked="" type="checkbox"/>	<i>Assurance</i>															
		<input type="checkbox"/>	<i>Information</i>															
	<input type="checkbox"/>		<input type="checkbox"/>															
2.	PURPOSE																	
	<p>NHS Barnsley CCG, together with partners, is proposing a new model for intermediate care to be implemented from 1 June 2021. This paper discusses the development of the new model and asks for Governing Body approval of the model and service specifications.</p>																	
3.	REPORT OF																	
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Jayne Sivakumar</td> <td>Chief Nurse</td> </tr> <tr> <td>Author</td> <td>Jayne Sivakumar Lucy Hinchliffe</td> <td>Chief Nurse Commissioning and Transformation Manager</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse	Author	Jayne Sivakumar Lucy Hinchliffe	Chief Nurse Commissioning and Transformation Manager						
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Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse																
Author	Jayne Sivakumar Lucy Hinchliffe	Chief Nurse Commissioning and Transformation Manager																
4.	SUMMARY OF PREVIOUS GOVERNANCE																	
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Management Team</td> <td>09/09/20</td> <td>Model approved in principle</td> </tr> <tr> <td>Clinical Forum</td> <td>01/10/20</td> <td>Model approved in principle and review of overarching specification</td> </tr> <tr> <td>Management Team</td> <td>13/11/20</td> <td>Timescales noted</td> </tr> <tr> <td>Clinical Forum</td> <td>03/12/20</td> <td>Medical oversight element noted and review of specification. Review of Discharge to Assess (D2A) pathways.</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Management Team	09/09/20	Model approved in principle	Clinical Forum	01/10/20	Model approved in principle and review of overarching specification	Management Team	13/11/20	Timescales noted	Clinical Forum	03/12/20	Medical oversight element noted and review of specification. Review of Discharge to Assess (D2A) pathways.
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5.	EXECUTIVE SUMMARY
	<p>This paper provides an overview of the work that NHS Barnsley Clinical Commissioning Group (CCG) and local partners have undertaken in relation to intermediate care services across Barnsley. The paper asks Governing Body to approve a new model which is a re-provisioning of services to be delivered within current resources focussing on care delivered at home first.</p>
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:
	<ul style="list-style-type: none"> • Approve the new ‘home first’ model for intermediate care. • Approve Service Specification 1 – Overarching Intermediate Care • Approve Service Specification 2 – For the 30 bedded unit • Approve Service Specification 3 – GP Medical Oversight • Approve the pathways for Discharge to Assess
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix A – Model overview • Appendix B – Service Specification 1 – Overarching Intermediate Care • Appendix C – Service Specification 2 – For the 30 bedded unit • Appendix D – Service Specification 3 – GP Medical Oversight • Appendix E – Project Timescales • Appendix F – Discharge to Assess • Appendix G – Briefing note for OSC and Healthwatch

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

1.	Links to Corporate Priorities, GBAF and Risk Register			
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):			
	1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	
	2.1 Primary Care		7.1 Transforming Care for people with LD	
	3.1 Cancer		8.1 Maternity	
	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>	
2.	Links to statutory duties			
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):			
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T)	See 3.5
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V)	
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1)	
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2)	See 3.6
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			Y
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
3.2	Management of Conflicts of Interest (s14O)			
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?			Y
3.3	Discharging functions effectively, efficiently, & economically (s14Q)			
	Have any financial implications been considered & discussed with the Finance Team?			Y
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?			Y

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

PART 2 – DETAILED REPORT

1.	INTRODUCTION/ BACKGROUND INFORMATION
	<p>1.1 Background</p> <p>Intermediate care services provide support for a short period of time to help people recover and increase their independence. It is a form of active rehabilitation supporting people to:</p> <ul style="list-style-type: none"> • Remain at home when they start to find things more difficult • Recover after a fall, an acute illness or an operation • Reduce the risk of admission • Decrease the length of a hospital stay • Reduce the risk of a readmission • Reduce the risk of admission to a care home. <p>Based on a person’s current health, abilities and wishes, they agree and work towards personal goals. The person is supported by staff trained to maximise their mobility and observe, encourage and guide, so the person can do things themselves, rather than to intervene or carry out tasks for them.</p> <p>There are four types of Intermediate Care Services in Barnsley. These are:</p> <ul style="list-style-type: none"> • <u>Reablement</u> - commissioned and provided by Barnsley Council and funded through the Better Care Fund. • <u>Home based</u> - commissioned by NHS Barnsley Clinical Commissioning Group (CCG) and provided by the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). The team is called the Neighbourhood Rehabilitation Service (NRS). • <u>Bed based</u> - commissioned by NHS Barnsley CCG and provided in two care homes with GP medical oversight provided by Barnsley Healthcare Federation. This includes the Acorn Unit, where BHNFT provide nursing and therapy. The bed base has is in-reach from the NRS. • <u>Crisis response</u> - commissioned by NHS Barnsley CCG and provided by SWYPFT. The team is called the Crisis Response Team. <p>For the CCG commissioned services, care is co-ordinated by the RightCare Barnsley team. Their job is to work with the patient, carer and healthcare professionals involved to determine what level of support someone may need and therefore which service is best for them at that time.</p> <p>As the list above suggests, intermediate care is something that involves all health and social care organisations working in Barnsley and is a key part of supporting patients as they go into and come out of hospital to make sure that patients receive the right care, at the right time, in the right place.</p> <p>1.2 Proposals for the new model – home first</p> <p>Together with partners, NHS Barnsley CCG is proposing to redevelop how intermediate care services are delivered. These partners include: Barnsley Council, Barnsley Hospital NHS Foundation Trust, Barnsley Healthcare</p>

Federation and South West Yorkshire Partnership NHS Foundation Trust. A review of intermediate care services came about in February 2020 however the progression of proposals was paused during the first wave of the coronavirus pandemic to enable focus on response. The opportunity to review the current provision came about as the contracts for the intermediate care bed bases within the independent sector were due to expire on 31/03/21. These contracts have been extended to 31/05/21 to alleviate pressure on the health and social care system. The contracts cannot be extended beyond this date.

Intermediate care services can currently support 120 people at any one time:

- 70 people who are in their own homes (including those people who reside full time in a care home)
- 50 people who are having a stay in a care home for rehabilitation. Currently, two care homes sites are used for this.

The proposed changes are that the service supports the same number of people but more in their normal place of residence (their home) and fewer in an intermediate care facility. The changes are proposed to come into effect at the earliest possible opportunity, with procurement timescales and contract dates; this would be 1 June 2021.

The proposal is that local services would still be able to support a minimum of 120 people across the pathway at any one time with a re-provisioning of the current model:

- Minimum of 90 in people's own homes
- 30 people who are having a stay in a care home for rehabilitation. The proposal is that one care home site would be used for this and this would become a specialist unit. This would mean that those people who reside within a care home, requiring additional levels of support, they would still move into the specialist unit if their condition requires this as would anyone else still living within their own home.

The proposed changes would mean that overall the same number of patients (or more) would be supported. The services would be resourced in a different way and be re-provisioned so that more resource is put into delivering care in people's home.

Over the pandemic there have been changes to the bed base, including the number of sites reducing from four to two. This includes the Acorn Unit moving out of Barnsley Hospital to the Buckingham Care Home so that the ward could be used for critical care. Currently the intermediate care facility is provided over two sites across Barnsley by carers in care homes with input from nurses, therapists and other healthcare professionals. It is proposed that in the new model, care in the bed base would be delivered by NHS staff (nurses and therapists) with input from other healthcare professionals. It is hoped that this would provide better outcomes for patients requiring intermediate care. These nurses and therapists would be from the Acorn Unit, which is a current intermediate care facility. The Acorn Unit was originally based in the hospital but had to be relocated during the pandemic. This unit would become a specialist intermediate care facility to care for these patients.

1.3 Number of patients who use the current pathways

Reviewing data from the 2019/20 financial year intermediate care services receive around 3,000 referrals per year however this includes referrals between the different intermediate care teams for the same patient, for the same episode of care. The number of individual patients who access the service is a maximum of 1,500 per year. Due to the nature of intermediate care, people who access the services can often be older people or people who are frail.

1.4 Development of the new model

In developing the proposed new model for intermediate care the following has been considered.

Reviewing national best practice - National best practice has been reviewed, in this case learning from other areas including the Newcastle Gateshead CCG vanguard for intermediate care, to help inform proposals for a future model. Newcastle Gateshead CCG has implemented a 'home first' model meaning that the resource is focussed in home based teams and the bed based was reduced. Health and social care professionals, patients and carers have fed back that this model is working well.

Reviewing the clinical needs of those who currently access the services - There is confidence that the new model is fit for patients clinically having reviewed clinical thresholds and health needs for past and present service users.

Reviewing what health and social care professionals have told us - The proposals have been reviewed by a number of clinicians so far, and there is broad support for the changes outlined. This includes input from the CCG's Clinical Forum and Management Team.

Reviewing what patients and the public have told us - As part of this work, we have reviewed what people have told us about healthcare services relevant to intermediate care. This is detailed in the section 3.6 Public Involvement & Consultation (s14Z2). In addition to the existing patient and public feedback already gathered, we will adopt the approach of mobilising the project and building in as a key component of an outcomes based service specification, a dedicated and defined process to scrutinise and review the changes on a regular basis from a patient and carer experience perspective. This will enable us to truly understand how it feels for the people who are in receipt of intermediate care services and the family members and carers who are supporting them and enable services to flex and adapt where required. The proposal is to mobilise the patient experience data capture as soon as practically possible so this data can begin to be obtained and to influence service delivery without delaying the implementation of the new model. In December 2020 this approach was reviewed and signed off by the Barnsley Overview and Scrutiny Committee and Healthwatch Barnsley.

From these different points, it is felt that the proposed 'home first' model is

	appropriate in terms of best outcomes for patient care and overall is something that is supported. The engagement and ongoing collection of patient experience data will add to collective understanding.
2.	DISCUSSION / ISSUES
	<p>2.1 Service specifications for the different pillars</p> <p>Three service specifications have been developed for the new model. An overview of the model can be found at Appendix A.</p> <p><u>Service Specification 1 – Overarching Intermediate Care</u></p> <p>The overarching specification is a refresh of the current service specification to highlight the changes to the model and is up to date in terms of local and national developments such as Primary Care Networks and Neighbourhood Teams. The specification includes the new approach to engagement and can be found in full at Appendix B.</p> <p><u>Service Specification 2 – For the 30 bedded unit</u></p> <p>For the last three years the intermediate care bed base has been provided across a number of sites. It is felt that one site would be more efficient in terms of staff time and resource. One site would also mean one way of working e.g. policies/procedures and would enable the unit to focus completely on rehabilitation and become a centre of excellence. It is therefore proposed that all the intermediate care beds (independent sector beds and the Acorn Unit) are situated on one site in the new model. In order to check if this is feasible, a market testing exercise commenced in September 2020. This identified 7 providers, 5 with Barnsley bases, who articulated interest in this opportunity. The specification for the bed base has been developed with partners and can be found in full at Appendix C.</p> <p>As BMBC would hold the contract for this element, it would be transferred to BMBC documentation and the CCG would work with BMBC to procure this element.</p> <p><u>Service Specification 3 – GP Medical Oversight</u></p> <p>Potential options for medical oversight of the 30 bedded unit were identified in an October paper to the CCG Clinical Forum. This included the review of the Enhanced Health in Care Homes (EHCH) specification and consideration of the broader intermediate care pathway including clinical pharmacists currently aligned to GP practices. However upon review it is felt that none of these options were robust enough as single options and a primary care medical oversight offer is required to meet the medical needs of these patients.</p> <p>The new 30 bedded unit will be staffed by nurses and therapists and will be Care Quality Commission (CQC) registered with BHNFT. This will bring benefits of having nurses on site for safer staffing purposes and although there are nurses on site it is felt that a daily GP ward round would be required; with on call provision including out of hours. The current provision (40 hours for 50</p>

beds over two sites) would be reduced to cater for the proposed 30 bedded unit.

The CCG's Medicine Management Team have started a pilot of community pharmacy support to intermediate care for November to mid-December to ease pressure on the system as medicine management can help to re-able patients from a medication perspective, reducing pressures on the system both in terms of support workers and therapists and readmissions in to hospital and to reduce drugs costs.

This pilot will be evaluated by the end of January 2021 in order to inform the medical input model going forward and the efficiencies this would make in the place base system in terms of medication usage, admission and readmissions to hospital. Early indications from the pilot is felt to have been a success and this element would be included in the new model.

Procurement was considered for the medical oversight element however the GP practice providing the oversight would continue to temporarily register patients at their practice and as so, it is felt that a Barnsley practice is required in terms of ease of access of the patient records and minimising any hurdles in the way of patient care. On these grounds of quality the plan is to request expressions of interest / quotes from Barnsley GP practices only for this service. This is due to take place in early 2021.

The current contract for GP medical oversight with Barnsley Healthcare Federation is due to cease on 31/03/21 so the new practice would work in the current model for 8 weeks (from 01/04/21 – 31/05/21) and then work in the new model from 01/06/21.

The specification can be found at Appendix D.

2.2 Timescales

Timescales are being worked up in partnership with BMBC joint commissioning and procurement teams and can be found at Appendix E.

To support system flow through the 20/21 winter period, the existing model and bed base will stay the same for the rest of the year with the continued ability to spot purchase beds as required.

2.3 Interdependencies and considerations

As intermediate care supports patients who are often frail and/or elderly and is therefore a service that intersects with the whole healthcare system including acute admissions/discharges, primary care and community there are a number of interdependencies to consider for this review.

Reablement

During summer 2020, it was acknowledged that working practices and clinical pathways between reablement and home-based elements required refinement to integrate the teams and deliver a more intensive team approach to provide

	<p>better outcomes so partners worked together to refine processes and the teams are working in a more integrated manner. There is a commitment from each organisation and individual colleagues involved that the ethos of partnership working will continue beyond the service launch date, so if any issues arise relating to service referrals / seamless delivery, these can be resolved quickly, as per this example.</p> <p><u>Discharge to Assess (D2A)</u></p> <p>The Discharge and Out of Hospital Group is leading on the Discharge to Assess modelling which aims to ensure that assessment for longer-term care and support needs is undertaken in the most appropriate setting and at the right time for the person. By having RightCare Barnsley as the co-ordinator for both (D2A and intermediate care) then continuity between both services/processes will be linked. More information relating to D2A can be found at Appendix F. Governing Body is asked to sign off the D2A pathways and to note that no CCG financial contributions are expected toward D2A as funding will be provided from within existing secondary care and community contracts on a recurrent basis..</p> <p><u>Neighbourhood Teams and MDT working</u></p> <p>The home based and crisis response elements of the service are Neighbourhood Team phase 1 services. The Neighbourhood Team mobilisation was paused due to the COVID-19 pandemic and steps are now being taken to re-start this work. By nature of the patients who require intermediate care, multi-professional care including MDTs is considered best practice.</p>
3.	DELIVERY OF STATUTORY AND GOOD GOVERNANCE REQUIREMENTS
3.1	<p>Clinical Leadership</p> <p>The CCG's Chief Nurse has provided Clinical Leadership to the project; the Chief Nurse has worked closely with intermediate care services and providers for a number of years.</p> <p>The project team has included senior clinicians from SWYPFT and BHNFT with input from clinicians at Barnsley Healthcare Federation and Yorkshire Ambulance Service.</p> <p>The model has had input from Governing Body GP Clinical Lead for Frailty and the GPs at the CCG's Clinical Forum on 01/10/20 and 03/12/20.</p>
3.2	<p>Management of Conflicts of Interest (s140)</p> <p>As the 30 bedded unit is due to be procured, conflict of interests has been managed in partnership with BHNFT. This included a market engagement exercise.</p> <p>Conflicts of interests for the GP medical oversight element will be managed so as not to give any potential provider an advantage.</p>

3.3	<p>Discharging functions effectively, efficiently, & economically (s14Q)</p> <p>The new intermediate care model of provision is expected to be costed within or below the current financial envelope of £7,592,721 per annum, final costs cannot be determined until all procurements have been undertaken but expenditure will be capped to within the current envelope.</p> <p>In terms of contract length, the new model would commence on 1 June 2021 for 3 years. There is a potential extension of 2 years; any decision to extend the contract would be taken to Governing Body for review prior to the end of the 3 year term; the provider would require 6 months' notice on any contract extension/termination so this would be winter 2023.</p>
3.4	<p>Improving quality (s14R, s14S)</p> <p>A Quality Impact Assessment (QIA) has been completed and discussed by:</p> <ul style="list-style-type: none"> • Chief Nurse of NHS Barnsley CCG • Director of Nursing and Quality of BHNFT • Director of Nursing and Quality and Deputy Chief Executive of SWYPFT <p>This has identified a number of quality benefits and two mitigated issues; and is available upon request.</p>
3.5	<p>Reducing inequalities (s14T)</p> <p>Potential issues with inequalities are identified in the Equality Impact Assessment which is available upon request. It has been anticipated that the principle of delivering care in people's homes could have an impact on people in a number of ways, including adaptations and equipment in homes, expectation of carers' role and support, fuel poverty, nutrition and isolation especially for those with no immediate family or support.</p> <p>As intermediate care services already deliver care in people's homes, the Neighbourhood Rehabilitation Team and Reablement Teams are experienced in offering support to people who do not have family support and linking patients with any relevant teams such as Warm Homes Team, Equipment and adaptations, social prescribing, and carer and family support services in Barnsley. If the teams became aware of any impacts on these services this would be reviewed from by the partnership. By taking the approach of ongoing engagement, it is hoped that any issues, such as impacts on services or family members and carers, are picked up and addressed. With the proposed model, there would be more NHS staff (in the community element) though final numbers have not yet been confirmed.</p>
3.6	<p>Public Involvement & Consultation (s14Z2)</p> <p>A s14Z2 form has been completed and is available upon request. The approach to public involvement is summarised below. A briefing was provided to the Barnsley Overview and Scrutiny Committee (OSC) and Healthwatch Barnsley on 18/11/20.</p> <p>On 01/12/20 OSC confirmed they were happy with the proposals for</p>

engagement in relation to the intermediate care work and on 08/12/20 Healthwatch confirmed the approach. A summary of the information provided is included below. The full briefing can be found at Appendix G.

From review of current available information, it is known that:

- Patients and carers feel supported and like the current service provision.
- The broad principle of receiving care closer to home has been supported by people in Barnsley through the feedback we have received to previous engagement work
- Health and social care professionals we have spoken to so far including GPs, nurses and carers support the proposals for the new model for intermediate care.

The CCG sought advice from The Consultation Institute on 30/10/20 in order to discuss the potential scale of communications and engagement activity required. Based on information and feedback already received through prior engagement it was felt that a suitable and proportionate approach to take in this instance would ideally be to plan and undertake a period of targeted engagement with people who have directly accessed or who are accessing the services outlined above and their carers or family members as well as obtaining the views of staff working across health and social care.

Following this conversation, the partner organisations met to discuss how the above could realistically and meaningfully be carried out and achieved at the current time and within the current climate without this feeling tokenistic towards capturing patient views and feedback and crucially without placing additional stress on front line staff to allow them to focus on delivering care. It is acknowledged that the patient cohort in relation to intermediate care tends to be mainly older people and vulnerable residents and again due to the current constraints around social distancing and infection prevention and control, being able to gain access to speak with the right people in order to obtain their views at the current time would need to be through front line staff who are already being asked to take on additional duties, roles and responsibilities and make adjustments where necessary just to keep local services functioning at this critical time.

In view of the above constraints and alongside the need to work at pace in order to ensure that local services can flex and meet the current demands required to support some of the most vulnerable members of our local communities in addition to the existing patient and public feedback already gathered, the proposal was to adopt the approach of mobilising the project and building in as a key component of an outcomes based service specification, a dedicated and defined process to scrutinise and review the changes on a regular basis from a patient and carer experience perspective. This will enable us to truly understand how it feels for the people who are in receipt of intermediate care services and the family members and carers who are supporting them and enable services to flex and adapt where required. The proposal is to mobilise the patient experience data capture as soon as practically possible so this data can begin to be obtained and to influence service delivery (noting the constraints listed above) without delaying the implementation of the new model.

All supporting communications, engagement and experience activity will be

	coordinated in partnership with those who provide the current services: South West Yorkshire Partnership NHS Foundation Trust (SWYPFT); Barnsley Hospitals NHS Foundation Trust (BHNFT); Barnsley Council and Barnsley Healthcare Federation.
3.7	<p>Data Protection and Data Security (GDPR, DPA 2018)</p> <p>A full Privacy Impact Assessment will be worked through when the new provider is known – though no issues are anticipated.</p>
3.8	<p>Procurement considerations</p> <p>Procurement will take place for the 30 bedded unit and the exercise will be completed by BMBC's Procurement Team. The CCG are working closely with the Head of Joint Commissioning on this exercise.</p> <p>Procurement was considered for the medical oversight element however the GP practice providing the oversight would continue to temporarily register patients at their practice and as so, it is felt that a Barnsley practice is required in terms of ease of access of the patient records and minimising any hurdles in the way of patient care. On these grounds of quality the plan is to request expressions of interest / quotes from Barnsley GP practices only for this service. This is due to take place in early 2021. It is proposed that the medical oversight outcome will be delegated to the CCG Primary Care Commissioning Committee (PCCC) to avoid any potential conflicts of interest.</p>
3.9	<p>Human Resources</p> <p>HR processes would apply to the nurses and therapists working in the Acorn Unit and the CCG are working with BHNFT regarding this.</p>
3.10	<p>Environmental Sustainability</p> <p>N/A</p>
4.	RISKS TO THE CLINICAL COMMISSIONING GROUP
	<p>Risk 1 – Capacity to deliver</p> <p>Providers and the local authority have flagged a risk that care home providers may not have the capacity to respond to the procurement due to resource and capacity being focussed on the coronavirus response and winter pressures. This may result in no responses being submitted or may impact on the quality of responses.</p> <p>In addition, providers and the local authority have flagged a risk that providers may not have capacity to mobilise the new services due to resource and capacity being focussed on the coronavirus response and winter pressures. This may result in delays to the service launch date or impact on the quality of the new service. To mitigate these risks, the timescales for the project have been extended for a 1 June 2021 start date. The contracts cannot be extended beyond this date.</p>

	<p>Risk 2 – no bids are received for the procurement (30 bedded unit) The service may not be attractive to potential providers and no bids may be received. The soft market test has mitigated this by identifying potential providers: 7 in total, 5 who have sites local to (within) Barnsley. There is a further risk that the financial model means that no bids are received. The proposed mitigation is to include financial parameters as part of the procurement and to review this regularly.</p> <p>Risk 3 – no interest is received for the GP medical oversight The service may not be attractive to potential providers and no bids may be received.</p> <p>Risk 4 – Staffing for the intermediate care facility There is a risk that therapists and nurses will not wish to be based in the community and issues will be encountered in staffing the intermediate care facility. This is mitigated by the unit having links and CQC registration with BHNFT therefore providing support for staff working there.</p>
5.	CONCLUSIONS & RECOMMENDATIONS
	<p>In conclusion this paper summarises the work completed by local health and social care partners in Barnsley to review and re-model intermediate care services.</p> <p>The new model is a re-provisioning of current services and aims to provide best outcomes for Barnsley patients and best use of the Barnsley pound. The new model aims to configure intermediate care pathways to support people to receive the right care, at the right time, in the right place.</p> <p>Noting constraints with engagement, the service specifications will be outcome based and ongoing feedback from patients and their carers and family members will shape service delivery throughout the lifetime of the contract.</p> <p>To enable the new model to go live on 1 June 2021, it is recommended that Governing Body:</p> <ul style="list-style-type: none"> • Approve the new 'home first' model for intermediate care. • Approve Service Specification 1 – Overarching Intermediate Care • Approve Service Specification 2 – For the 30 bedded unit • Approve Service Specification 3 – GP Medical Oversight • Approve the pathways for Discharge to Assess noting this will be contained with current existing resources within providers.
6.	APPENDICES TO THE REPORT
	<ul style="list-style-type: none"> • Appendix A – Model overview • Appendix B – Service Specification 1 – Overarching Intermediate Care • Appendix C – Service Specification 2 – For the 30 bedded unit • Appendix D – Service Specification 3 – GP Medical Oversight • Appendix E – Project Timescales

	<ul style="list-style-type: none">• Appendix F – Discharge to Assess• Appendix G – Briefing note for OSC and Healthwatch
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Intermediate Care Model

Hospital - Discharge to Assess (Step Down)

Pathway 1

Up to 45% of patients are expected to be discharged from hospital on this pathway

Pathway 2

Up to 4% of patients to be discharged on this pathway

Pathway 3

Up to 1% will be discharged from hospital on a long term placement in to a Care home

Four Pillars of Intermediate Care

Co-ordinated by a Single Point of Access (SPA) RightCare Barnsley

Pillar 1

Reablement

Provided by BMBC.

Patient supported in their own homes.

Integrated aims and working practices with home based.

Pillar 2

Home based

Expected length of stay up to 3 weeks.

Up to 130 beds across the pathway

Provided by the Neighbourhood Rehabilitation service (part of Neighbourhood Teams)

Integrated aims and working practices with reablement.

Pillar 3

Bed Based

Expected length of stay up to 6 weeks.

30 bedded unit, catering for people with more complex needs.

Unit run and supported by nurses and therapists from the acute hospital.

Medical oversight TBC.

Pillar 4

Crisis Response (24/7)

Expected length of stay 48 hours

Immediate intervention (within 2 hours) of referral.

Provided by the Crisis team (part of Neighbourhood Teams).

Step up from community

To follow the same pathways as Discharge to Assess in the community.

Service Specification Home First – Intermediate Care in Barnsley

Service Specification No.	IMC/20
Service	Intermediate Care – A ‘Home First’ Model
Commissioner Lead	Jayne Sivakumar – Chief Nurse
Provider Lead	
Period	3 years (with potential for 2 year extension)
Date of Review	December 2023

1. Population Needs
<p>National/local context and evidence base</p> <p>1.1 National Context</p> <p>Over the next five years all parts of the country will be asked to increase the capacity and responsiveness of community and intermediate care services to those who are clinically judged to benefit most. This includes improved responsiveness of community health crisis response teams to deliver services within two hours of referral in line with NICE guidelines where clinically appropriate and delivering reablement care within two days of referral to those patients who need it. Preventing unnecessary admission to hospitals and residential care, as well as ensure a timely transfer from hospital to community (NHS Long Term Plan, 2019).</p> <p>In 2020, changes to the process for patients to be discharged from hospital was published in the form of guidance ‘COVID-19 Hospital Discharge Service Requirements’ advising all acute and community hospitals to discharge patients as soon as they are clinically safe to do so utilising a Discharge to Assess model and four patient discharge pathways. For the avoidance of doubt patients being discharged to assess on pathways 1-3 will be included as interdependency in the service specification.</p> <p>Collaboration with other services and sectors beyond the NHS is the key to deliver on the broader aim of improving population health and wellbeing – not just on delivering better quality and more sustainable health care services.</p> <p>1.2 Local Context</p> <p>Closer integration between health and social care is a fundamental part of both national policy and of local strategy and is essential for population health management. The NHS Long Term Plan (2019) sets out a clear vision for closer working between NHS organisations, social services and the wider health and care system.</p> <p>Whilst there has been significant progress with health and care integration locally there is a need to accelerate the pace of change. There is growing pressure on budgets.</p>

Growth in activity, particularly non-elective hospital admissions, and cost will outstrip growth in funding unless we deliver sustainable service transformation.

We want to create a system for health where governance and accountabilities, contracts and finances, services and pathways, workforce, IT, estates and engagement and involvement are all focused on achieving better health outcomes for local people.

Our Vision

The future of health and care in Barnsley is to create an integrated joined up health and care system. A system where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other across services regardless of where they are seen, be that in hospital, in the community or at home.

Patients and their families are supported and empowered by what feels like "one team", each delivering their part without duplication. Our goal is to dismantle boundaries at the point of delivery of care.

The creation of a simpler, integrated health and care system would support a shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance.

The aspiration would be for the "one team" to be considered to include Social Care and Voluntary Services.

Holistic care and support

Health and care services in Barnsley will offer holistic care and support providing parity of esteem which is fundamental to our approach to integrated health and care services. Health and care staff will have strengths based care and support planning conversations that seek to address a whole person's life including co-morbidities and other risk factors, rather than just assessing a narrow set of needs.

Holistic care and support aims to maximise choice and control and make positive changes in people's lives, in terms of wellbeing, resilience, independence and connections to others. These factors are not only as important to people as physical health needs, they can also improve their ability to self-care.

Neighbourhood service model

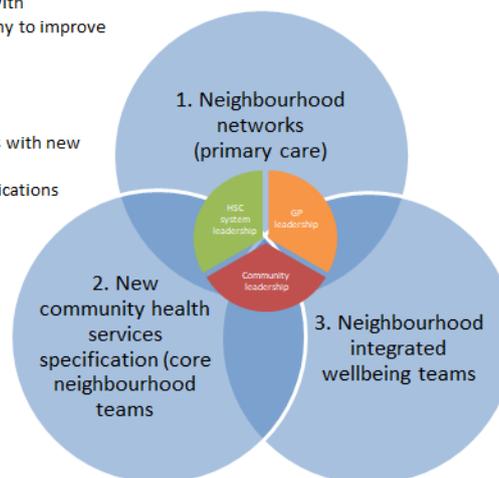
In Barnsley we have been working together to develop a neighbourhood model of service delivery that aligns to the six area geographies in Barnsley. There are three complimentary programmes of work focussed on neighbourhood development -

1. Groups of GP practices working together and with community services at a neighbourhood geography to improve local healthcare services –

- Sharing practice and service improvement
- Providing primary care at scale
- Improving access to primary care
- Developing extended general practice teams with new roles
- Delivering seven new national service specifications

2. Core teams of community nurses and allied health professionals working with GPs and practice teams to provide joined up services for people with complex needs, at risk of crisis or to facilitate discharge from secondary care -

- Shared leadership and management across primary and community care
- Risk stratification
- Single assessment and multi-disciplinary care planning processes
- Case management and care coordination
- Support for self-management



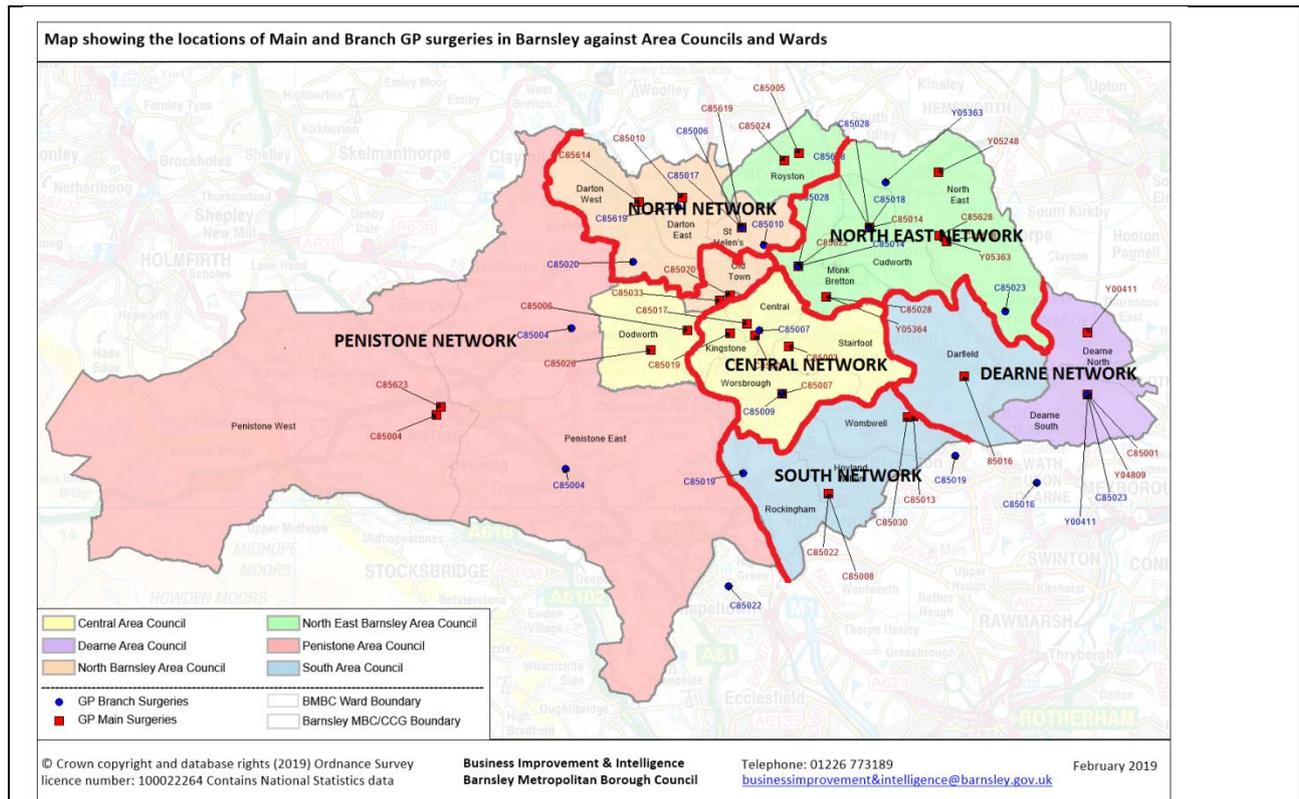
3. Networks health and care staff and wider system stakeholders working together to improve the health and wellbeing of the local population –

- Strengths based approach - mapping assets across neighbourhoods
- Community engagement and co-production
- Determining local priorities and actions
- Neighbourhood needs assessment using an integrated dataset and appreciative enquiry
- Enabling different organisations to collaborate and make decisions about neighbourhoods, with local people, in their communities

Barnsley Primary Care Network (PCN) and Neighbourhood Networks

Primary Care Networks (PCN) support groups of GP practices to come together in partnership with community services, social care and other providers of health and care services. PCNs build on the core of primary care to enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

Barnsley Primary Care Network has six neighbourhood networks to deliver the neighbourhood service model, providing clinical leadership from primary care.



Local Health Needs

As per the Borough Profile (2019)¹ the population of Barnsley is circa 243,341. There are currently around 46,532 people aged 65+ living in Barnsley, making up 19.1% of Barnsley's population.

In addition to this:

- The proportion of Barnsley residents aged 65 and over is projected to increase to 60,800 in 2030. It is anticipated that this will lead to an increase in the number of people living with and dying from long-term conditions.
- The health of people in Barnsley is generally worse than the England average. Deprivation is higher than average and Barnsley is ranked as 39th most deprived local authority out of 326
- The percentage of people aged 65+ still at home 91 days after a period of reablement (80.7) is lower than both the England (82.9) and regional (84.2) rates. This is a reduction from the previous year where the Barnsley rate was higher than both the England and regional rates.

1.2 Service Model

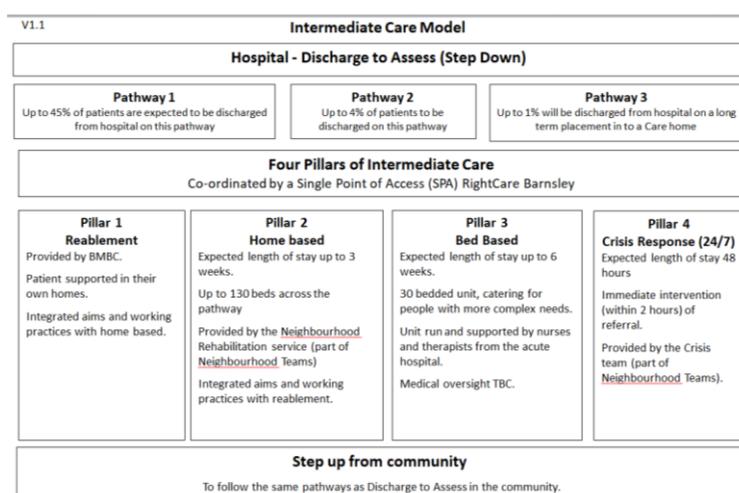
The Barnsley health and social care system, including NHS Barnsley Clinical Commissioning Group (CCG), Barnsley Hospital NHS Foundation Trust (BHNFT), South

¹ Barnsley Borough Profile 2019: <https://www.barnsley.gov.uk/media/11759/our-borough-profile-20190724.pdf>

West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Council and Barnsley Healthcare Federation and Yorkshire Ambulance Service are working in partnership to deliver a new integrated intermediate care service.

The new model will provide a truly integrated service with seamless care for people accessing intermediate care services, carers and families. Figure 2 below illustrates the support available from the services: Reablement; Home Based; Bed Based and Crisis Support.

Figure 2: Intermediate Care Model



People will be referred for the right support for their needs via a Single Point of Access (SPA) delivered by RightCare Barnsley. The SPA will act as care co-ordination and will direct the patient to the right care, right place for their needs at that time.

The service will adopt a person-centered approach, taking into account cultural differences and preferences working with the patient to develop goals in a collaborative way that optimizes independence and wellbeing.

A key priority in delivering this service specification will be for the service to deliver a 'home first' model allowing more people to be cared for in their own homes where possible. In addition the teams will work seamlessly together as 'one team' utilising multi-disciplinary team meetings and care planning, with the person at the centre of their care.

1.3 Local Engagement

This specification has been developed in collaboration with stakeholders and will be commissioned by NHS Barnsley CCG. Within Barnsley there has been recent work to understand what people think about children and young people's mental health services.

This includes:

Long term plan engagement (2019)



Barnsley LTP
Engagement Feedback

Neighbourhood Teams engagement (2019)



Developing
neighbourhood team:

For this service specification and for intermediate care services, the approach for engagement and involvement of patients, their carers and family members was agreed in December 2020.

There is agreement across partners to mobilise the project and build in as a key component of an outcomes based service specification, a dedicated and defined process to scrutinise and review the changes on a regular basis from a patient and carer experience perspective. This will enable services to truly understand how it feels for the people who are in receipt of intermediate care services and the family members and carers who are supporting them and enable services to flex and adapt where required. The proposal is to mobilise the patient experience data capture as soon as practically possible so this data can begin to be obtained and to influence service delivery for the lifetime of the contract.

The provider is expected to work with the commissioner to develop and capture experience data of patients, carers and family members and agree any necessary changes to the service delivery as appropriate.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Locally defined outcomes

The Barnsley Health and Wellbeing Board recently adopted an integrated care outcomes framework (ICOF). The IMC service will contribute to delivery of many of these outcomes working in partnership with other services, providers and residents. The areas where the IMC service will be expected to impact directly are signalled with an “✓”.

A1. Improve health and wellbeing	Healthy life expectancy at birth (Male)	
	Healthy life expectancy at birth (Female)	
	Excess winter deaths (3 years, all ages)	✓
A2. Reduce health inequalities by ensuring improvement is fastest for those with greatest needs	Inequality in life expectancy at birth (Female)	
	Inequality in life expectancy at birth (Male)	
	Percentage of all live births at term with low birth weigh	
B3. People are supported to lead healthy and productive lifestyles and are protected from illness	Smoking prevalence in adults	
	Admission episodes for alcohol-related conditions	
	Year 6: Prevalence of overweight and obese	
	Percentage of physically active adults	✓
	Air pollution: fine particulate matter	
B4. Wider determinants of people's health and wellbeing are prioritised	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	
	School Readiness: the gap between the bottom 20% and the median for all other children achieving a good level of development at foundation stage	
	Young people not in education, employment or training	
	Social isolation: percentage of adult social care users who have as much social contact as they would like	✓
C5. People feel emotionally well and resilient	Children subject of a child protection plan with initial category of neglect: rate per 10,000	
	Self-reported wellbeing – high happiness score: % of respondents	
	Suicide rate	
C6. People with poor mental health are better supported in the community	Average length of wait to partnership (treatment) for Child and Adolescent Mental Health Services	
	Improving access to psychological therapies: access	
	Hospital admissions where there was a primary diagnosis of drug related mental and behavioural disorders	
	Mental health admissions to hospital: rate per 100,000 population	
D7. People receive services rated as high quality	Hospital	✓
	Community and mental health services	✓
	Primary medical services	
	Adult social care	✓
	Children's social care services	
	Percentage of care home beds (suitable for a person with dementia, aged 65+) which received an overall	✓

	rating of 'good' or 'outstanding'.	
D8. There are fewer unplanned hospital and residential care admissions and people spend less time in hospital	Inequality in unplanned admissions for chronic ambulatory care sensitive and urgent care sensitive conditions	✓
	Emergency hospital admissions due to falls in people aged 65yrs and over	✓
	Total hospital bed days per 1,000 registered population	✓
	Total delayed transfers of care	✓
D9. People coming to an end of their lives receive services which are responsive to their needs and preferences	Percentage of people who have three or more emergency hospital admissions during the last 90 days of life	✓
	The number of people on GP palliative care register per 100 people who died	✓
E10. People with long-term health and care needs and their carers have a better quality of life	Health-related quality of life for people with a long term mental health condition	
	Health related quality of life for people with long term conditions	✓
	Health related quality of life for carers	✓
E11. People can manage their own health and maintain independence, wherever possible	Proportion of people who are feeling supported to self-manage their condition	✓
	Proportion of people who use services who have control over their daily life	✓
	Gap in employment between those with a learning disability and overall employment rate	
E12. People have a positive experience of work and education	Overall indicator of staff engagement (NHS Staff Survey)	✓
	Proportion of council employees who would recommend it to others as a good place to work (BMBC Employee Survey)	
	Sickness absence in the labour market (ONS data)	✓
	Pupil absence in schools	

The service will be expected to perform and operate to these service outcomes and also to have a positive impact on:

- People's outcomes and levels of satisfaction (including carers and family members)
- The number of people feel independent (a measure of the help needed with activities of daily living).
- The number of people feeling treated with dignity and respect. There is room for improvement about communicating with and involving people who use services and managing expectation about the short-term nature of the service.
- The number of people still at home 91 days after being discharged from hospital to a reablement/rehabilitation service
- The number of people able to remain in their own home following input from

intermediate care services.

- The number of people using intermediate care services meeting their goals (wholly or partially).

3. Scope

3.1 Aims and objectives of the service

Aim 1	To provide timely responses and easy access to and seamless integrated care for patients with community health needs
Objectives	<ul style="list-style-type: none"> • Ensure that access to all elements of the Intermediate Care Service including responding rapidly to an urgent request to avoid an admission. This must be available 24 hours a day 7 days a week and 365 days a year • Single point of access and clinical triage, accessible to all, and available 24/7/365 where there is need, working with NHS providers, social care and commissioners. • Provide collaborative patient care in the context of the wider multidisciplinary team across primary, secondary and social care as well as the independent and voluntary sector and specialist nursing teams • Establish and manage relationships across all IMC services and neighbourhoods, where appropriate Barnsley-wide to ensure providers across the health and social care economy are aware of the range of functions the IMC service provides and that IMC patients and carers are aware of and can access all relevant support services • The providers are required to develop transparent and trusted relationships between health and social care services across the health economy to enable more effective and efficient service delivery • The providers will enable rapid timely access for urgent referrals and a consistent response time across the service. • The service will acknowledge all referrals on receipt and advise the referrer of the response time to action the referral • The providers are required to ensure they fully understand the needs of the patient referred into the service and provide mechanisms to ensure services are built and tailored around the needs of the patient and their carers. • The providers are required to deliver care in people homes and where care at home is not possible, to provide services in a range of community settings including residential homes, nursing and care homes, community clinics, Intermediate care facilities etc. Where appropriate co-locating services offering convenient access (at weekends and evenings where this is responsive to demand and the needs of patients) • The providers are required to develop formal joint working

	<p>agreements, systems and processes, shared leadership and governance to provide an integrated whole intermediate care service.</p> <ul style="list-style-type: none"> The provider is required to ensure communication and provision of simple information upon discharge from the service ensuring patients, carers and the GP are aware of continued management and support needs and services and how to re-access the IMC service if required
Aim 2	To provide coordinated joint care planning across organisational boundaries where appropriate to ensure patients with LTCs, End of Life (EoL) needs, and other community healthcare needs are managed effectively in the community
Objectives	<ul style="list-style-type: none"> Home first The provider is required to develop close working relationships and joint working processes with Social Care that ensure seamless delivery of integrated health and social care services The provider is required to develop clear pathways and protocols to enable proactive efficient management of patients along a continuum of care The provider is required to deliver a community MDT approach to care delivery to effectively plan and co-ordinate service delivery, actively seeking and encouraging face to face involvement with GPs and relevant partners The provider is required to work with commissioners and GP practices to develop and utilise risk stratification and profiling technology to identify and target services to those with most need in the community. The provider is required to deliver joint care planning/ advanced care planning for patients referred to the service ensuring plans cover the totality of the community service. The provider is required to enable patient navigation functions where one professional has responsibility for ensuring the patient and their carers can effectively navigate the community service to ensure all needs are met effectively. The provider is required to facilitate patient's preferred place of care during End of Life care provision. The provider is required to enable shared decision making to empower patients and carers, and allow increased involvement and ownership of care provision and management and to support carers to deliver care in the most appropriate setting. The provider is required to deliver patient education and self-management as part of service delivery The provider is required to establish and utilise effective links with other health economy providers including 3rd sector links to enable holistic provision of care to patients.
Aim 3	To provide crisis intervention and care escalation to maintain patient care within the community setting where it is safe and

	appropriate to do so (championing 'home first')
Objectives	<ul style="list-style-type: none"> • The provider is required to provide a Crisis Response including specialist function to crisis situations in all community settings (domiciliary, residential, nursing and care homes) to enable continued management of patients with the community setting and prevent inappropriate admissions to acute settings. • The provider is required to provide a care escalation function increasing service provision to patients within the community setting as their care needs increase to enable continued management of patients within the community setting and prevent admission. • The provider is required to provide service input into step up care facilities including community intermediate care beds, respite beds and community units to ensure discharge planning is supported from admission. • The provider is required to develop formal joint working agreements, systems and processes with partner and interface services. • Support the reduction of admission and re-admission by proactively 'stepping up' patients who require extra support at any given time
Aim 4	To co-ordinate and facilitate early/timely discharge to ensure patients receive care in a community setting where it is safe and appropriate to do so
Objectives	<ul style="list-style-type: none"> • The provider is required to plan, co-ordinate and facilitate discharge arrangements that support patients to die in their preferred place of care. • Where a patient known to the service is admitted to hospital or long term care, the provider is required to provide a care escalation response supporting delivery of care and providing service input to enable discharge at the earliest possible opportunity. • The provider is required to work holistically and assume whole service ownership to ensure all patients' needs are identified and addressed for transfer to the community setting to ensure successful discharge and minimise failed discharges and readmissions. The provider is required to appropriately manage risk in de-escalation of patients to the community setting utilising the support of medics and specialist clinicians to enable effective, safe and reliable discharge and coordination of services. • The provider is required to enable delivery of care closer to home and the de-escalation management of patients to the lowest possible care setting at the earliest opportunity to maximize patient independence. • The provider is required to develop close working relationships and formal joint working agreements, systems and processes with acute services and discharge facilitators

Aim 5	To use innovation to drive quality, patient experience and value for money
Objectives	<ul style="list-style-type: none"> • Transform the classic task based approach to liberate capacity and autonomy, promote effective case management and care brokerage • Provide safe, high quality, culturally sensitive therapy and nursing care for those people receiving intermediate care • Provide holistic care for all adults referred to the service, designing and delivering personalised care plans to meet individual health needs • The provider is required to implement joined up IT systems to enable more effective provision of care and increased communication across the service • The provider is required to actively engage with and support the development of the Barnsley Shared Care Record • The provider is required to implement systems that support remote and flexible working arrangements • The provider is required to know whether a patient has been admitted/has accessed OOH and emergency services through utilising borough-wide information and data sharing systems that are in place • The provider is required to ensure that electronic systems are in place to actively share all patients' personalised care plans, notes, treatment and discharge information with GPs and other partners who are involved with the patient's care. • The provider is required to work closely with social care to develop a single assessment framework, care plan and single care record that reduces the need for patients to tell their story numerous times • The provider is required to extensively market their service across the health economy to both health and social care professionals and the community. • The provider is required to deliver a public communications and engagement function to market their service and deliver innovative community health solutions • The provider is required to utilise innovative technology to support service delivery where this results in more efficient use of resource and empowers patients to self-manage/ monitor their condition i.e. the use of telemedicine/ Telehealth • The provider is required to actively involve service users and carers in evaluating, shaping and improving the services they use.
Aim 6	To support people to live well through better prevention
Objectives	<ul style="list-style-type: none"> • To understand the local population's health needs including the determinants of illness and poor health • To facilitate connections between different services and assets in communities including the community and voluntary sector • To adopt a principle of "making every contact count" by offering

- | | |
|--|--|
| | <p>advice and signposting to support people to live healthier lifestyles for example smoking cessation, exercise and diet</p> <ul style="list-style-type: none"> • Support patient activation through health coaching and motivational interviewing support people to take control over their health and wellbeing journeys |
|--|--|

3.2 Service Description

Intermediate Care is a range of integrated services for assessment, treatment, rehabilitation and support for older people and adults at a time of transition in their health and support needs. As services delivered between hospital and home, they support people to get back their independence, mobility and confidence after an accident, illness or injury, or deterioration in a condition. The services are delivered in within people's own homes or in residential settings based within the community. The care is person-centred, focused on rehabilitation and delivered by a combination of professional groups.

The scope of this new service is designed to ensure that:

- People receiving intermediate care services are supported to return or remain at home wherever possible
- Following an acute hospital admission a patient returns and remains in their normal place of residence (reduce the risk of a readmission)
- Those at home requiring extra support to prevent a hospital admission receive the right care and support to remain at home
- People recover and retain independence after a fall, an acute illness or an operation
- People who require admissions to acute hospital or care home beds have as short a length of stay as possible (decrease the length of stay).

RightCare Barnsley will broker the right level of intervention depending on the needs of the patient at that time. This will include 24 hour beds for rehabilitation and recuperation and 'virtual' bed base support in a patient's own home via enhanced support at home.

See service model in section 1.2

The Intermediate Care service is based on achieving outcomes, the time to do this will vary but this is likely to be a maximum of 6 weeks with the majority of people being discharged from the service within 6 weeks or less.

The four pillars of Intermediate Care

Pillar 1 – Reablement (provided by BMBC)

- A type of intermediate care providing the person to regain skills, confidence and capabilities they may have lost due to a period of ill health, disability or entering the care system following a crisis having spent time in a hospital setting or adult social care facility.

- This service is provided by the local authority and the patient will be referred directly into this service after receiving a functional assessment via either the discharge to assess pathway or RightCare Barnsley.

Pillar 2- Home based

- Provides short term services to people in their own home, promoting independence, self care and enabling people to reach/ regain an optimum level of independence.
- Following the service principles the aim is wherever possible to get people 'Home First'

Pillar 3 – Bed Based

- Provides short term services as above to people in either a care home setting or a community hospital setting in a 30 bedded unit.
- The use of bed based services will be for those people who initially need a significant level of observation; support and high frequency of clinical oversight i.e. care not available through a home based package.
- The type of bed-base service each patient is placed into will be indicated by their needs which are identified at the point of assessment whether that is from Secondary Care or the patient's home. These can be the bed base within a non-acute setting in a hospital.
- The provision of 24 hour bed based services will be provided in an environment that meets CQC standards all of which should be able to care for people with dementia/memory problems where intermediate care intervention has been deemed as appropriate.
- The bed-base element of service will be indicated by individual needs which are identified at the point of assessment whether that is from Secondary Care or the patient's home. This will be in single site in a non-acute setting. The provision will be a mixture of 24/7 nursing & intensive assessment and 24/7 care and intensive rehab, to enable a step down to home where possible

Pillar 4 – Crisis Response

- Crisis response will be available 7 days a week, 24 hours a day, 365 days a year to rapidly respond to patient needs to avoid an admission, readmission and to support timely discharges from the hospital as defined in the new neighbourhood teams specification
- The role of Crisis Response must be clearly articulated to all partners. This will support the much needed shift in identifying and 'stepping up' patients earlier rather than patients being admitted to acute care with the majority of patients being 'stepped down' into the service.

The four pillars are co-ordinated by a Single Point of Access

Central to the service will be RightCare Barnsley. RightCare Barnsley will be the single point of access for the service during the hours of 8am and 8pm 7 days a week including bank holidays.

RightCare Barnsley will be the single point of access for the 24 hour bed base for recuperation and rehabilitation and will place patients into these beds according to the needs of the patient at that time. RightCare Barnsley will monitor and report on the 24 hour bed base activity which will include length of stay.

Outside of these hours robust contact arrangements via a single number to the service including the Crisis Response element must be made with BHNFT – ED, CDU, AMAC and the wards, YAS - ECP's, OOH's and IHEART Barnsley.

Rehabilitation and recuperation

When choosing the service a patient requires the following grid has been designed to ensure that the patient is placed in the right place to meet their needs the first time. (noting the interdependency with D2A)

	Carer Respite/Place of Safety	Recuperation	Rehabilitation
Remaining in own home	NA	Reablement	Intermediate Care Team & possibly Reablement
Requiring 24 hours Care	Adult social care/ RightCare SPA	Recuperation beds	Designated Care Homes Only
Requiring Nursing Care	Emergency Placement	NA	NHS type Community Hospital facility

Core principles

When the patients' needs change where ever possible these are met by wraparound care rather than moving the patient.

The service must be led by a credible leader who understands the ethos required to provide an exceptional service and is passionate about the aims of the service.

Each episode of care will be individual but the service must be able to provide access to a wider MDT:

- Occupational therapy
- Physiotherapy
- Social work via partnership working
- Registered Nurses
- Community Specialist Nurses
- Health care assistants and care workers
- Access to medical staff as required

- Staff with expert knowledge to support people with mental health needs, dementia and people with learning disabilities
- Access to other disciplines, including the integrated community equipment service and housing services
- Generic Workers who can provide both therapy and nursing support
- Pharmacists

Patients will be reviewed regularly to ensure they are receiving the right care and support in the right setting. The Derby Score will be used to demonstrate the effectiveness of the intervention whilst tracking a patient through the episode of care.

The service must adopt the right to reside approach (adopted in the acute setting) across the intermediate care bed base from a virtual bed in patients homes to the 24 home bed base in the care home setting. This will assist the best utilisation of resource across the system.

Patients will be reviewed regularly to ensure they are receiving the right care and support in the right setting. A tracker will be developed to demonstrate patient dependency at a glance. The Derby Score will be used to demonstrate the effectiveness of the intervention whilst tracking a patient through the episode of care.

Shared Assessment Frameworks and Personalised Care Planning

The providers will contribute to the development of a single shared care record and once developed fully implement across IMC

The goals of each patient will include mobility, self-care, continence and activities of daily living such as food preparation as well as resumption of hobbies and social activities. A loneliness assessment tool i.e. UCLA Loneliness Scale must be used to identify patients who are or are at risk of social isolation and loneliness.

Shared assessment frameworks across health and social care will lead to a personalised care plan for each patient, where the patient and their carer's are key participants in any decisions made.

The assessment will consist of a Comprehensive Geriatric Assessment, a recognised falls assessment and a recognised frailty assessment for those people over 65 years of age. These assessments will be reviewed as the episode of care progresses.

The focus will be on active treatment and therapeutic intervention detailed through the personalised care plan. The care plan must be outcome based and agreed by and with the individual patient and/or their primary carer.

The care plan will be written in a language understood by the individual and/or their primary carer.

Response Times (Clockspeed)

All decisions will be based on risk and clinical need and be clearly communicated to the referrer by the assessing clinician. The primary route for all crisis response and new referrals will be via the single point of access. NT clinicians will undertake clinical triage for referrals direct to the NT and determine the appropriate response time as appropriate to clinical need. As NTs develop we anticipate that there will be increasing communication between primary and community care facilitating joint working to support patient's needs.

Type	Time	Description	Service offer
Crisis	2 hrs	At risk of hospital admission and requires assessment because of – <ul style="list-style-type: none"> • A diagnosed condition such as a UTI or chest infection • Is experiencing a deterioration / exacerbation of a long-term condition • Has become unable to manage at home due to recent hospital discharge / recent fall • Patients with a sudden deterioration of terminal condition • Patient becoming, or are at risk, of a mild to moderate dehydration requiring sub-cutaneous fluid • Patients with a combination of the above factors, along with social / cognitive / memory problems that may require a place of safety, whilst investigations can be taken to confirm or exclude a physical condition. 	Neighbourhood team/GP home visiting if patient is housebound NHS 111 or urgent GP appointment if able to attend Step up bed if place of safety required
Urgent	24 hrs	At risk of deterioration to crisis point without same day assessment because of – <ul style="list-style-type: none"> • Is experiencing an exacerbation of a long-term condition that is normally stable • Deteriorating terminal condition • Patient at risk, of a mild to moderate dehydration requiring sub-cutaneous fluid • Currently safe to remain at home 	Neighbourhood team/GP home visiting if patient is housebound NHS 111 or urgent GP appointment if able to attend
Routine	72 hours	In a stable condition but requires care or support after a short illness.	Neighbourhood team.

			Routine GP appointment if able to attend.
Proactive/ Planned	7 days	Stable long-term condition or health need or identified as at risk of deteriorating health through risk stratification. Will benefit from preventative interventions.	Neighbourhood team. Routine GP appointment if able to attend.

4. Interdependence with other services / providers

Discharge to Assess

The pillars and principles of Intermediate Care are supported by the Discharge to Assess model pathways 1-3 (which is not covered by this specification but mentioned here to show the interdependency to patient pathways and patient flow)

The aim of the Discharge to Assess model is to:

- identify the appropriate discharge pathway based on the patient's individual needs
- complete functional assessments to take place in patients own home and not in the acute hospital setting
- ensure there is a direct referral route into the reablement service

Pathway 1

It is expected that 45% of people discharged home will require up to 6 weeks of recovery health and social care services to maximise their independence and stay at home for longer.

Pathway 2

4% of people will be discharged from hospital to a bedded rehab unit to support their return to home

Pathway 3

1% of people will be discharged straight into a care home as a long term placement.

Some of these patients will require a referral to NHS Funded Continuing Health Care for an assessment to inform a package of care to help with patient's health care needs and requirements.

After patients have been 'Discharged to Assess', and the correct discharge pathway has been identified RightCare Barnsley (SPA) will broker the right level of intervention depending on the needs of the patient at that time.

This could include interventions to help the patient functional better in their own home from therapy support to reablement or it could include therapy or nursing input on an intermediate care unit.

- NHS Funded CHC (after rehabilitation is maximised)
- Personal Health budgets

5. Acceptance and exclusion criteria

5.1 People should meet all of the criteria set out below for referral to the single point of access:

- A resident of BMBC or registered with BCCG
- Over the age of 18
- Experiencing an episode of illness or exacerbation of a pre-existing condition, or life limiting long-term condition or recovery from surgery or other procedure
- Not requiring a level of medical input only available in an Acute Hospital agreed by the MDT discharge planning process
- Not requiring technological input only available in an Acute Hospital agreed by the MDT discharge planning process
- Not requiring Out-of-Hours diagnostics
- Not requiring access to specialist rehabilitation defined in the current specialist services commissioning definitions
- Requires this service rather than discharge into an agreed pathway *e.g.* neurology or the stroke service
- Is likely to require more than one health/social care discipline to be involved.
- A reasonable expectation of recovery including time in a bed based component if required
- People can be supported, even if they are not nutritionally stable. People should be able to consent and comply with interventions. Where consent is an issue, as in all services a mental capacity assessment must be undertaken and a best interest meeting held if necessary, the outcome integrated into the referral and care planning process.

5.2 Parity of Esteem

- People with dementia will not be excluded from the service but this may need to be delivered as part of a longer-term support package co-ordinated by the expert dementia service
- People with a learning disability/mental health need or other diagnosis/vulnerability will not be excluded if they meet the criteria for the service as alternative to an admission to hospital or speed up discharge from hospital. The service will demonstrate it can make the reasonable adjustment required
- People whose primary need is end of life care should be supported through end of life care services. However the service will not exclude people if they are experiencing an episode of illness or exacerbation of a pre-existing condition

- People living in all forms of housing and support accommodation should have access to the service
- People who have on-going housing needs including people who are homeless or at risk of being homeless should have access to the service

6. Population covered

The service will be for adult patients who are registered or temporarily registered with a practice that is part of NHS Barnsley CCG. The provider must ensure that the service is equitably provided across Barnsley, in response to need, particularly in relation to the allocation of resources to ensure that patients have equal access to services which are comparable in terms of quality and responsiveness.

Boundaries

This service is commissioned on a Barnsley registered population basis in line with “Who Pays? Determining responsibility for payments to providers” guidance published 12th August 2013. The provider has full responsibility for the delivery of this service to all Barnsley registered patients in line with General Condition 12 of the NHS standard contract. If a patient is resident outside of the Barnsley footprint but registered with a Barnsley GP, it is the responsibility of the provider to ensure services are delivered in line with this specification to that patient. However, in areas where mutually beneficial agreements can be put in place with providers that cover neighboring CCG’s that are not detrimental to the patients care or safety permitted sub-contracts will be considered by the CCG in line with General Condition 12.

7. Applicable Service Standards

7.1 Applicable national standards (e.g. NICE) Must comply with NICE standards due 2017

The National Institute for Health and Clinical Excellence (NICE) have produced a number of guidelines on rehabilitation pathways for people. The Intermediate Care service should understand these guidelines, but recognise that the pathway for different specific condition- based needs will extend beyond the scope of this episode of care.

7. Applicable quality requirements

7.1 Applicable Quality Requirements (See Schedule 4A-C)

8. Location

The provision of 24 hour home based support will be led by the most appropriate health or social care practitioner and will meet CQC standards for community and/or domiciliary care provision.

Delivery is not necessarily dependent on location of person, where in patient services are provided they meet CQC standards and are conducive to rehab plus dementia friendly.

Intermediate Care – Care Home Specification

Please note: this specification will be transferred to the BMBC corporate template.

Contract Term: 3 years with the potential for additional 2 years from 1 June 2021.

1.0 PROJECT OVERVIEW

1.1 Introduction

The future of health and care in Barnsley is to create an integrated joined up health and care system, that is why Intermediate Care Services in Barnsley is provided as part of a formal Alliance Contract working with all parts of the health and care system within the Barnsley geographical footprint .

As a result of a system wide review, a revision to the commissioned beds providing 24 hour care (as part of the Intermediate Care pathway) has been identified in order to support people to remain in their own homes for longer and reducing the need for long term residential care.

2. SCOPE OF SERVICES

2.1 Overview of the Intermediate Care Pathway

This service specification sets out the vision and direction for the provision of Intermediate Care and Emergency Short Stay Care Beds for Barnsley residents on either a step up or a step down from hospital pathway.

The Provider will form part of our collective **Neighbourhood Rehabilitation Service (NRS)** model by facilitating 30 beds in one setting; on a hotel type basis.

24 hour care is provided by the **staff from BHNFT** staff 7 days per week (therapist, nurses and support workers)

Any equipment required will also be provided by the **BHNFT**.

The provider will accept referrals into the 30 beds that:

- Supports short term recuperation and/or crisis intervention with limited therapeutic support
- Supports rehabilitation for up to 6 weeks
- Supports the transition from Independent sector bed to home.
- Assists in rehabilitation and reablement activities to optimise recovery, enables patients to take control of their lives and supports patients to regain their independence.
- Facilitates early discharge from hospital, as part of the Intermediate Care pathway.

- Prevents admission to acute settings from Emergency Departments and the community.
- Avoids preventable or premature admission to long term residential or nursing home care by supporting and facilitating rehabilitation and reablement.
- Promotes independence and improve outcomes for people recovering from illness, injury or trauma.

The Provider will:

- Identify, assess, make recommendations and take actions about any areas of risk related to care home provision

2.3: Service Description / Care Pathway

Referrals in to the 30 beds will be sent via RightCare Barnsley straight to the unit.

The **BHNFT** staff situated on site will offer; safe care and rehabilitation for people who meet the Intermediate Care criteria.

The practices of **the nursing staff** will be governed by Barnsley Hospital NHS Foundation Trust who will accept liability in the event of adverse incidents.

The unit will be supported by IPC at BHNFT for risk assessment advice and guidance purposes.

2.4 Discharge Processes

The Provider will once the room is vacated be responsive to cleaning the room making it ready to accept a new admission as soon as possible.

2.5 Accommodation requirements

The Provider must be able to provide, as a minimum:

- A dedicated area for Intermediate Care patients with easy access to communal and outdoor areas.
- A Home from home environment.
- EMSA compliant Elderly Mixed Sex accommodation.
- A Dementia friendly environment
- Single rooms with facilities and disabled access.
- Doors and entrances that have Effective Clear Opening Widths that comply with current standards (BS8300) and building regulation.
- Disabled facilities for bathing and showering and sufficient space in bathrooms and toilets for up to 3 staff and a patient.
- Sufficient space around beds/communal areas for therapy (and equipment)
Note: there will be a requirement for the use of bariatric equipment in some circumstances.

- A call alarm system to enable patients to get help.
- Furniture and fittings appropriate for patients, including those with physical disabilities.
- Lockable cabinets for self-medication
- Three meals a day, catering for specific dietary requirements. Tea/Coffee refreshments in bedrooms to be provided and water refreshed throughout the day
- Infection prevention and cleanliness standards that are in line with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - regulation 12 – safe care and treatment and regulation 15 – premises and equipment. These requirements can be met by ensuring compliance with the ten criteria contained within the Code of Practice for the prevention and control of infection and related guidance (2015). IPC in line with the most recent COVID 19 Care Home guidance
- The ability to section off beds for people who have infectious illnesses for example, COVID019, C-Diff, sickness and diarrhoea.

2.6: Therapy Space requirements

The Provider will make available adequate space to deliver physiotherapy and occupational therapy to pursue rehabilitation, recuperation and reablement goals. This includes:

- Storage space for rehabilitation, recuperation and reablement equipment and additional resources for patients/students (such as hand-outs and books).
- Additional storage available for emergency equipment (urgent and crisis support).
- Activity and therapy space away from the patient's room.
- Outdoor therapeutic space.
- Dedicated office space for the staff and reablement staff) to use as their base (for undertaking administrative working including updating records and making telephone calls). Telephone and data points must be available within this space.
- Private space for weekly MDT team meetings, confidential discussions, family meetings and capacity assessments.

2.7: Equipment requirements

BHNFT would bring some of the equipment from the hospital/ stores

Standard Equipment to be Provided by the Care Home Provider(s) –	
Moving & Handling	<ul style="list-style-type: none"> • Height-adjustable profiling beds • Bed-rails and bumpers • Over-bed trolley table • Hoist-sling, standing • Slings

	<ul style="list-style-type: none"> • Hoist scales • Slide sheets • Handling belt • Bath equipment, bath hoist, shower chair • Sliding boards • Turn tables • Rota stand
Mobility	<ul style="list-style-type: none"> • Transit wheelchairs (including Bariatric) • Grab rails • Walking sticks • Wheeled zimmer frame • Zimmer frame • Gutter frame
Seating	<ul style="list-style-type: none"> • Variety of chairs to meet individual needs and promote patient independence including high riser chairs and chair raisers.
Skin	<ul style="list-style-type: none"> • Mattress – soft foam, high pressure relief and low air loss mattresses (up to grade four pressure sore management) • Cushions – pressure relieving
Elimination	<ul style="list-style-type: none"> • Commode/commode chair (including Bariatric if required) • Bed pans • Urinals • Raised toilet seats • Stoma Bags, wipes and skincare products • Catheters • Catheter Care including tube and bag • Disposable gloves and aprons • Disposable wipes and tissues and other cleaning materials (e.g. hand gel) • Access to incontinence products appropriate to the patient
Respiratory Support	<ul style="list-style-type: none"> • Catheters • Oxygen mask and tubing • Basic resuscitation trolley
Assistive Technology	<ul style="list-style-type: none"> • Communication aids • Call systems • Communication aids- signs to assist patients with hearing/visual and cognitive impairments
Nutrition Food and Drink	<ul style="list-style-type: none"> • Adaptive cutlery • Non slip mats
Nursing Care	<ul style="list-style-type: none"> • Blood glucose monitors • Body spillage kits • Weighing scales.

The Provider will ensure all equipment:

- Complies with current health and safety regulations and Infection control standards.
- Is properly maintained and calibrated in accordance with manufacturer's instructions.
- Complies with local protocols for the provision of community equipment from other agencies.
- Provided by Barnsley Integrated Community Equipment Store / Satellite Store is returned following patient discharge.

2. 8 Accessibility / Acceptability (including parity of esteem):

- People with COVID 19 will not be excluded from the service if they meet the criteria.
- People with dementia will not be excluded from the service but this may need to be delivered as part of a longer-term support package co-ordinated by the expert dementia service.
- People with a learning disability/mental health need or other diagnosis/vulnerability will not be excluded if they meet the service criteria. The Provider must make reasonable adjustment where required.
- People whose primary need is end of life care should be supported through end of life care services. However, the service will not exclude people if they will benefit from an episode of intermediate care intervention.
- The Provider should have systems in place to identify specific characteristics that may be barriers to potential and ongoing access, and make appropriate adjustments.
- The Provider must make reasonable provisions for patients who are non-English speaking and those with sensory and / or mild cognitive impairments.
- The Provider will involve patients and their families/carers, as partners, in how the service is delivered, evaluated and modified within the parameters of this service specification to ensure the service meets patient needs.
- The Provider should have systems/procedures/policies in place to respond to age, culture, religious beliefs, disability and sexual orientation and gender sensitive issues regarding accessibility and acceptability.

2.9: Applicable national standards, pertinent to the care home provider.

The Provider will maintain Care Quality Commission registration and adhere to the Essential Standards of Quality and Safety.

It is expected that the Provider ensures that policies and procedures and practices are regularly reviewed and that the following list of standards/good practice guidance is, where appropriate, adhered to.

- The National Service Framework for Older People
- The National Service Framework for Mental Health

- National Minimum Standard for Care Homes for Older People (Section 20, Health and Social Care Act, 2008)
- Department of Health (DOH) Guidance as issued
- The Care Act, 2014
- National Institute for Clinical Excellence (NICE) Standards
- The Administration and Control of Medicines in Care Homes – Royal Pharmaceutical Society of Great Britain
- Mental Capacity Act 2005
- Code of Practice for the Prevention and Control of Infection and related guidance (2015)

Care Home Provider(s) must ensure compliance to the NHS Standard Contract and service specification.

3.0 REQUIREMENTS OF THE PROVIDER

3.1 Service Providers Responsibility

The successful Provider will provide 30 beds on a hotel type basis to facilitate intermediate care /emergency short stay care services for the residents of Barnsley.

3.2 Quality Standards

The Provider will have all relevant policies and procedures in place.

For the avoidance of doubt, nothing in this specification is intended to prevent the Service Provider from setting higher quality standards than those laid down in the Contract.

The Provider will have a robust system for monitoring complaints and suggestions; feedback from service users will inform service delivery.

The Provider will submit reports summarising any complaints, investigations and remedial actions

3.3 Health and Safety

The Provider of this service will be required to adhere to the Health and Safety at Work Act 1974 at all times and any other relevant guidance and directives in force or subsequently issued. In addition the Provider is required to achieve accreditation under one of the Safety Schemes in Procurement.

The Service Provider will ensure that:

- All materials used in carrying out the service comply with the Control of Substances Hazardous to Health Regulations
- All materials, and equipment, are stored in a safe and proper manner

- Environmentally friendly materials are used whenever possible
- All staff are equipped with appropriate training, (including needle search training) staff development and supervision.
- Where an appropriate British Standards Specification or British Standard of Code of Practice is issued by the British Standards Institution is current at the date of the tender, all goods and materials used or supplied and all workmanship shall be in accordance with that standard
- All staff employed or engaged by the Service Provider is informed and are aware of the standard of performance that they are required to provide and are able to meet that standard.
- The adherence of the Provider's staff to such standards of performance is routinely monitored and that remedial action is promptly taken where such standards are not met
- All staff employed or engaged by the Provider has been subject to a DBS clearance, where required, and an acceptable outcome determined.
- For the avoidance of doubt, nothing in this specification is intended to prevent the Provider from setting higher quality standards than those laid down in the Contract.

3.4 Environmental Requirements

Project sustainability is key. The successful Provider will be expected to give consideration to the whole lifespan of the project, beyond the term of this contract.

The Provider will be required to comply with all legislation and Council policy in relation to the disposal and recycling of waste.

3.5 Equality and Diversity Requirements

The successful service Provider will be required to ensure that the service is free from bias and acknowledges and respects gender, sexual orientation, age, race, religion, culture, lifestyle and values. If any needs are required as per the Equalities Act, such as language or disability, these needs will be provided for during the term of the contract.

4.0 PERFORMANCE MEASURES

4.1 Contract Monitoring

Following the award of the contract the Council will hold an inception meeting with the successful Provider to review the following;

- The appointment/assignment of a Contract manager for both parties
- An overview of the staff to be engaged in the service delivery

- A contract management meeting schedule for the duration of the contract (Quarterly as a minimum)

The Provider will need to be able to demonstrate the effectiveness of the service in terms of delivering the agreed outcomes, outcome measures and outputs. Throughout the contract term the successful Provider will provide all information detailed with the Service Specification.

There will be quarterly meetings with the NRS Lead, Proactive Review Lead and a CCG representative.

Contract review meetings will take place at 3, 6 and 12 months and as required.

5.0 CLIENT RESPONSIBILITIES

The terms and conditions highlight the procedures and requirements for this contract

The provider is asked to provide details of the following specific requirements:

Insurance Cover

- Employers liability Insurance (Minimum Level of cover £10 Million)
- Public liability Insurance (Minimum Level of cover £5 Million)
- Medical Malpractice Insurance –(Minimum Level of cover £5 Million)

Health and Safety Policy

Equality and Diversity Policy

Safeguarding Policy

Data Protection Policy

The Council will ensure the successful Provider is given a key point of contact for any enquires in relation to the contract.

6.0 PAYMENTS AND INVOICES

6.1 Payment Terms

Payment for work is outlined in **Form of Contract (Terms and Conditions)**. As per clause D of the terms and conditions payment will be made by the CCG.

Service Specification No.	IMC-MO-21
Service	Medical Oversight of Intermediate Care Services
Commissioner Lead	NHS Barnsley CCG
Provider Lead	TBC
Period	1 April 2021 – 31 May 2021 (transition) 1 June 2021 – 31 March 2024
Date of Review	December 2023

1. Population Needs

1.1 Local context and evidence base

The Intermediate Care Service (bed base provision) provides short term rehabilitation to service users in a residential home setting; to enable people access a place of safety/ avoid admission to hospital with short term health interventions (step up) and /or to recover following hospital treatment and supports early discharge from hospital (step down).

Intermediate care service is predominantly lead by therapists with support from carers, nursing staff, pharmacists and GPs

Intermediate care bed base services are currently provided from:

- Highstone Mews (HSM) care home located in Worsborough - 12 beds (staffed by HSM carers with input from the neighbourhood rehabilitation services NRS)
- Buckingham care home (Acorn Unit) located in Penistone - 15 beds on Acorn Unit. (staffed by BHNFT nurses and therapists with input from pharmacy)
- Buckingham House located in Penistone - 14 intermediate care beds. (staffed by Buckingham House carers with input from NRS)
Further beds are available at Buckingham House on a spot purchase basis (up to 10 beds).

From 01/06/2021 intermediate care bed base services will be provided from one 30 bedded unit in the Barnsley Borough and will be staffed by BHNFT nurses and therapists with input from BHNFT pharmacy team and community pharmacists.

The 30 bedded unit will be procured separately via BMBC in January 2021.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Locally defined outcomes

The objective of medical cover is to:

- Ensure that the medical care needs of residents are effectively met and monitored during their stay in the Rehabilitation beds.
- Lead the MDT daily ward rounds
- Focus on medical interventions that support the service user's rehabilitation needs within the targeted timescale not exceeding four weeks unless where identified as part of an MDT

3. Scope

3.1 Aims and objectives of service

The General Practice who provides this enhanced service would be expected to:

- work within the current service from 1 April 2021 – 31 May 2021 as a transitional period
- work to the new model (30 bedded unit) 1 June 2021 – 31 March 2024
- temporary register patients on the Intermediate Care caseload on to the practice systems
- Attend the site, on a daily basis to lead the MDT ward round (time to be agreed with the unit staff and practice). Patients will already have been screened / triaged by senior RCB staff.
- Use technology and digital solutions
- Be available for any urgent medical requests i.e. non-critical pain

- provide advice in connection with the patient's health needs; and the referral of the patient for other services as required
- Liaison with the patients registered GP, as required
- Working as part of the NRS Multi-Disciplinary team to facilitate early discharge from hospital; the prevention of admission to acute settings from Emergency Departments and the community and avoids preventable or premature admission to long term residential or nursing home care
- Escalating back to RightCare Barnsley (RCB) if transfer or current condition not appropriate in this setting

Service provision must be:

- Enabled via temporary registration of Intermediate Care Patients to the GP Practice
- Responsive to patients needs in the commissioned Intermediate Care bed base
- Able to prioritise and deploy clinical input based on the needs of the patients
- Person centred and shaped around the needs of family and carers, where appropriate. Providing appropriate help, advice and support for family and carers.
- Input into comprehensive and evidence based practitioner audits reviewed against agreed quality standards.
- Delivered in partnership to ensure a seamless service for all.
- The primary care team will be part of a Multi-disciplinary Team that provides a comprehensive rehabilitation, recuperation, reablement and care service to patients on the Intermediate Care Pathway

3.2 Population covered

Patients registered with a Barnsley GP.

3.4 Any acceptance and exclusion criteria and thresholds

Medical Emergencies

- Any medical emergencies in the unit will require 999 activation and therefore will not require input from the GP practice
- If a patient starts to deteriorate the staff on the unit will follow the 'Deteriorating Patient Protocol' provided by BHNFT.

Out of hours

- Between the hours of 8pm and 8am primary care review will be triaged to the Out of Hours provider in Barnsley (NHS 111).

The provider is required to implement their own arrangements to ensure that they are able to deliver continuity of service for sickness, holidays and other absences. Any Locum cover arranged by the provider should be provided by a suitably qualified, experienced and registered GP at no extra cost to the CCG.

The GP should record all decisions made that leads to readmission to hospital including a full rationale on the reasons for readmission.

3.5 Interdependence with other services/providers

Ward Round / MDT

- All patients will have been reviewed and triaged by senior nurses at RCB and staff in the unit – prior to the ward round reviews

Urgent requests for patient review and prescription

1. Patients requiring a place of safety/ hospital admission avoidance will require medication reviews/ reconciliation
(this maybe be completed by the community pharmacists (as per the pilot completed by the CCG's Medicines Management Team)
prescription request will be carried out in primary care
2. Patients being stepped down from hospital will already have medicine reconciliation by BHNFT pharmacy staff any requests for prescriptions for these patients will need to be filled out via a BHNFT treatment care signed by the GP (this can be done electronically) and the medication acquired from the hospital pharmacy.

At this time the protocols and procedures of BHNFT do not allow for the 'ward' nurses/ therapists to prescribe/ administer medication without authorisation from a medic and with BHNFT staff in place on the unit this is the safest clinical way to operate. This is currently under review and staff will be put on a prescribing course as and when availability allows.

Intermediate Care Project Timescales (Version 1.6)

Activity	Timescales for new service start 01/06/21
Governing Body – sign off new model	14/01/21
Procurement for bed base (BMBC)	
Go live	18/01/21(30 days)
Close	17/02/21
Evaluation and moderation panel	18/02/21 – 06/03/21
Procurement Reports to Governing Body	11/03/21
Notify bidders of outcome	12/03/21
10 day stand down	12/03/21 – 22/03/21
Mobilisation for new model	23/03/21 (10 weeks)
Expression of interest for GP medical oversight (SY Procurement Service)	
Go live	18/01/21 (2 weeks)
Close	31/01/2020
Evaluation and review – report to PCCC	01/02/21 – 12/02/21
Update to Governing Body	11/03/21
Mobilisation for current model	22/02/21 (5 weeks)
Mobilisation for new model	23/03/21 (10 weeks)
Medical oversight commences at current sites	1 April 2021
New service model goes live	1 June 2021

Overview of Discharge to Assess Pathways

Figure 1 – Project Structure

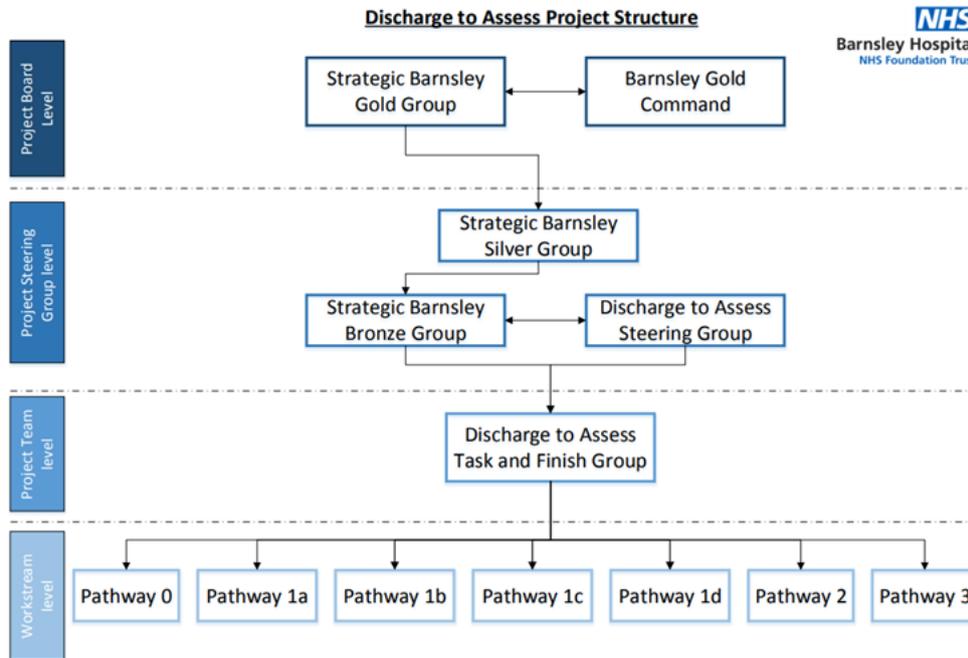
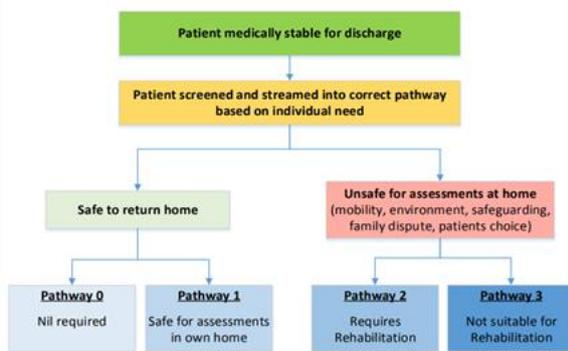


Figure 2 – Pathway Flow Chart



Pathway 0 (Overview)

This pathway is for patients requiring no further input on discharge and is deemed safe to return to own home. Each patient will be followed up with a phone call within 24 hour of discharge to ensure they are safe in their own home. During the Covid-19 pandemic the Barnsley Healthy Lives team supported with the follow up phone calls to patients discharged within 24 hours. However, since 27th July 2020 this service has now been handed to RightCare Barnsley. RightCare will offer advice/support and escalate concerns as needed ensuring a hospital avoidance approach is maintained.

Pathway 1 is made up of four different streams for discharge dependent on the patient need:

Pathway 1a (Overview)

This pathway is for patients that are medically stable to leave the acute trust and safe to be assessed within their home for further input from social services, reablement, warmer homes or volunteer services. These patients may require a new package of care or an increased package of care, the care needs can be identified better to meet the patients' needs within their own environment.

To support the Discharge to Assess model, in April 2020 the Hospital Social Work team made the decision to complete assessments within patient homes and out of a hospital setting. A patient checklist will be completed within 48 hours of discharge and submitted to CHC until an assessment for Continuing health care is completed and to confirm funding for the care package. Reablement team supports the patient during the interim whilst a care package is sourced. Social Worker completes assessment and would refer onto social prescribing, reablement, warmer homes and volunteer services.

If patient was identified as pathway 1a and did not require social care input RightCare would screen and refer patient to social prescribing, reablement, warmer homes and volunteer services. Patients may require assessment through pathway 1b before referral to 1a.

Pathway 1b (Overview)

This pathway is to support completion of therapy assessments within patients own home, providing equipment and referring on for ongoing Rehabilitation pathways and into other pathways to meet patient needs.

Pathway 1c - (Overview)

This pathway is to maintain patient's early discharge for fast track patients, maintaining safe discharge with early packages of care and more accurate care plans as they are developed individually to the patient's requirements. This pathway provides a 5 day, 9am to 5pm service supporting end of life patients back to their own homes or care placement. During the pandemic Fast Tracks were completed by the Community teams within patients' homes or within a 24 hour care setting. A meet and greet service was implemented to ensure that the patient was safe and had the appropriate care in place at home however this process posed potential risk to the patient. Therefore, since July 2020, Fast Tracks are now completed within the acute by 1.8 WTE Band 6 End of Life Facilitators (SWYPFT) and Discharge Team and care is commissioned by CHC, this process mitigates any risk to the patient and provides an effective and timely service for patients.

Pathway 1d – (Overview)

This pathway was required to maintain patients nursing needs on discharge through the Discharge to Assess model and to maintain access to medicines management on discharge incorporating support for readmissions and advanced care planning. In April 2020 to support the Discharge to Assess model, the medicines management referrals were completed by the assessing team (social, therapies or community nursing etc.) rather than the acute trust.

Pathway 2 – (Overview)

This pathway is to support patients that require inpatient rehabilitation ensuring correct placement and continued ongoing therapy with regular reviews requiring intermediate care. To support with the Discharge to Assess model, in April 2020 the decision was made to complete patient assessments in their own home setting or intermediate care setting rather than in the acute trust.

Pathway 3 – (Overview)

This pathway is to support patients within a 24 hour care setting either as permanent place of residence or temporary place of residence and ensure smooth transition from acute trust for patient's ongoing assessments under social services or CHC fast track, and to maintain any therapy needs for patients. To support with the Discharge to Assess model, in April 2020 a decision was made for all patients deemed unsafe to return home for assessments but not requiring intermediate care would be discharged to a Discharge to Assess bed (temporary 24 hour placement) to have outstanding assessments completed. The aim of these beds is to provide a safe environment to complete assessments rather than in an acute bed, therefore reducing length of stay at the acute and providing an efficient and timely process for patients to return to their own home with the support required. A patient checklist will be completed within 48 hours of discharge by social services and submitted to CHC.

Briefing prepared for Cllr. Jeff Ennis, Chair of Barnsley Overview and Scrutiny Committee and Adrian England, Chair of Healthwatch Barnsley

This briefing note has been prepared to provide an overview of the work that NHS Barnsley Clinical Commissioning Group (CCG) and local partners are undertaking in relation to intermediate care services across Barnsley.

We would like to gain your feedback regarding the proposals outlined below and in particular as to whether you are happy to support the proposed approach to engaging with patients; their carers and family members and members of the public on an ongoing basis to gather data about their experiences of using intermediate care services.

Background Information

What is the current service like?

Intermediate care services provide support for a short period of time to help people recover and increase their independence. It is a form of *active rehabilitation* supporting people to:

- Remain at home when they start to find things more difficult
- Recover after a fall, an acute illness or an operation
- Reduce the risk of admission
- Decrease the length of a hospital stay
- Reduce the risk of a readmission
- Reduce the risk of admission to a care home.

Based on a person's current health, abilities and wishes, they agree and work towards personal goals. The person is supported by staff trained to maximise their mobility and observe, encourage and guide, so the person can do things themselves, rather than to intervene or carry out tasks for them.

There are four types of Intermediate Care Services in Barnsley. These are:

- Reablement - commissioned and provided by Barnsley Council
- Home based - commissioned by NHS Barnsley Clinical Commissioning Group (CCG) and provided by the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). The team is called the Neighbourhood Rehabilitation Service
- Bed based - commissioned by NHS Barnsley CCG and provided in two care homes with medical oversight by Barnsley Healthcare Federation
- Crisis response - commissioned by NHS Barnsley CCG and provided by SWYPFT. The team is called the Crisis Response Team.

For the CCG commissioned services, care is co-ordinated by the RightCare Barnsley team. Their job is to work with the patient, carer and healthcare professionals involved to determine what level of support someone may need and therefore which service is best for them at that time.

As the list above suggests, intermediate care is something that involves all health and social care organisations working in Barnsley and is a key part of supporting patients as they go into and come out of hospital to make sure that patients receive the right care, at the right time, in the right place.

What is being proposed?

Together with partners, NHS Barnsley CCG and Barnsley Council are proposing to redevelop how intermediate care services are delivered. These partners include: Barnsley Council, Barnsley Hospital NHS Foundation Trust, Barnsley Healthcare Federation and South West Yorkshire Partnership NHS Foundation Trust.

A review of intermediate care services came about in February 2020 however the progression of proposals was paused during the first wave of the coronavirus pandemic. The opportunity to review the current provision came about as the contracts for the intermediate care bed bases were due to expire on 31/03/21. These contracts have been extended to 31/05/21 to alleviate pressure on the health and social care system. The contracts cannot be extended beyond this date.

Intermediate care services can currently support 120 people at one time:

- 70 people who are in their own homes (including those people who reside full time in a care home)
- 50 people who are having a stay in a care home for rehabilitation. Currently, two care homes sites are used for this.

The proposed changes which we would like to bring into effect are that the service supports the same number of people but more in their normal place of residence (their home) and fewer in an intermediate care facility. We would like to bring the changes into effect at the earliest possible time, with procurement timescales; this is currently 1 June 2021.

Our proposal is that local services would still be able to support a minimum of 120 people across the pathway at one time with a re-provisioning of the current model:

- Minimum of 90 in people's own homes
- 30 people who are having a stay in a care home for rehabilitation. The proposal is that one care home site would be used for this and this would become a specialist unit. This would mean that those people who reside within a care home, requiring additional levels of support, they would still move into the specialist unit if their condition requires this as would anyone else still living within their own home.

The proposed changes would mean that overall the proposals mean that the same number of patients (or more) would be supported. The services would be resourced in a different way and be re-provisioned so that more resource is put into delivering care in people's home.

Currently the intermediate care facility is provided over two sites across Barnsley by carers in care homes with input from nurses, therapists and other healthcare professionals. It is proposed that in the new model, care in the bed base would be delivered by NHS staff (nurses and therapists) with input from other healthcare professionals. It is hoped that this would provide better outcomes for patients requiring intermediate care. These nurses and therapists would be from the Acorn Unit, which is a current intermediate care facility. The Acorn Unit was originally based in the hospital but had to be relocated during the pandemic. This unit would become a specialist intermediate care facility to care for these patients

How many people would this affect?

Reviewing the data we have from the 2019/20 financial year intermediate care services receive around 3,000 referrals per year however this includes referrals between the different

intermediate care teams for the same patient, for the same episode of care. The number of individual patients who access the service is a maximum of 1,500 per year.

How has the proposed new model for Intermediate Care been developed?

In developing the proposed new model for intermediate care the following has been considered.

Reviewing national best practice

National best practice has been reviewed, in this case learning from other areas including the Newcastle Gateshead CCG vanguard for intermediate care, to help inform proposals for a future model. Newcastle Gateshead CCG has implemented a 'home first' model meaning that the resource is focussed in home based teams and the bed based was reduced. Health and social care professionals, patients and carers have fed back that this model is working well.

Reviewing the clinical needs of those who currently access the services

There is confidence that the new model is fit for patients clinically having reviewed clinical thresholds and health needs for past and present service users.

Reviewing what patients and the public have told us

As part of this work, we have reviewed what people have told us about healthcare services. This is detailed in the section below. During recent engagement exercises people in Barnsley have told us that they prefer to receive healthcare closer to, or in, their own homes.

Reviewing what health and social care professionals have told us

The proposals have been reviewed by a number of clinicians so far, and there is broad support for the changes outlined. More information can be found in the section below.

From all these different points, it is felt that the proposed 'home first' model is appropriate in terms of best outcomes for patient care and overall is something that is supported. The proposed engagement and ongoing collection of patient experience data will add to our understanding.

How has feedback from patients and the public informed the model for intermediate care to date?

Views of current services

There is a range of patient and carer feedback from the current intermediate care services. With thanks to SWYPFT for sharing this information. The surveys which captured patient experience data from April 2019 – September 2020 were completed anonymously on hand held devices whilst the patients were accessing services, whether at home, in the intermediate care bed bases, or the Acorn Unit.

From this we can deduce that patients and carers:

- Felt they had a good or very good experience of intermediate care (95% of those surveyed)
- Felt that they are involved in decisions about their treatment / next steps (94% of those surveyed)
- Felt they have benefitted from the service (93% of those surveyed)
- Felt the team did their best to help them become more independent (99% of those surveyed)

- Felt happy with the progress they had made whilst being cared for by the service (93% of those surveyed)

The surveys found that, in summary, patients are satisfied with the care and support they receive from the current services. This has helped in part to shape the proposed new model as it suggests that the range of services in place is working for patients and their families.

We have reviewed what people have told us already about healthcare services in order to help shape and develop elements of the model. With partners, we have undertaken several pieces of patient, public and professional engagement over the last 18 months where we have heard from 450 people.

Whilst we know this doesn't give us the whole picture and doesn't mitigate against carrying out further conversations specifically in relation to this work, the key points from previous engagement which have helped to inform the direction of travel and new proposed model for intermediate care is that people we have spoken to prefer to receive care closer to, or in, their own homes where possible.

Further information is provided below which describes the engagement mentioned above in more detail.

What patients, the public and stakeholders told us about the NHS Long Term Plan (Spring and Summer 2019)

During Spring and Summer 2019 NHS Barnsley CCG talked to patients, members of the public and a wide range of stakeholders about their views of the NHS Long Term Plan to help shape how we bring the plan to life. This included a workshop with Barnsley CVS for the third sector, a workshop with adult learners and a number of focus groups with members of the public at local venues. Healthwatch Barnsley carried out over 250 surveys and also ran a number of focus groups. The Healthwatch feedback reports are available to view here: <https://healthwatchbarnsley.co.uk/home/about-us/our-reports/>

Key points from this feedback were that:

- People want more services to be provided **locally**, and see GP practices as an appropriate place to provide many of these services.
- The different parts of the NHS need to **work together** in a more integrated way.

What people told us about developing Neighbourhood Teams in Barnsley (Summer 2019)

During Spring and Summer 2019 NHS Barnsley CCG talked to patients, members of the public and a wide range of stakeholders about their views of the NHS Long Term Plan to help shape how we bring the plan to life.

Key points relevant to the new model for intermediate care:

- **Single point of access** - The team needs to have excellent knowledge of what is available, when and where. There needs to be the right clinical and administrative skill mix. It needs to be easy and quick for people to refer into. It needs to be flexible and support good communication for everyone using it and not add unnecessary steps into the process.
- **Consistent response times** are important. They need to be developed with consideration of other response times in both health and social care services. They

should take into account specific profession's guidelines. There should be good communication and conversation with the person receiving care in relation to appointment/visit times for example.

- **One team.** Everyone should feel part of one team, where there is trust and respect for each other's professions and the decisions made. There should be clear leadership. There should be face to face contact within teams. People shouldn't feel isolated, whichever team they work in and wherever they are based. There should be strong professional leadership, which is valued and recognised.

Discussion with Barnsley Patient Council

An introduction and overview of intermediate care services and proposals for developing these services was provided to members of the Barnsley Patient Council at their meeting which took place via Zoom on 28 October 2020.

Several members of the group have had direct experience as carers of family members who had accessed local intermediate care services and were asked if they would like to be involved in shaping this work going forwards.

Four members of the group have agreed to provide their support in shaping any public facing information and helping to develop the ongoing communications, engagement and experience activity relating to this work.

What have health and social care professionals told us about intermediate care services?

Feedback received from professionals working in the current service

Providers

From speaking to health and social care professionals who provide the current services, it is felt that one site which is a specialist intermediate care facility would be:

- More motivating and have better outcomes for patients, rather than a care home. It is one environment with more rehabilitation focus on each individual and the unit would be seen as a recovery unit and not a long term facility, which would motivate individuals plan.
- More efficient in terms of staff time and resource especially those who provide 'in-reach' services into the care homes e.g. the Neighbourhood Rehabilitation Team.
- It would allow the unit to focus completely on rehabilitation and become a centre of excellence.

Soft Market Test

During engagement in October 2020 with care home providers (soft market test) they told us what they think work, and what could work better about intermediate care services. We heard from the providers who engaged in this process that they felt an intermediate care facility would be more motivating and have better outcomes for patients, rather than a care home. They felt that one environment would be seen as a recovery unit and not a long term facility, which would motivate individuals to recover and get well before they moved home with appropriate support in place.

Feedback from committees and partners

The Discharge and Out of Hospital work stream which is attended by NHS Barnsley CCG, Barnsley Council, Barnsley Healthcare Federation, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Yorkshire Ambulance Service have had input into the proposals. The group are on board with the vision for the proposals for intermediate care services.

The proposals for the new model have also been discussed by the CCG's Clinical Forum which is a committee of clinicians. This committee were supportive of the proposals for a 'home first' model.

We are proposing to continue to engage with staff relating to the development of the clinical model and post-mobilisation to make sure any necessary changes can be made.

Where we are currently and proposed next steps

We already know that:

- Patients and carers feel supported and like the current service provision.
- The broad principle of receiving care closer to home has been supported by people in Barnsley through the feedback we have received to previous engagement work
- Health and social care professionals we have spoken to so far including GPs, nurses and carers support the proposals for the new model for intermediate care.

The current gaps are that we do not currently know what patients/carers think of the proposed new model; and we do not currently know how the proposal to have one site rather than two would impact on patients, service users and carers.

The proposal to move to one site may affect people in different ways:

- More people overall would receive care at home, with a support package tailored to their individual needs to enable this to be possible.
- People who are requiring higher levels of support due to the complexity of their needs would receive care at a specific intermediate care facility with care from nurses and therapists.
- One site means some people would have further to travel and some people would have less far to travel. The site within Barnsley would not be known until after procurement exercise has taken place.
- Other specialist facilities are based at one site e.g. hospital services. This helps to create a centre of specialist care.

Proposed approach in relation to our communications, engagement and experience activity

The CCG sought advice and met with an associate from The Consultation Institute on 30/10/20 in order to discuss the potential scale of communications and engagement activity required. Based on the above information and feedback already received through prior engagement relating to the broad direction of travel (at the time of our conversation at the end of October) it was felt that a suitable and proportionate approach to take in this instance would ideally be to plan and undertake a period of targeted engagement with people who have directly accessed or who are accessing the services outlined above and their carers or family members as well as obtaining the views of staff working across health and social care.

Current constraints

Following the above conversation, we came together as partners to discuss how the above could realistically and meaningfully be carried out and achieved at the current time and within the current climate without this feeling tokenistic towards capturing patient views and feedback and crucially without placing additional stress on front line staff to allow them to focus on delivering care.

We know that the patient cohort in relation to intermediate care tends to be mainly older people and vulnerable residents and again due to the current constraints around social distancing and infection prevention and control, being able to gain access to speak with the right people in order to obtain their views at the current time would need to be through front line staff who are already being asked to take on additional duties, roles and responsibilities and make adjustments where necessary just to keep local services functioning at this critical time.

In view of the above constraints and alongside the need to work at pace in order to ensure that local services can flex and meet the current demands required to support some of the most vulnerable members of our local communities in addition to the existing patient and public feedback already gathered, we are now proposing to adopt the approach of mobilising the project and building in as a key component of an outcomes based service specification, a dedicated and defined process to scrutinise and review the changes on a regular basis from a patient and carer experience perspective. This will enable us to truly understand how it feels for the people who are in receipt of intermediate care services and the family members and carers who are supporting them and enable services to flex and adapt where required. The proposal is to mobilise the patient experience data capture as soon as practically possible so this data can begin to be obtained and to influence service delivery (noting the constraints listed above) without delaying the implementation of the new model.

Delivered in partnership

All supporting communications, engagement and experience activity will be coordinated in partnership with those who provide the current services: South West Yorkshire Partnership NHS Foundation Trust (SWYPFT); Barnsley Hospitals NHS Foundation Trust (BHNFT); Barnsley Council and Barnsley Healthcare Federation.

Timescales

Subject to gaining your approval of the proposal and approach outlined above, we would hope to begin taking the above proposals forwards prior to the end of November with a view to keeping you updated at prior agreed and regular intervals throughout.

If you would welcome a conversation, have any questions or require any further information, on any of the above please do not hesitate to get in touch with us via the contact details below.

Key CCG Contacts

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Date: 18 November 2020

GOVERNING BODY

14 January 2021

Cancer Programme Assurance

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR			
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>
	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input type="checkbox"/>
2.	PURPOSE			
	<p>The purpose of this report is:</p> <ol style="list-style-type: none"> 1. To provide Governing body with assurance about the cancer programme position and update on the Cancer priorities within the Governing Body Assurance Framework (GBAF). These are outlined in the table below. 2. To provide assurance to the Governing body and Barnsley population that the CCG has a plan in place for managing the impact of COVID on the pathways. 3. To outline the future and current actions being undertaken by the CCG to instil confidence to the governing body that a Third Phase NHS Response to COVID-19 restoration plan is in place. 			
	Priority	Progress /assurance		
	Preventing cancer incidence	Refer to the section restoring and maintaining screening and Prevention Programmes		
	Reduced Inequalities especially those diagnosed at emergency admission	Refer to the section Minimising harm due to Covid on the cancer pathways		
	Better cancer survival to be diagnosed at stage 1 or 2	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements		
	Implement rapid assessment and diagnosis pathways for all tumour sites	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements		
	Improve care and treatment - embed new cancer waiting times system	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements		

	Access to the most modern cancer treatment	This is embedded within the cancer programme															
	Increasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of life	This is monitored by CCG QIPP assurance governance															
	Improve Patient Experience along pathways and Living With and Beyond Cancer (LWBAC)	On track and delivered via the LWABC programme															
	Deliver Survivorship Program (LWABC) including recovery package Stratified follow up pathways breast, prostate and urology rolled out	On track and delivered via the LWABC programme															
	Commissioning for Value adopted if appropriate	This is adopted when appropriate. Refer to conclusion section of the report															
	Achieve 10 waiting time standards including the 62 day referral-to-treatment cancer standard and 28 day faster diagnosis standard and pre-covid position	Refer to the section : Restoring the 28 days referrals to diagnosis pathway service improvements and ensuring that the capacity is in place to meet the restoration demand in diagnostic testing at the start of the cancer pathway															
3.	REPORT OF																
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Executive</td> <td>Jamie Wike</td> <td>Chief Operating Officer</td> </tr> <tr> <td>Clinical Leads</td> <td>Dr Kadarsha Mr M Simms</td> <td>Cancer Governing Body Clinical Lead Secondary Care- Governing Body Member</td> </tr> <tr> <td>Author</td> <td>Siobhan Lenzionowski</td> <td>Lead CAT Manager</td> </tr> </tbody> </table>			Name	Designation	Executive	Jamie Wike	Chief Operating Officer	Clinical Leads	Dr Kadarsha Mr M Simms	Cancer Governing Body Clinical Lead Secondary Care- Governing Body Member	Author	Siobhan Lenzionowski	Lead CAT Manager			
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4.	SUMMARY OF PREVIOUS GOVERNANCE																
	The matters raised in this paper have been subject to prior consideration in the following forums:																
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Clinical Forum	7/1/2021	Provided clinical guidance to Commissioners about the main priorities implementation															

5.	EXECUTIVE SUMMARY
	<p>The aim of this paper is to provide an assurance update to the Governing Body for the CCG cancer programme, which is part of the CCG GBAF.</p> <p>It is also to instil confidence to the Barnsley public and the Governing body that actions are in place to respond to the directive to CCG's by NHSE/I published on the 14th December 2020 of the expected Phase 3 full recovery of NHS cancer services in England, including ensuring that care for all patient groups continues to be safe, effective and holistic. This directive from NHSE/I sets out the national NHS plan to deliver this third phase Cancer services recovery plan. These priorities are to by April 2021:</p> <p>Aim 1. Restore demand to at least pre-pandemic levels Aim 2. Reduce number of people waiting longer than they should Aim 3. Ensure sufficient capacity to manage future demand</p> <p>This includes additionally to :</p> <ul style="list-style-type: none"> • Restore the number of people coming forward appropriately • Ensure sufficient diagnostics in COVID safe environments • Expand surgical hubs • Increase endoscopy to “normal” levels • Restart all cancer screening programmes • To reduce referral to treatment long waits (31, 62 and 104 days) • Put in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment <p>This paper focuses on providing assurance about four areas that are the major priorities for the cancer restoration programme. These are:</p> <ol style="list-style-type: none"> 1. Minimising harm due to Covid on the cancer pathways 2. Restoring the 28 days cancer referrals to diagnosis pathway service improvements 3. Ensuring that the capacity is in place to meet the restoration demand in diagnostic testing at the start of the cancer pathway 4. Restoring and maintaining screening programmes <p>These priorities will be delivered via a:</p> <ul style="list-style-type: none"> • Focus on delivering the rapid diagnostic pathways components across the lower GI, lung and vague symptoms pathways by April 2021 • Continuing to clinically prioritise and review patients whom have been referred or are waiting for treatment to ensure the risk to their long-term health outcomes are minimised. • Working with the Cancer Alliance and the Trust to fully maximise the efficiency of the capacity that is available and the restoration to pre-covid referral and capacity levels. • With the Primary Care Network and the Barnsley wide integrated delivery system focusing on restoring early diagnosis referrals and targeting tumour or screening pathways that have been affected by

	<p>COVID, that are widening the health inequalities experienced by the population of Barnsley.</p> <p>They are a number of risks to the delivery of these areas. This includes :</p> <ul style="list-style-type: none"> • The continuing current operational pressures due to COVID within the Trust and Primary Care are a risk to the programme progressing as expected and may change the initial planned timescales agreed and planned. • The impact of COVID on staff resource available to progress this work • The capacity to deliver pre-Covid capacity levels due to COVID restrictions within services. • The impact of people behaviour choices with presenting at services or postponing interactions with services due to the COVID situation. <p>The cancer programme has identified improvement actions for each of these areas and therefore is requesting that this assurance report be approved.</p>
6.	GOVERNING BODY IS ASKED TO:
	<ul style="list-style-type: none"> • Note the information that is providing assurance for the cancer programme delivery and approve this assurance paper.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix A: Further information on Behavioural science theory work • Appendix B: RDC high level plan and groups terms of reference.

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

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer	✓	8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		<i>Cancer delivery</i>
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act):		
	Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)
	Duty to promote the NHS Constitution (s14P)	x	Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		Yes
	Approved the paper content		
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

1.	DISCUSSION / ISSUES
	<p>During the past 6 months the Cancer pathway delivery has been significantly affected by the impact of COVID with services having prolonged delivery timescales; patients being unable to attend appointments and resources being moved away from these pathways to meet the unexpected COVID demand. Services are continuing to work on aiming to move back to pre-Covid delivery in line with the 'Third Phase of NHS Response to COVID-19' that was published on the July and December 2020. There is also a national cancer service delivery taskforce overseeing this recovery programme.</p>

The cancer programme remains in the majority on track to meet the CCG GBAF priorities, as outlined within the table on page one.

There are a number of areas that are a priority for the CCG and therefore this assurance report will focus on these priority areas:

These four areas are outlined in more detail within the sections below:

1. Minimising Harm due to Covid on the Cancer Pathway

Barnsley as part of the Cancer Alliance (CA) is taking part in a group that is focusing on minimising harm to 6 patient cohorts. This group was established to respond to the work instigated by the Yorkshire and Humber NHS/I Medical Director and as it was identified as an SY&B Integrated Care System (ICS) priority.

The focus of this work has been about minimising the harm to 6 Patient Cohorts. These are:

1. People referred via the 2 ww cancer pathways or on a cancer pathway including those on surveillance
2. People delaying care or treatment due to Covid
3. Patients who are currently on elective waiting lists and have been waiting for some time (and may continue to do so) as 6% may have a diagnosis of cancer via this route
4. Patients who had been on an elective waiting list but had been removed for the list and referred back to Primary Care without their procedure having been carried out
5. Patients who have 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. This has now been resolved.
6. The management of potential new referrals by General Practitioners and alternatives to referrals / patients whom are not presenting to services

The key findings are that:

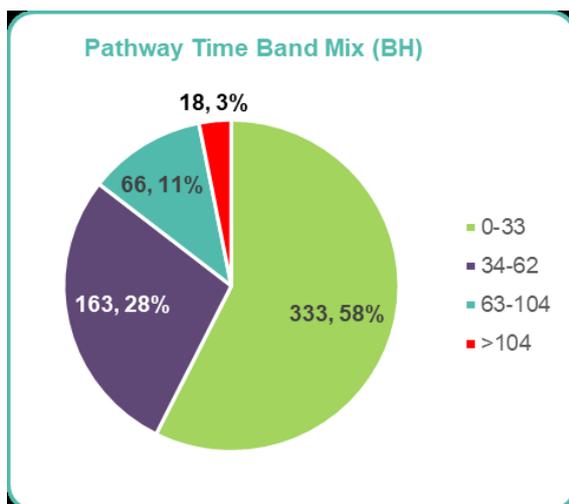
- Barnsley mapping highlighted that all areas have quality assurance plans and processes in place including risk stratification and regular reviews to ensure patients are being clinically prioritised
- There are a number of innovative practices taking place or planned to further reduce the harm to this cohort of people including:
 - The Trust is testing using NHS volunteers to provide transport to people for whom this may be a challenge.
 - For people waiting more than 104 days from referral to treatment on the cancer pathway they have been personally contacted by the trust to ensure they understand their situation. This also allows the Trust to gain further information that will support them to clinically prioritise their referral appropriately.
 - The Trust has recently developed and adopted an enhanced root cause analysis (RCA) template for people with cancer

whose pathway breaches the RTT 62 day standard – but also those that exceed 104 days from referral by a GP.

- Patients continue to report that they would prefer increased communication with providers around the status of their referral and surveillance services. Services have been writing or informing people to contact the provider if they are concerned about their condition to mitigate this risk
- Safety Netting processes are in place across Primary Care and within the Trust but further information is needed for the CCG to be assured that there is consistent Quality Assurance practice in place across these services
- Further working is planned around reducing the barriers that are stopping people wanting to use health care services or attend the additional independent sector provision procured by NHSE/I that is available.

In addition the following improvement actions are in place or planned to ensure the restoration of services are in line with NHSE/I directives:

- Weekly SITrep meetings are being held between Trusts, the CA and NHSE/I to focus work on actions that will reduce the risk to patient whom are on prolonged cancer pathway. For people waiting more than 104 days from referral to treatment this has reduced from 90 people to 18 over the last 6 months. This has occurred by BHNFT prioritising these people and individually contacting each patient to resolve any issues they may be facing.
- The current position for referral timescales provided by BHNFT at 14 December 2020 is outlined in the diagram below. i.e. 84 people are waiting for a diagnosis or treatment to start after 62 days from being referred by their GP.



Over the next 6 months the Trust is aiming to restore this performance to a pre-covid position i.e. that people are given a diagnosis within 28 days and approximately 8-10 people (15%) will not have had a treatment date or a diagnosis agreed by day 62.

- The development of a set of Harm Reduction Principles for the CA has been adopted by the CCG and Trust to provide further safety netting and clinical prioritisation assurance for patients whom are on a pathway

- The Barnsley surveillance group is analysing current referral data and will use the findings to target restoration activities to the groups and the pathways with the greatest Health Inequalities impact
- Preparation work is underway to introduce the faecal immunochemical test (FIT) as a primary care cancer exclusion tool for the lower GI pathway. This may reduce by 50% the number of patients whom need a 2WW referral or endoscopy provision. Currently at BHNFT (14/12/2020 from ERS unvalidated data) the volume of prolonged pathways are 142 people waiting more than 33 days for a diagnosis from referral by a GP. This would reduce by half following the introduction of the FIT test.
- Considering how to take into account the balancing of prioritising referrals and treatment options for patients that include quality of life factors compared to procedural ones for e.g. if the patient is a carer that this may impact on more people than the patient and should this harm reduction factor be considered as part of this prioritisation process
- Embarking on implementing the use of Behavioral science theory to nudge people in areas with low cervical screening coverage to attend their routine cervical screening. Early evidence demonstrates that an early implementer practice shows a 50% increase in cervical screening attendance in 'seldom heard' areas that have used this method to support Covid restoration levels
- Starting in January 2021 using the Behavioural science theory work via a Barnsley system group to reduce harm from missed cancers for three initial tumour sites identified that have had the greatest impact due to Covid. These are Lung, Upper GI and Head and Neck. (Refer to Appendix A for further details about this work)
- The Primary Care Network (PCN) is using the additional new roles to reduce harm to people due to Covid. For example, using the health and wellbeing workers to target people whom are not coming forward for screening or attending Primary Care appointments
- Continue to target communication and engagement activities to ensure people are aware of the current situation and that the management of their care or referrals maybe be impacted e.g. a first OPD may be virtual or clinically triaged; they may have a prolonged time period before they receive treatment or a diagnostic test
- There are anecdotal reports and feedback via the Cancer Quality Board that there is inconsistent practice in relation to the quality and personalisation of virtual and face to face consultations being experienced by patients, by Trust clinicians. For example, not allowing carers to accompany a vulnerable person or not recognising the importance of family/carers being present virtually or face to face if a particular situation necessitates this and will reduce a psychological harm to the patient.

As a result Barnsley CCG on behalf of the ICS/CA is planning to work in partnership with patients, family members, carers and clinicians by February 2021 to develop locally agreed principles and framework /guidance regarding accessing and carrying out face to face and virtual consultations for Cancer care during the Coronavirus Pandemic.

- Restoring capacity to pre-covid levels and using additional funding as it become available to reduce the harm to people for example: increasing

imaging capacity; preparing business cases to respond if capital funding sources become available; extending service delivery times; increasing staffing capacity to minimise harm to people, as it becomes available.

2. Restoring the 28 Days Cancer Referrals to Diagnosis Pathway Service Improvements

Over the last 6 months the number of people waiting for a diagnosis after being referred for a suspected within 28 days has considerably increased. In April 2020 the Trust was working on having a number of pathways that could provide a diagnosis to patient within 28 days from referral. This was for lower and upper GI, lung, head and neck, and the breast pathways.

This work was paused due COVID but has re-started and it is anticipated that 60% of this improvement work is currently in place at this time. This includes the introduction of new head neck lump triage and straight to test pathway and the restoration of a nurse/endoscopy triage and straight to test pathway for upper and lower GI. This work is already reducing the number of people whom need a first our patient appointment (OPD) and increasing the number of people who receive a diagnosis within 28 days.

In addition the following improvement actions will be taking place over the next 6 months to support this priority:

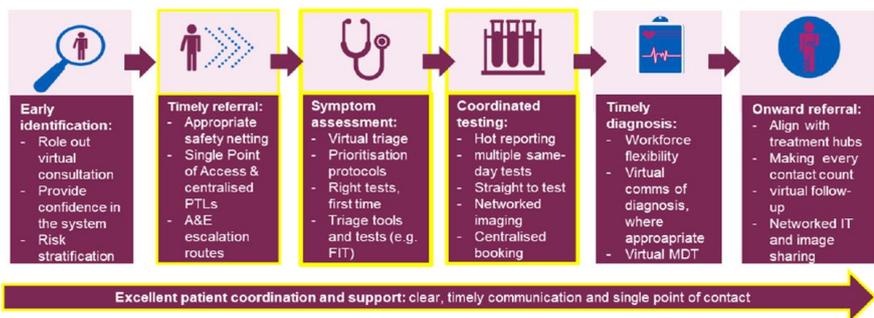
- Within Primary Care (from February 2021) a new cancer clinical decision making tool is being implemented. This will support further GP's to increase early diagnosis referrals and complete the information BHNFT needs to speed up the pathway timescales for the person
- The increased implementation of the Rapid Diagnostic Pathway Components (RDC) will make a number of cancer pathway more efficiency and reduce the time required that a patient takes to receive a diagnosis.

The aim of increasing the seven rapid diagnostic components (RDC), as outlined in the diagram below, is to make the pathway much quicker for the patient, in as least steps possible and to ensure the patient care is co-ordinated more efficiently and the patient experience much improved.

Diagram1: Seven Rapid Diagnostic Components

Adopting Rapid Diagnostic Centre Principles:
 Local systems should adopt the seven RDC components to quickly respond to diagnostic backlogs in a way that is safe for patients and staff. This will ensure:

- Patients receive support and accurate advice on how to safely access services
- Resources are used in the most productive way to reduce backlogs in cancer diagnostic services;
- Diagnostic services are accessed based on clinical need
- Innovations are embedded to 'lock in' beneficial changes and help overcome Covid19 related issues
- Workforce is used flexibly to adapt to service capacity and patient needs, and protect staff
- Ensure the optimal patient and carer personalised experience along the pathway.



To manage this project and associated overlapping areas the CCG has set up a specific RDC oversight and steering group. This group comprises of representatives from BMBC, the PCN, CCG, BHNFT and patients.

It has recently produced a high level implementation plan that outlines the actions that will be delivered by April 2021 to embed the components along a number of pathways. (Refer to appendix B for the plan and groups terms of reference).

The implication for the CCG and providers will be :

- increased co-ordination and navigation for the patient and between primary care and Trusts if they are considered to have ‘suspected cancer’ via a specific staff member whom will have this role
- the introduction of a trans perineal biopsy procedure into BHNFT to minimise health complication for people on the urology pathway
- embedding faster diagnosis within 28 days across the head and neck, lung and upper/lower GI pathways
- increasing and embedding the vague symptoms pathway across Primary Care to reduce the number of people being diagnosed with cancer at a late stage
- increasing more patient referrals that can be triaged by nurses and do not need a face to face appointment before having a diagnostic test
- upskilling staff to take on more tasks that do not require a higher staff grade level to free up staff to manage the care of patients who have more complex care needs
- Reducing the number of appointments people will need and increasing the number of tests that can be undertaken over one day, reducing the number of people diagnosed with cancer at a late stage or via route referral pathways.
- Minimising the number of people who are diagnosed with cancer at a later stage and improving the efficiency and clinical decision making across a number of the cancer 2 week wait pathways.
- This work is a national priority for NHSE/I and the CCG has therefore received additional funding to progress this work during 2020/21 (£200,000) and 2021/23 (£200,000).

2. Ensuring that the Capacity is in Place to Meet the Restoration Demand to Pre-Covid Levels

Currently due to COVID social distance restrictions at BHNFT and Weston Park cancer centre these services are working at a reduced capacity level (BHNFT is at 90% pre-covid levels and in some areas can only provide 40% space for people to attend appointments). There is also a lack of staff resource or space to increase this capacity or to provide mobile provision to increase demand and reduce the backlogs built up due to COVID.

To improve this variation and meet this demand a number of actions are being undertaken or planned :

- the clinical decision making tool for Primary care will improve the number of appropriate referrals into acute services and clinical prioritisation of referrals
- The CCG and PCN are work together to ensure there is consistent uptake by primary care and the embedding of any new pathways that can support the restoration.
- The CCG and partners are working on increasing community diagnostic capacity via considering developing a health and wellbeing places to provide increased capacity and cancer services in community venues. This is subject to a capital funding bid.
- BHNFT are increasing the skills of staff in order that they can meet the increased demand e.g. training staff to be able to undertake biopsies to reduce the burden on areas that are fragile
- Working with the South Yorkshire and Bassetlaw ICS around a network of pooled staff that could meet this demand; increasing endoscopy and radiology imaging reporting capacity.
- BHNFT are working on using teledermatology images to triage the 2 week wait referrals from primary care. At this time only 8% of these referrals become diagnosed with cancer. This will reduce the number of first appointments required for these referrals and release staff time to focus on other areas of the pathway that are more pressurised.
- Continue to use the independent sector capacity commissioned by NHSE/I for patients and to reduce treatment waiting time
- A nursing workforce strategy has been adopted to increase the gap in this workforce numbers and competency level within this staff mix i.e. increase the number of Cancer Nurse specialists, Associate Nurses; cancer support workers.
- Continue to consider the viability of using mobile provision to increase capacity and restore services to pre- covid waiting time levels
- Adapt and adopt the endoscopy programme increasing BHNFT current and future Endoscopy capacity so can meet patient demand and activity in line with Cancer Waiting times.

3. Restoring and Maintaining Screening and Prevention Programmes

Over the last 6 months a number of screening programmes were impacted by Covid. At this time only Cervical screening has had minimal impact on the pathway, as it re- started in June 2020. With bowel screening restarting again

	<p>in early September.</p> <p>The last screening service to re-start was Breast and this began in mid-September. This has the greatest restoration risk, as the current BHNFT breast screening service due to Covid conditions is only able to operate at a 40% capacity activity within the current resources. The Trust and Public Health England (PHE), whom are the commissioners of this service, are aware that this is a risk and that it will impact on phase 3 restorations for a significant period.</p> <p>To mitigate this risk a number of actions are in place :</p> <ul style="list-style-type: none"> • BHNFT has raised this risk with PHE and requested support to increase the capacity. Currently PHE response to the Trust is that funding is not available or the workforce to provide additional capacity. • PHE are prioritising the outstanding screening waiting list based on clinical prioritisation to minimise the risk of harm to women during this period. • PHE are developing a process of inviting women for screening based on a length of time since their last test, rather than the current 'round' invitation system. This will reduce the time women are waiting to called for an appointment • BHNFT have developed an internal business case for a mobile screening unit proposal. The trust at this stage is unable to fund this provision at this time, due to lack of funding as it is £400,000 annual costs to provide this facility • BHNFT has shared the mobile provision business case with PHE and upskilling two staff to provide sustainability and additional capacity into the service to reduce the backlog. • The CCG has raised with PHE the risks that this situation poses to the early diagnosis of breast cancer and women's survival and morbidity outcomes. It is also working with the PCN to increase screening rates to groups that are low attendees and encouraging women to present to services if they have any suspicious symptoms. This work is being delivered in conjunction with the PCN health and wellbeing workers. <p>This risk to restoration is not impacting on the symptomatic Cancer breast pathway as screening is not part of this pathway. But it may impact on preventing cancer incidence and the time that a person is diagnosed with cancer and go onto impact on their survival prognosis or treatment options.</p> <p>4. Conclusion</p> <p>In conclusion the cancer programme deliverables outlined above will lead the CCG to meeting the Governing Body Assurance Framework cancer priorities and the Phase Three Cancer restoration delivery. It also provides a framework upon which the Primary Care Networks and Barnsley Integrated Delivery group can base their mobilisation and priority planning decisions upon. The Governing Body it therefore asked to approve this assurance report.</p>
Refer	<p>DELIVERY OF STATUTORY AND GOOD GOVERNANCE REQUIREMENTS No material issues identified</p>

3.1	Management of Conflicts of Interest (s14O) Not Appropriate
3.2	Discharging functions effectively, efficiently, & economically (s14Q) Not appropriate
3.3	Improving quality (s14R, s14S) This programme will support the delivery of other CCG improving quality duties by focusing on reducing clinical and safety harm to people on the cancer pathway and improving patient safety and experience via a number of deliverables outlined in this paper that will contribute to this duty.
3.4	Reducing inequalities (s14T) This programme will focus on reducing HIE to areas/people affected by impact of covid conditions on the cancer programme deliverables.
3.5	Public Involvement & Consultation (s14Z2) As outlined in the report
3.6	Data Protection and Data Security (GDPR, DPA 2018) Not Appropriate
3.8	Human Resources - Not Appropriate
3.9	Environmental Sustainability Not appropriate
5.	RISKS TO THE CLINICAL COMMISSIONING GROUP
	<p>Risk to delivery of the 62 day wait NHS Constitution standard if clear pathways from cancer diagnosis to treatment are not developed; capacity in place to meet the demand and services are able to respond to the impact of Covid restrictions on delivery of the Cancer Waiting Times.</p> <p>2. Risk to delivery of early diagnosis if:</p> <p>(a) the CCG does not effectively promote to the people of Barnsley the national screening programme</p> <p>(b) Practices do not consistently apply NICE guidance for cancer diagnosis and referral and deliver the PCN DES.</p> <p>3. Risk that, if the CCG does not have a clear local strategy for delivering cancer priorities and performance, Barnsley people morbidity and mortality from cancer will be impacted negatively for people at risk of cancer; Living With and Beyond Cancer (LWABC) and improving 62 day target and delivering 10 CWT standards .</p> <p>4. Risk that the incidence of cancer is not reduced, and of poorer outcomes post treatment, if steps to promote healthy lifestyles for Barnsley people are not successful.</p> <p>To note that the current operational pressures within the Trust and Primary Care are a risk to the groups work progressing as expected. This is due to the limited staff resource available to work with the CCG to provide the necessary information to mitigate these risks.</p> <p>The risks to the CCG of this paper not being approved are :</p> <ol style="list-style-type: none"> 1. The Cancer Programme will not be implemented 2. The CCG will be unable to meet the statutory and constitutional targets requirements 3. Barnsley population cancer outcomes will not continue to be improved.

6.	CONCLUSIONS & RECOMMENDATIONS
	Governing body are asked to : 1. Accept this assurance report.

Using Behavioral ‘Nudges’
Science to Reduce
Inequalities in Cancer Care
Services & Reduce COVID
Impact

Socialising Introduction

A decorative graphic at the bottom of the slide featuring several overlapping, wavy lines in shades of teal, light blue, green, and grey.

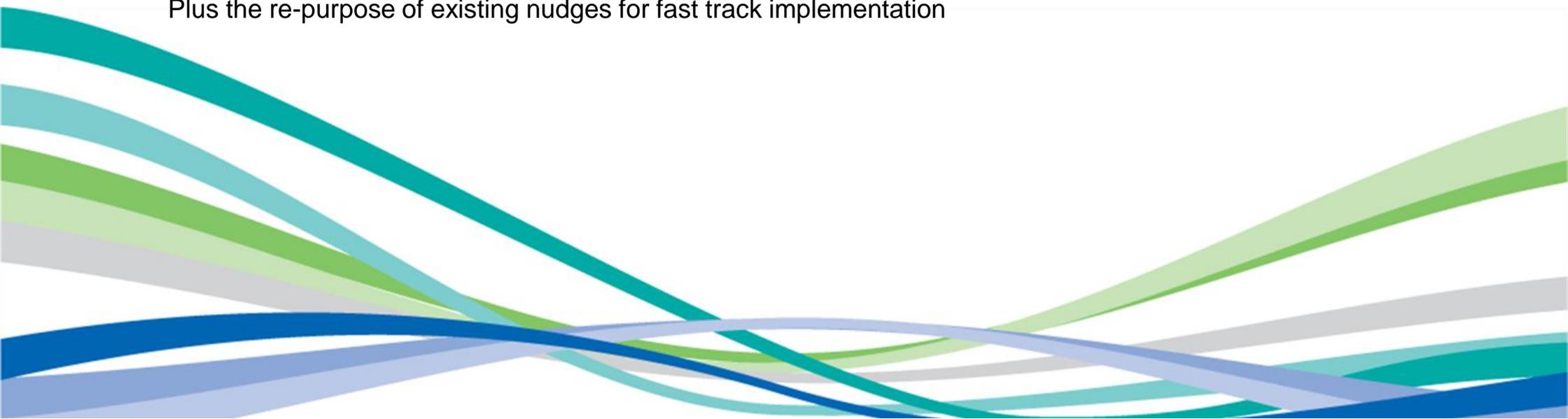
Background

Behavioural science is a new approach we are exploring – based on the study of “human habits, actions and intentions” spanning the fields of psychology, HR, economics and organisational behaviour. It recognises that traditional approaches such as educating or informing people don’t work as well as we previously thought and incorporates a much wider set of factors – for example:

1. People are heavily influenced by who communicates information – engagement workers, Housing Officer; Doctors and Nurses who have authority, trust and respect (MESSENGER)
2. People are strongly influenced by what others do (NORMS)
3. People respond to incentives in terms of what they will gain and more importantly lose (INCENTIVES)
4. People respond to what feels novel or relevant to them (SALIENCE)
5. People act in ways that make them feel better about themselves (EGO)

- Used already in screening in other areas in the ICS - seeing increase in people who previously never came forward for cervical screening.
- This trialling the approach for increasing cancer pathways uptake with focus on HIE i.e to reduce harm from missed cancer referrals and patients dropping out of treatment due to COVID etc. .

- CA has embarked on implementing the use of Behavioral science theory to nudge people in deprived areas with low cervical screening coverage to attend their routine cervical screening. Early evidence demonstrates that an early implementer practice shows a 50% increase in cervical screening attendance in hard to reach areas compared to January 2020 to support Covid restoration
- The CA is adapting this work across the wider cancer system to reduce harm from missed cancers, using three simple concepts:
 - Push – use of targeted nudges with community connectors that engage with identified population to push them to their GP instead of sitting on symptoms
 - Pull - use of targeted nudges to engage those identified through the primary care workforce to pull people into the primary care system rather than sitting on symptoms
 - Stick with – use of nudge messages across the identified cancer specific treatment pathways to ensure patients access services, diagnostics and complete treatment pathways
- This will be with three initial tumour sites identified that have had the greatest impact from Covid, these are Lung, Upper GI and Head and Neck.
- Further analysis is to be completed by the beginning of December to identify populations and demographic areas where missed cancers are likely and harm increased due to the widening inequalities from the impact of Covid. Plus the re-purpose of existing nudges for fast track implementation



CA priorities

The priorities for delivery this year include:

- Fully embedding all seven principles within Non Site Specific Pathways – Vague Symptoms
- Implementing all the RDC principles in Lower GI pathways
- Preparation for implementing RDC principles in UGI, Urology, Head and Neck, and Lung pathways
- suggest establishing the Urology Transperineal Biopsy pathway is an initial area of focus
- For short term posts keen to ensure that places are considering the future sustainability of those posts.
- Defining Navigation – what is it, clarify what we want to achieve, expectations & outcomes
- define the skills and competencies that contribute to effective clinical and admin triage and to clarify what we want to achieve, the expectations & outcomes for early pathway management.
- system wide approach to advice and guidance working with the existing ICS group to ensure a consistent approach
- system wide RDS communication strategy
- CDG developing RDC optimal pathways
- ensure that places consider how they plan to measure the impact of the use of funding
- address health inequalities
- capture within the plan particular work in skin and head and neck by clinical delivery groups
- Support project management and consider for a longer timeframe with 12 months as a minimum.

In place Dec 2020:

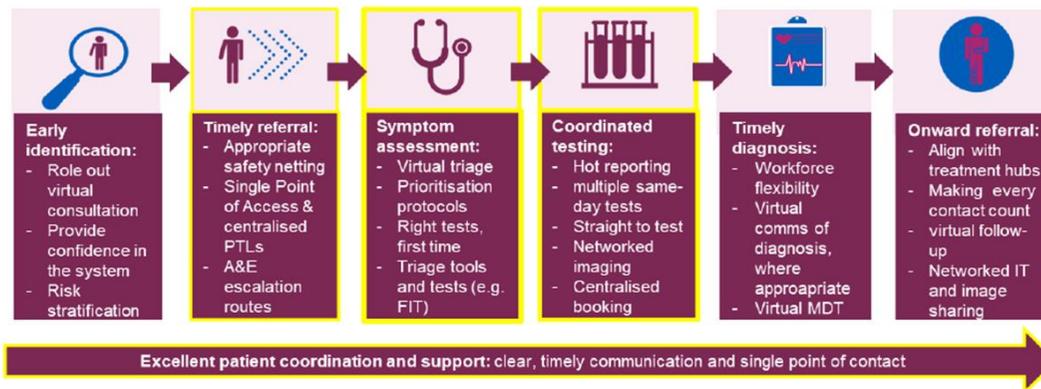
- Earlier Identification : Primary care initiated tele dermatology pathway (routine); vulnerable index to identify and support HIE ; Behavioural insight project starting in December ; PC decision making tool to be in place by March ; targeted communications ; new posts in PCN and BMBC engagement/Health and Well Being
- Timely Referral: Primary care initiated vague symptom pathway but not fully used , via ERS , 2WW forms
- Symptom Assessment and Co-ordinated testing : Increasing Pathway improvements – using nurse led triage; Optimum lung; STT Upper and Lower GI; lump pathway; standards of care protocols; allocating specific Radiology Slots

- Ongoing Referral : MDT optimisation work underway; clinical validation and prioritisation in place for routine referrals
- Excellent Patient Care and Co-ordination : not a culture that the RDC pathway is from identification to onward referral – all one team approach; MDT Co-ordinators for tracking referrals
- Scoping identified – good foundation in place but need to build on existing work and have consistent implementation across Barnsley e.g increase referrals into new pathways; working as 1 system on this work

Adopting Rapid Diagnostic Centre Principles:

Local systems should adopt the seven RDC components to quickly respond to diagnostic backlogs in a way that is safe for patients and staff. This will ensure:

- Patients receive support and accurate advice on how to safely access services
- Resources are used in the most productive way to reduce backlogs in cancer diagnostic services;
- Diagnostic services are accessed based on clinical need
- Innovations are embedded to 'lock in' beneficial changes and help overcome Covid19 related issues
- Workforce is used flexibly to adapt to service capacity and patient needs, and protect staff
- Ensure the optimal patient and carer personalised experience along the pathway.



High Level Project plan 7 12 2020

RDC project plan Timeline	Wc 16/11	w/c 23/11	w/c 30/11	w/c 7/12	14-Dec	By 31/12	By 31/1/2021	By 28/2/2021	By 31/3/2021	31/4/2021
Set up oversight/steering group – Barnsley wide sub group BCSG	█									
First funding template submitted	█									
BCSG agree staff model Dec 2020-dec 2021	█					█				
Scoping work summarised	█									
Second funding template agreed by CA						█				
Agree JD , management and location of roles for project			█							
oversight/steering group meetings			█				█	█	█	█
Produced and agreed initial project plan			█							
Advertise posts						█				
QIA/EIA / produced						█				
VS educational events delivered						█	█			
MOU agreed with CA by CCG						█				

recruit
ment
plan

Roles	Funding from BHN FT & RDC	1 year Cost (With On Cost)	length	Cost 20/21	Funding source	period	Cost 21/22	RDC funding	BH NFT funding	Employed by	Organisation agreed & informed CCG in writing	JD ready	Advert signed off	Sent to NHS jobs	Advertised	Closing date	Shortlisting	Interviews	Panel Members	Decision Made	Ref signed off and Approved	Contract signed	start date	Fund to Provider	IT Equip Order
Dates											14/01/2020	31/12/2020	04/01/2021	06/01/2021	06/01/2021	17/01/2021	18/01/2021	25/01/2021		25/01/2021					
Band 7 RDC Project manager FT		£49,910.00	1 month	£4,159.17	RDC money	11 months	£45,750.83	£49,910.00		PCN									Siohan L, J Crossland, S Andrews						
Band 7 RDC		£49,910.	1 m	£4,159.1	BH NF	11 m	£45,750.		£49,91	BH NFT									Sio bh						

Barnsley Rapid Diagnostic Pathway (RDP) Oversight & Steering Group

Terms of Reference

3/12/2020

DRAFT

Rapid Diagnostic Pathways Oversight & Steering Group Terms of Reference

1. Introduction

The commitment to roll out Rapid Diagnostic Pathways in England forms an important part of the wider strategy for delivering faster and earlier diagnosis, and an improved experience, for cancer patients. In particular RDP will support the delivery of ambitions in the NHS Long Term Plan to diagnose 75% of cancer patients at an early stage and to ensure that, by 2028, 55,000 more people will survive cancer for at least five years. It will also support the 28 Day Faster Diagnosis Standard, which was introduced in April 2020. RDP will complement work to improve screening programmes, augment the potential of artificial intelligence (AI) and genomic testing and utilise Primary Care Networks to improve early diagnosis in their localities

The ambitious vision for RD programme is that in time it will offer:

- A single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer
- A personalised, accurate and timely diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally

Whilst RDCs will be for patients with cancer-related symptoms, most patients seen by an RDC will not have cancer. A key wider benefit of RDCs will, therefore, be diagnosing serious non-cancer conditions more efficiently as well.

2. Purpose

The prime purpose of the Oversight and Steering group is to adopt the seven RD components to quickly respond to diagnostic backlogs in a way that is safe for patients and staff:

This will ensure

- Patients receive support and accurate advice on how to safely access services
- Resources are used in the most productive way to reduce backlogs in cancer diagnostic services;
- Diagnostic services are accessed based on clinical need.
- Innovations are embedded to 'lock in' beneficial changes and help overcome COVID19 related issues
- Workforce is used flexibly to adapt to service capacity and patient needs, and protect staff
- Ensure the optimal patient and carer personalised experienced along the pathway.

The seven RD components are

- Early identification
- Timely referral
- Broad assessment of symptoms
- Co-ordinated testing
- Timely diagnosis
- Appropriate onward referral
- Excellent patient co-ordination and support

Responsibilities

The Oversight and Steering Group will be accountable, to the Barnsley Cancer Steering Group (BCSG) and to the Barnsley Integrated Delivery group.

The Steering Group will be responsible for producing the project plan for 20/21 and having specific oversight for the RDC work in Barnsley. The group will also identify and produce a project plan for the RDC 2021/22 medium and long progression work. It will directly report into the Barnsley Cancer Steering Group (BCSG) for governance and reporting purposes and to other Barnsley wide groups when needed re: to escalate issues/agree system wide working.

3. Membership

Membership of the Steering group will be as follows:

STEERING GROUP ROLE	NAME	DESIGNATION	RESPONSIBILITY FOCUS
Chair	Siobhan Lendzionowski	Lead Commissioning and Transformation Manager	Accountable for Programme delivery and to BCSG and CCG
Clinical Lead	Dr Hussain Kadarsha	CCG Governing Body Clinical lead for cancer	To support the CCG in raising the standards of cancer care in Barnsley and providing senior CL oversight
Secondary Care CCG Governing Body Lead	Mike Simms	Secondary Care CCG Governing Body Lead	To provide strategic clinical support and oversight
Patient and Public Advisory Role	Alan Higgins		To provide an advisory role and input into the programme delivery from a Patient and Public perspective
BHNFT Representative	John Crossland	Lead Cancer Manager	Coordination of work programme with BHNFT input
	Sara Andrews	Macmillan Trust Lead Cancer Nurse	Coordination of work programme with BHNFT

			input
	Julia Dicks	Consultant Oncoplastic Breast Surgeon and BHNFT Clinical Cancer Pathway Lead	Clinical oversight for programme within BHNFT
BMBC representative	Rachel Payling	Head of Healthy Communities	Coordination of work programme with BMBC input
Primary Care Network representatives	Gloria Tawiah	PCN Project manager	Coordination of work programme with Primary Care input
	Dr Andy Mellor	PCN Clinical Lead Cancer	Coordination of work programme with Primary Care input and clinical oversight
Cancer Alliance PMO representative	Marianna Hargreaves/Georgia Thompson		To provide oversight and input from a CA wider perspective
CCG Programme Support	Emma Bates	Commissioning and Transformation Manager	Coordination of work programme for BCSG and the CCG
ICS Hosted Network representative	Katie Roebuck	Hosted Network Manager Urgent and Emergency Care & Gastroenterology	To provide an advisory role and input into the programme delivery from the hosted network and ICS elective programme perspective

Each Participant shall delegate to it a representative if they are unable to attend as necessary to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Other members/attendees may be co-opted as necessary onto the group .

4. Quorum

A Steering Group meeting will be deemed quorate where a minimum of 3 group members, one of which should be a clinician, the Programme Manager and at least one other partner than the CCG plus the Secretariat are present.

Reporting Arrangements

The decisions of the Steering Group will be formally recorded in appropriate action logs.

The Steering Group Chair shall report formally to the BCSG and into the Barnsley Integrated Delivery group. The project structure and supporting work groups will be developed and agreed as part of this groups remit.

5. Administration

The development of the Steering Group will be provided initially by the CCG's Commissioning and Transformation Team and from the RDC Project team when in place.

6. Frequency

The Steering Group meetings will be held monthly but the frequency will be reviewed in 3 months i.e. March 2021.

The length of Steering Group meetings will vary, depending on the needs of the Programme at the time.

7. Review

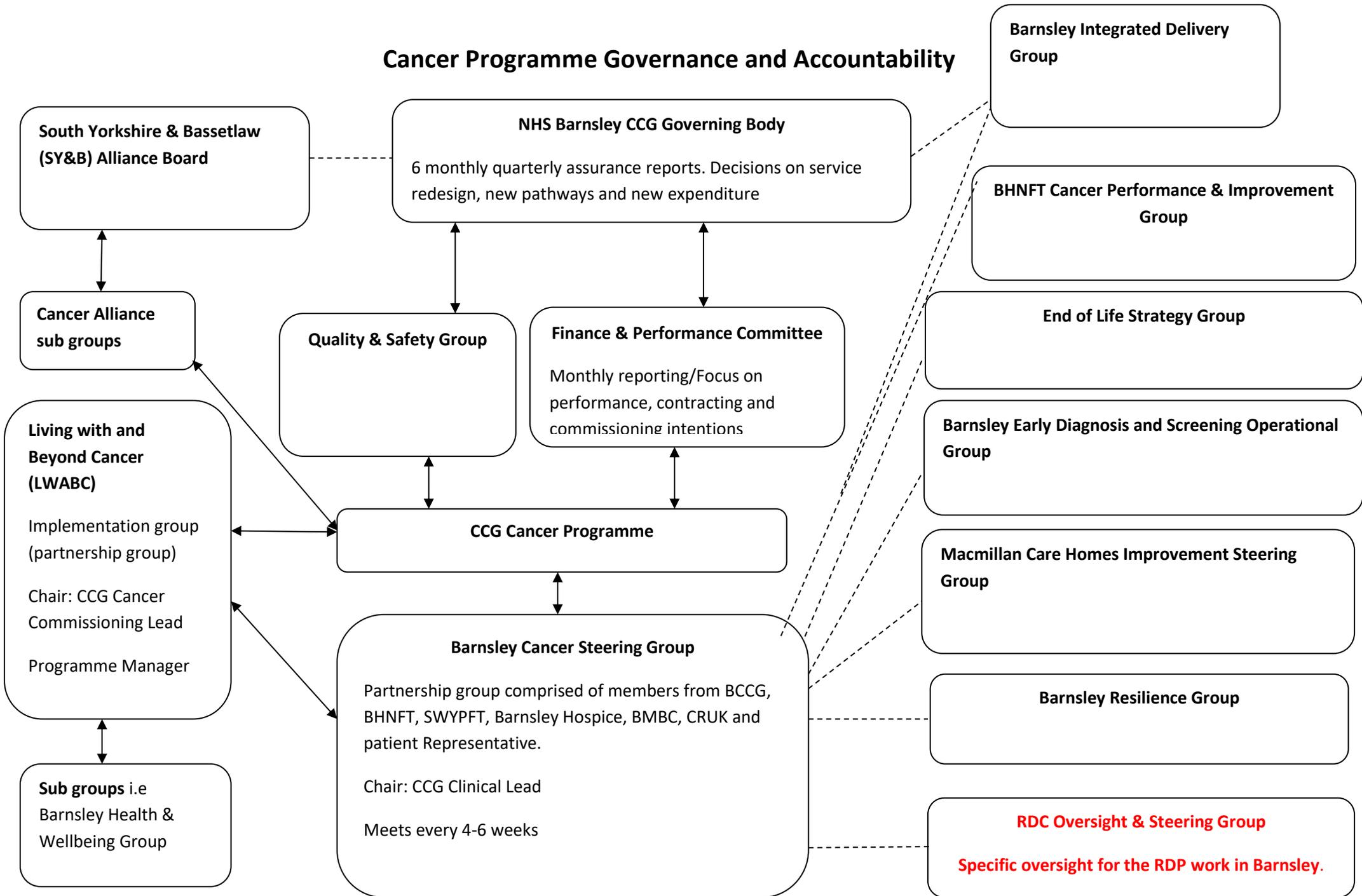
The Steering Group should review at least annually its own performance, membership and the Terms of Reference.

8. Partnership Principles:

To achieve the terms of reference the group as a partnership adopts the principles below:

- Will develop Integrated working transcending organisational boundaries
- support the Right Service in the Right Place at the Right Time principle
- Improve access to the cancer pathways for people via the RDP Components
- In support of the above create improved and new integrated model of rapid diagnostic pathways and ways of working that will improve the quality of life outcomes for the Barnsley population
- The Group will function through engagement between its members so that each member makes a decision in respect of, and expresses its views about, each matter considered by the group
- Will ensure that group members have the authority to make decisions at the group on behalf of their organisation or group
- Any conflicts of interest will be expressed as appropriate by the members

Cancer Programme Governance and Accountability



South Yorkshire & Bassetlaw (SY&B) Alliance Board

NHS Barnsley CCG Governing Body

6 monthly quarterly assurance reports. Decisions on service redesign, new pathways and new expenditure

Barnsley Integrated Delivery Group

BHNFT Cancer Performance & Improvement Group

Cancer Alliance sub groups

Quality & Safety Group

Finance & Performance Committee

Monthly reporting/Focus on performance, contracting and commissioning intentions

End of Life Strategy Group

Living with and Beyond Cancer (LWABC)

Implementation group (partnership group)

Chair: CCG Cancer Commissioning Lead

Programme Manager

CCG Cancer Programme

Barnsley Early Diagnosis and Screening Operational Group

Macmillan Care Homes Improvement Steering Group

Sub groups i.e
Barnsley Health & Wellbeing Group

Barnsley Cancer Steering Group

Partnership group comprised of members from BCCG, BHNFT, SWYPFT, Barnsley Hospice, BMBC, CRUK and patient Representative.

Chair: CCG Clinical Lead

Meets every 4-6 weeks

Barnsley Resilience Group

RDC Oversight & Steering Group
Specific oversight for the RDP work in Barnsley.

GOVERNING BODY - PUBLIC

14 January 2021

Integrated Care at Barnsley Place Assurance Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR														
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>												
	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>												
	<i>Information</i>	<input checked="" type="checkbox"/>													
2.	PURPOSE														
	<p>The purpose of the report is to update the CCG Governing Body on the development of integrated care at place level, priority area 5.2 of the NHS Barnsley CCG Governing Body Assurance Framework 2020-21. The report provides with an update on priority areas of work and principle areas of risk and should be read alongside the updated Governing Body Assurance Framework.</p>														
3.	REPORT OF														
	<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>Clinical Lead</td> <td>Nick Balac</td> <td>Chair</td> </tr> <tr> <td>Executive Lead</td> <td>Jeremy Budd</td> <td>Director of Strategic Commissioning and Partnerships</td> </tr> <tr> <td>Author</td> <td>Joe Minton</td> <td>Professional Manager</td> </tr> </tbody> </table>				Name	Designation	Clinical Lead	Nick Balac	Chair	Executive Lead	Jeremy Budd	Director of Strategic Commissioning and Partnerships	Author	Joe Minton	Professional Manager
	Name	Designation													
Clinical Lead	Nick Balac	Chair													
Executive Lead	Jeremy Budd	Director of Strategic Commissioning and Partnerships													
Author	Joe Minton	Professional Manager													

4.	SUMMARY OF PREVIOUS GOVERNANCE						
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th style="background-color: #d3d3d3;">Group / Committee</th> <th style="background-color: #d3d3d3;">Date</th> <th style="background-color: #d3d3d3;">Outcome</th> </tr> </thead> <tbody> <tr> <td>NA</td> <td></td> <td></td> </tr> </tbody> </table>	Group / Committee	Date	Outcome	NA		
Group / Committee	Date	Outcome					
NA							
5.	UPDATE REPORT						
5.1	<p>Introduction</p> <p>The spirit of partnership working is an embedded way of working in Barnsley and is also reflected in the partnership structures that we have in place, the Barnsley Integrated Partnership Group and also the supporting Barnsley Integrated Delivery Group, as well as Health and Wellbeing Board (HWB). These integrated governance groups continue to meet on a monthly and weekly basis and have also all been receiving valuable facilitation and feedback from colleagues appointed from the Local Government Association, which has been positive and will allow the partnership to take the next steps – of even tighter integration – with confidence.</p> <p>BICP has noted the consultation document issued by NHSEI on the 26th December referred to in the <i>Chief Officers Report (item 10 on the Governing Body Agenda for January)</i>. BICP has been working as a partnership to respond to this alongside our ICS colleagues in order to ensure the primacy of place in any new governance arrangements that are recommended or approved.</p> <p>The following sections provide an update on associated priority area (5.2) of the CCG Assurance Framework.</p>						
5.2	<p>Out of hospital care (including primary care networks)</p> <p>The CCG was working with SWYPFT and Barnsley Primary Care Network to mobilise integrated multi-disciplinary teams in each of the six neighbourhoods in Barnsley. Some of this work was put on hold due to the COVID-19 response both in the spring and when there was a local resurgence of cases in the Autumn. Some of this work has continued throughout and other parts, such as the staff consultation, will commence again at an appropriate time. The neighbourhood teams programme board that was overseeing the mobilisation is being recast as the care closer to home board from January 2021 and its programme will incorporate some of the developments that have been brought about by the pandemic, for example, discharge to assess. The terms of reference, including membership, is being reviewed.</p> <p>An update on the development of the Barnsley Primary Care Network is covered under priority area 1.2 of the assurance framework.</p>						
5.3	<p>Development of integrated provider governance and shared leadership out of hospital, building on the PCN and or Neighbourhood Teams mobilisation</p>						

	<p>The COVID-19 pandemic has highlighted the benefits of partnership working between primary and community care with the Barnsley Healthcare Federation (BHF) and the Primary Care Network working with SWYFPT to support local care homes, roll out staff testing and the local COVID-19 vaccination programme. BHF and SWYFPT have been developing a local partnership agreement that will strengthen governance and shared leadership.</p> <p>5.4 Population health management including PHMU, integrated care outcomes framework and local profiles and needs assessments</p> <p>The response to the COVID-19 pandemic has seen a strengthening of local health intelligence arrangements, including data sharing, that will continue help to ensure the population health needs are prioritised throughout response, recovery and restoration. A senior population health analyst has been recruited to support the work of the COVID-19 intelligence cell. The intelligence cell continues to provide regular surveillance reports for command, control and coordination in groups and working with the South Yorkshire Data Cell to support the South Yorkshire Resilience Forum.</p> <p>5.5 Set out how the local health system will specifically reduce health inequalities by 2023/24 and 2028/29</p> <p>The NHS England and NHS Improvement Phase Three letter brought with it a welcome focus on health inequalities which have been exacerbated by the COVID pandemic. The letter included eight urgent actions on health inequalities that were unpacked with Governing Body at a development session in August 2020. The CCG is working with partners to ensure that better understanding and tackling inequalities underpins all of shared priorities.</p> <p>5.6 Development of a place-based workforce strategy</p> <p>The Barnsley Integrated Workforce Group (BIWG) continues to oversee the delivery of the local workforce transformation programme working with partners in Barnsley and regional and national bodies through the SYB Integrated Care System workforce hub. There are several strands to this programme including the establishment of Barnsley Project Echo hub that will deliver training and development for the adult social care independent sector workforce from January 2021, plans to improve and expand student placements, a virtual simulation event for schools to promote jobs and careers in health and care and to create a Barnsley Health and Social Care Academy.</p> <p>Across SYB, the primary care and workforce hub are rolling out the strategic workforce modelling tool, learning from the successful project completed in Barnsley in 2019.</p> <p>In December 2020 the CCG recruited to the role of place-based workforce lead. The post that is part-funded by Health Education England will bring much needed capacity to support this important work.</p> <p>5.7 Estates</p> <p>The Barnsley Strategic Estates Group is working to develop a strategic area</p>
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wide approach to estates to ensure partner organisations work as collaboratively as possible. We intend to coproduce a Barnsley strategic estates strategy in 21/22.

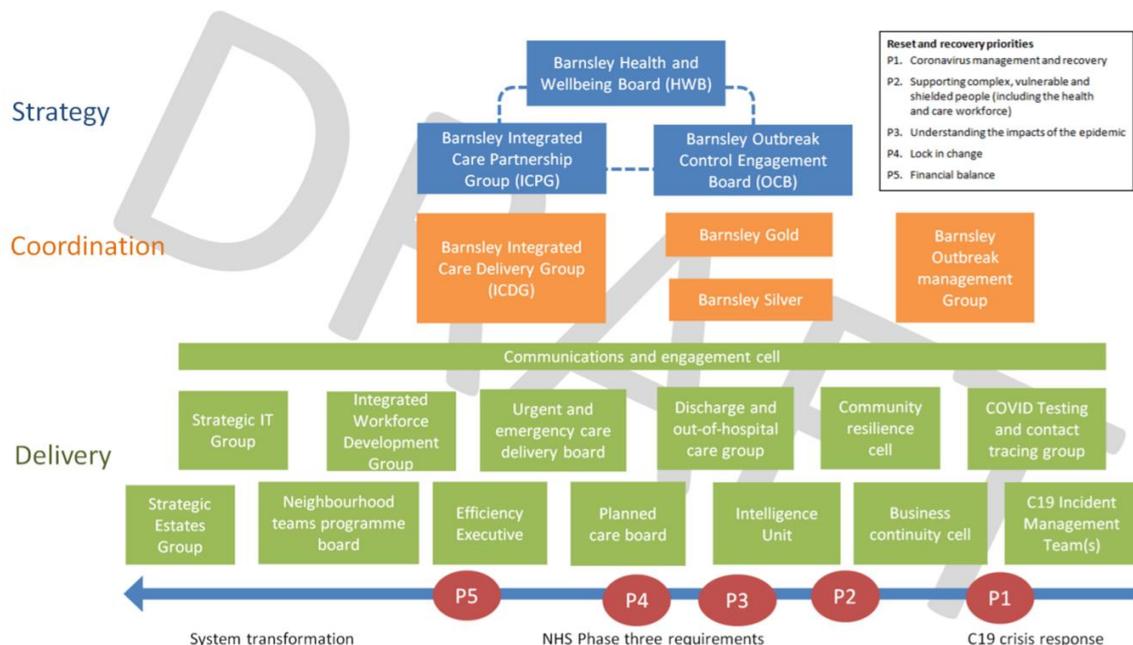
Barnsley CCG has continued work on proposals to develop neighbourhood health and wellbeing hubs across Barnsley, beginning in the Dearne. This proposal is currently in development, but is on a reserve list for the SYB ICS Primary Care Capital Board in order to potentially access any capital monies that might become available later in the spring.

5.8 Integrated commissioning with BMBC

There have been two joint commissioning workshops with leads from the CCG and BMBC in September and December 2020. Both partners are committed to strengthening joint commissioning arrangements. Task and finish groups have been established to bring together key stakeholders to develop vision statements and initial priorities focussed on a life course approach – Starting Well, Living Well and Ageing Well. An update on joint commissioning BMBC will be brought to Governing Body in March 2021.

5.9 Development of integrated delivery arrangements to support Phase 3 requirements, five priorities and to deliver financial balance

Following the first wave of the COVID pandemic Barnsley Integrated Care Partnership (BICP) undertook to update and refresh the local strategy for health and care. The key priorities that our place agreed to make centre stage in our recovery and reset plan for the remainder of 2020/21. Our full recovery and reset plan and our progress to date and key milestones was subsequently approved by the BICP and partners have been working together to deliver this. The chart below illustrates the partnership groups that are responsible for coordination and delivery of the work plan.



5.10	<p>Principal threats to delivery</p> <p>There has continued to be engagement from partners in the development of local partnership arrangements despite the challenge presented by the COVID-19 pandemic.</p> <p>The consultation document issued by NHSEI sets out options to further integration and signals potential legislative changes that could remove some of the barriers that have existed in recent years. The priority being given to this nationally, as well as the detail of the possible changes could remove or at least reduce some of the threats to delivery identified in the assurance framework. Of course, the period of change ahead introduces other uncertainties and challenges, particularly around the possible pace of change.</p>
5.11	<p>Next steps</p> <p>Over the next 12 months, our partnership will be focussing on the following objectives:</p> <ol style="list-style-type: none"> 1. To deliver the recovery and reset plan that we have collectively developed and agreed 2. Delivering the C19 vaccination programme 3. To further strengthen our Barnsley Integrated Care Partnership, looking at how we can make robust collective decisions and effectively manage the Barnsley Pound to deliver the best outcomes for the people of Barnsley 4. We will work together to fully mobilise our Neighbourhood Teams in our 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 5. We will support 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 6. Revisiting and further strengthening our joint commissioning arrangements between the CCG and the Local Authority, to ensure that we have one integrated commissioning plan for Barnsley, focussed on the life course – Starting Well, Living Well and Ageing Well 7. Having a clear and consistent one voice for Barnsley within our ICS, through the continued development of our Barnsley Integrated Care Partnership governance.
6.	THE GOVERNING BODY IS ASKED TO:
	Note this update for information and assurance.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	N/A

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

1.	Links to Corporate Priorities, GBAF and Risk Register			
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):			
	1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	✓
	2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
	3.1 Cancer	✓	8.1 Maternity	
	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:		5.2	
2.	Links to statutory duties			
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):			
	Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	✓
	Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)	✓
	Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	✓
	Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	✓
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			Y
	Proposals to be signed off by virtual Governing Body meeting			
3.2	Management of Conflicts of Interest (s14O)			
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?			NA

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

GOVERNING BODY

14 January 2021

Local Maternity Service Update

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR		
	<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>		
2.	REPORT OF		
		Name	Designation
	Executive / Clinical Lead	Chris Edwards	Accountable Officer
	Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)
3.	SUMMARY OF PREVIOUS GOVERNANCE		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	Group / Committee	Date	Outcome
	SY&B ICS Local Maternity Board	Monthly in 2020	Noted
	Governing Body	June 2020	Noted
	Maternity Commissioner Forum	16/12/2020	Noted and recommended action undertaken
4.	EXECUTIVE SUMMARY		
	<p>Governing Body have been kept informed of the progress made within the South Yorkshire and Bassetlaw Integrated Care System Local Maternity System (SYB ICS LMS) in transforming maternity services within the region to deliver the recommendations of 'Better Births – Improving Outcomes of Maternity Services in England – A Five Year Forward View for Maternity Care.'</p> <p>One of the key challenges highlighted, and a priority as one of the Long Term Plan ambitions, is the drive towards continuing to implement delivery of maternity services utilising the Continuity of Carer (CoC) model. The national CoC target to be achieved by the end of March 2021 is 35% and Barnsley Hospital NHS Foundation Trust will comfortably achieve this.</p>		

	<p>The current Coronavirus pandemic has brought it's own challenges and Barnsley Maternity Services have responded proactively to ensure the safety of their service users, providing additional emotional health and wellbeing support remotely via video / on-line sessions.</p> <p>In December 2019 the first report (known as the Ockenden Report) of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust was launched. The report outlines local actions for the Trust but also immediate and essential actions for all Trusts within the wider system that are required to be implemented to improve safety in maternity services across England.</p> <p>The key local challenges continue to be to work towards increasing the Continuity of Carer to 51% by March 2022, reducing smoking rates in pregnancy, increasing the breastfeeding rates and developing a midwifery led unit to provide a robust third option for women to choose where they birth.</p>
<p>5.</p>	<p>THE GOVERNING BODY IS ASKED TO:</p>
	<ul style="list-style-type: none"> • Note the contents of this report
<p>6.</p>	<p>APPENDICES / LINKS TO FURTHER INFORMATION</p>
	<ul style="list-style-type: none"> • N/A

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

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	4.1
2.	Links to CCG's Priority Areas	Y/N
	1 - Urgent & Emergency Care	
	2 - Primary Care	
	3 - Cancer	
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	
	6 - Efficiency Plan	
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	
	8 - Maternity	Y
	9 - Compliance with Statutory and Regulatory Requirements	
3.	Governance Arrangements Checklist	
3.1	Financial Implications	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	NA
	Are any financial implications detailed in the report?	
3.2	Consultation and Engagement	
	Has Comms & Engagement Checklist been completed?	NA
	Is actual or proposed engagement activity set out in the report?	
3.3	Equality and Diversity	
	Has an Equality Impact Assessment been completed and appended to this report?	NA
3.4	Information Governance	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	NA
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	NA
3.5	Environmental Sustainability	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	NA
3.6	Human Resources	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	NA

PART 2 – DETAILED REPORT

1.	INTRODUCTION/ BACKGROUND INFORMATION
	<p>Barnsley Maternity Services are making good progress in transforming local maternity services by implementing the recommendations of 'Better Births'. The local maternity services perform well against both local and national peers and are seen as an exemplar service in respect of the Continuity of Carer model, acting as a 'buddy' to other Trusts in the region by providing additional support / leadership.</p>
2.	DISCUSSION/ISSUES
	<p>To re-cap, the recommendations outlined in Better Births to transform maternity services in England cover the following aims:</p> <ul style="list-style-type: none"> • Personalised care • Continuity of carer • Safer care • Better post-natal and perinatal mental health care • Multiprofessional working – breaking down barriers between midwives, obstetricians and other professionals • Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed • A fair payment system <p>Barnsley maternity services are making good progress in all areas including implementing The Saving Babies Lives Care Bundle 2 (launched in 2019). Further details of this national programme can be found at https://www.england.nhs.uk/mat-transformation/saving-babies/</p> <p>It has been previously highlighted that the local provision for bereavement support for women who suffer childbirth is not good and progress in this area has been limited as a consequence of the current pandemic. There continues to be on-line support via Sands, The Lullaby Trust and Child Bereavement UK.</p> <p>The local aspirations in relation to stillbirth remain as previously reported:</p> <ul style="list-style-type: none"> • Seven-day service for ANDU • A number of maternity staff to be trained to deliver Level 2 Stop smoking support • Consultant-led preconception clinic • Dedicated and sound-proof Bereavement Suite <p>There is already a substantial action plan being progressed as part of the Maternity Stop Smoking Service.</p> <p>Barnsley Maternity Unit's continuity of carer initiative continues to link into and compliment the collaborative work with the Local Authority and</p>

Neighbourhoods Project within the Wath-upon-Deane area of Barnsley. The Unit has been successful in developing new and innovative ways of working to deliver continuity of carer to the most disadvantaged women in Barnsley.

Personalised Care planning is provided by the Wellbeing Team which includes Perinatal Mental Health Midwife, Teenage Pregnancy, Substance Misuse and Bereavement Midwife. The target to be achieved in relation to Personalised care plans is 100% by March 2021 and the Barnsley maternity service are improving their service-user engagement and promotion of real-time feedback to inform service transformation.

The Specialist Mental Health Midwife has seen her workload significantly increase as a consequence of the current pandemic and has responded by offering telephone and video consultations throughout the day. The Specialist Perinatal Mental Health service has been funded to achieve the access targets as recommended within the Long Term Plan and receives positive feedback from local women who have utilised the service.

Towards the end of 2019 the South Yorkshire and Bassetlaw Local Maternity Service submitted a regional bid to become an early implementer of a Maternal Mental Health service (previously referred to as Maternity Outreach Clinics). The South Yorkshire bid was centred around the Sheffield model which provides low level emotional health and wellbeing support to those women who it is felt are not appropriate for IAPT services nor unwell enough to be referred to the Specialist Perinatal Mental Health service. The South Yorkshire and Bassetlaw ICS bid was successful and a progress update will be provided in future reports.

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

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

In December 2019 the first report (Ockenden report) of the independent review in to maternity services at the Shrewsbury and Telford Hospital NHS Trust was published. In addition to local actions the report contained essential actions that all Trusts across England needed to implement immediately to improve safety in maternity services. These actions included:

1) Enhanced Safety

1. a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly

2. b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) Listening to Women and their Families

1. a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
2. b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) Staff Training and working together

1. a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
2. b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
3. c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) Managing complex pregnancy

4. a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
5. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance

6) Monitoring Fetal Wellbeing

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle

	<p>2 and national guidelines.</p> <p>7) Informed Consent</p> <p>a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.</p> <p>A letter of compliance to these actions was required to be sent by Trusts to the Regional Chief Nurse – Barnsley Hospital NHS Foundation Trust issued their letter within the required timeframe.</p>
3.	IMPLICATIONS
3.1	<p>Financial implications</p> <p>As outlined within the report.</p>
3.2	<p>Consultation & Engagement</p> <p>Consultation in relation to the Barnsley Place Plan for Maternity Services has primarily been in conjunction with Maternity Voice Partnership and a number of public events have been held in and around Barnsley.</p>
3.3	<p>Equality & Diversity</p> <p>No significant issues identified.</p>
3.4	<p>Information Governance.</p> <p>No significant issues identified.</p>
4.	RISKS TO THE CLINICAL COMMISSIONING GROUP
	The CCG needs to ensure that the transformation of maternity services in Barnsley are aligned to the recommendations within 'Better Births' and that the aspirations within the local based plan are supported.
5.	APPENDICES TO THE REPORT
	None
6.	CONCLUSION
	Good progress continues to be made in Barnsley Maternity Services towards delivering the recommendations of 'Better Births' building on the good practice that is already embedded within the maternity services. There are a number of challenges identified within this report that we need to work to overcome but the Barnsley Maternity Services are working closely with Barnsley CCG and the SYB ICS LMS to ensure that solutions are safe, effective and of the highest

	quality possible.
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GOVERNING BODY

14 January 2021

Suicide prevention and bereavement support update

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR																	
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>									
2. PURPOSE																	
	The purpose of this report is to provide Governing Body members with an update on the issues and challenges in relation to suicide prevention plans and bereavement support.																
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Governing Body	September 2020	Noted and GB Development session to be arranged															
5. EXECUTIVE SUMMARY																	
	Suicide prevention is a key priority both locally and nationally. NHS England has provided targeted funding to invest in suicide reduction plans on a regional basis. Barnsley Public Health Team lead on both the local place-based plans and the South Yorkshire and Bassetlaw ICS Suicide Prevention Plans. The investment provided by NHS England was to be targeted at reducing the number of suicides nationally by a minimum of 10% and whilst significant progress has been made																

the factors are so diverse and system-wide that much more is required.

Suicide Prevention

The year 2020 has been a significant challenge to everyone and sadly this has been reflected in the number of suspected suicides that we have seen within the Barnsley borough. Unfortunately there were 41 deaths linked to suicide in Barnsley in 2020, which is significantly higher than 2019 (27 Deaths) and also significantly higher than 2018 (20 Deaths). Due to Barnsley's robust Suspected Real Time Surveillance (RTS) Arrangements with South Yorkshire Police (developed as a key element of the SYB ICS Suicide prevention plans and targeted investment) it enables us to be alerted to all suspected suicides in Barnsley (and South Yorkshire & Bassetlaw) within 48 hours, which is useful for a number of reasons including:

- Support those bereaved by suicide – We know that those who are bereaved by suicide are much more likely to take their own life.
- Respond to any potential suicide clusters through community response planning and vulnerability mapping. This could be through a variety of types of clusters such as people who were known to each other or linked through circumstantial reasons. E.g. Veterans, males of a similar age, LGBTQ+.
- Identify other key themes through holding suspected suicide learning panels (SSLP's). SSLP's are held quarterly to discuss the context of each death in order to identify any key learning as well as key themes and trends that are presenting early to enable us to take responsive, preventive approaches to mental health and suicide prevention. Key themes emerging from the deaths in 2020 include Men (not middle aged but across the life course); those who have made previous attempts on their life; Physical pain & LTC's and substance misuse.

Whilst covid-19 has had a significant impact on Barnsley resident's mental health we remain unsure as to exactly how much this has attributed to the increase of deaths we have seen locally. A recent study based on all areas who submit RTS has been conducted and the preliminary findings were that suicide rates nationally has not increased during the pandemic. However, there were exceptions, particularly in areas with high deprivation, which may reflect the deaths seen in Barnsley

Whilst these findings are informative they remain speculative at this stage until all official figures are published. The other caveat of note is that only approx. 40% of England's Local Authority's have an established RTS system in operation. That said the findings from the report focus on tackling known risk factors that are likely to be exacerbated by the pandemic and which it is crucial to be aware of . These factors include depression, post-traumatic stress disorder, hopelessness, feelings of entrapment and burdensomeness, substance misuse, loneliness, domestic violence, child neglect or abuse, unemployment, and other financial insecurity.

Appropriate services must therefore be made available for people in crisis and those with new or existing mental health problems and we must remain alert to emerging risk factors for suicide but also recognise how known risk factors may be exacerbated—and existing trends and inequalities entrenched—by the

current pandemic. Our local RTS system combined with the SSLP's allow us to do this.

Outlined below are a number of schemes implemented locally / regionally to help reduce the number of people who take, or consider taking, their own lives:

Attempted Suicide Follow up Service

BMBC & SWYPT have managed to secure funding from a mixture of NHS Winter Pressures Funding and BMBC one off investment funding to pilot an attempted suicide follow up service. From deaths in 2020 we know that at least 45% of people had at least one previous attempt on their own life. Therefore BMBC & SWYPT have invested £95,000 to secure extra capacity to ensure those that have made an attempt on their life have the relevant follow up and support and care planning. The service will look to pick up people who are presenting at SPA (Single Point of Access) as suicidal and who need additional support whilst they may be waiting to access secondary mental health care.

Established Attempted Suicide and Self Harm Task Group

A South Yorkshire & Bassetlaw Task group has been convened to consider how we could best obtain data on attempted suicides and self-harm in addition to the RTS we currently have. Key organisations including SYP, YAS, ED departments across the patch are working with us to collect this and the Public Health Team is in conversation with NHS Digital about how they may be able to support larger scale system changes to SNOMED codes used in ED to improve how data is collected, which will in turn improve how we respond to emerging issues.

Buddy Scheme-Creative Minds - SWYPT

Short-Term:

Creation of the Buddy System and community building, by pairing Participants and Volunteers through shared hobbies, interests and activities (both current and aspired post Covid-19). Begin the process of generating stories.

Medium-Term:

Collect community-written narratives from Buddied pairs and whole community, to display them as an anthology of the people involved in the project.

Relationships continue to build through engagement.

Long-Term:

Development of new skills and interests and widening of community participation. Increase in cultural capital, development of interpersonal skills, and further engagement with additional, physical and face-to-face activities when possible.

Team Talk -Barnsley FC

Team Talk is a low-level mental health initiative where local men can meet, open up, take some time out and talk about issues in a relaxed, supportive

environment. It offers a combined approach to mental health drawing together social activities and peer support in a football setting.

Weekly sessions, facilitated by our male coaches, will take place on an evening (to be decided) at our Indoor Training Facility at Oakwell Stadium, home of Barnsley Football Club. These sessions will be available to all men with pre-booking required through our website and will involve the following:

1. An informal 'safe space' with facilities including our indoor AGP, pool, table tennis, darts, cards and computer games. Participants can take part in the different activities, socialise, take some time out and build new friendships.
2. A separate "Chat Room" enabling peer-support where beneficiaries can open up and talk about their mental health. These sessions will enable beneficiaries to share their experiences, discuss concerns or anxieties, support one another and offer suggestions for self-care.

Things to Live for – Creative Recovery

When things in life are tough, your heads a mess and you're on the edge, it's time to make changes. 'Things to Live For' is a fresh project using art to refocus and reconnect. Don't worry, you don't need to be Banksy, it's about open and honest conversations and meeting people that understand where you're at. We'll go and see some Art, get inspired, and make something great.

Its a free 7 week course, half a day each week (town centre). The Course is led by an Art Therapist and Street Artist. It's funded through BMBC.

#AlrightPal

The #AlrightPal campaign is all about starting the conversation around mental health and wellbeing as a first step towards suicide prevention. Talking to others to check that they're alright offers support from friends and family, and an opportunity for early referrals for specialist help. Visit

www.barnsley.gov.uk/AlrightPal to find tips on how to start a conversation and lots of advice and information about services that can help.

Mental Health & Suicide Prevention Training

In 2019-20, Chilypep delivered 21 training courses to 415 participants from over 28 organisations in Barnsley under the Suicide Prevention funding. The total number of attendances (421) is greater than number of participants because some participants attended more than one course. 2020 delivery has been hindered due to covid-19 as the provider has had to change all their materials to deliver these courses online and will be commencing in the new year with key groups such as ED staff, bank staff, solicitors etc (This is due to the high number of deaths we have seen where money/debt, relationship breakdowns and access to children has been an issue.) BMBC has just secured another £20k from the police and crime commissioner to extend this offer in the new year.

Bereavement Support

It has been generally acknowledged that bereavement support, particularly with regards to children and young people is lacking within the borough but limited progress has been made, as outlined below:

The Listening Ear South Yorkshire bereavement service was set up in April 2020 to help people who have lost loved ones during the coronavirus pandemic. This has now been extended until the 31st Jan 2022. This service is open to anyone who has lost loved ones during this difficult time, whether from the virus or otherwise. Local health and care organisations across South Yorkshire wanted to ensure that there were services available to support people whilst they may be physically distant from their families and friends. Since launching in April 2020, almost 1000 appointments have been accessed by people from across Barnsley, Doncaster, Rotherham and Sheffield with overwhelmingly positive feedback. People can self-refer or referrals can be made by police, GPs and primary care staff, hospital bereavement services, mortuary staff, funeral directors, coroner's office, crematorium and bereavement services staff and community and faith organisations. The service is free to call on 0800 048 5224, email: helpline@listening-ear.co.uk or via the website: www.listening-ear.co.uk/refer

AMPARO Suicide Bereavement Service. AMPARO has been in Barnsley for just over 2 years and has been extremely well received by those who have used it. It provides support for anyone affected by suicide. Support can be provided one-to-one, to family groups, groups of colleagues or peers – whatever is preferred by the person and is most appropriate to their situation. The service can be delivered at home or wherever they are most comfortable. This is currently being undertaken remotely via phone and video calls due to the pandemic. The service is completely confidential and can provide short-term or longer-term support, depending on the needs of the service user.

AMPARO is not a counselling service but it does provide emotional and practical support. The experienced Liaison Workers listen to your needs and assist you in accessing the support you need, whilst helping with a range of practical matters such as: dealing with police and coroners; helping with media enquiries; preparing for and attending inquest and helping you to access other, appropriate, local support services. This service has also been extended until 31st Jan 2022

Barnsley SOBS

Survivors of Bereavement by Suicide exist to meet the needs and break the isolation experienced by those bereaved by suicide. They are a self-help organisation and aim to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. They also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations.

Barnsley SOBS offer a unique and distinct service for bereaved adults across the UK, run by the bereaved for the bereaved. The service currently helps around 7000 people each year and continue to grow in response to significant unmet demand. Barnsley now have a number of people who have been bereaved by suicide and trained to deliver support to others.

Bereavement support for Children Young People & Families.

BMBC has secured a small pot of funding to commission a 12-month pilot to support Children Young People & Families who have been bereaved. The tender

	<p>will go live on the 11th January 2021 and close on the 25th January 2021. The tender panel will meet on the 27th to score the bids with the aim of awarding the contract to the successful provider by the end of January 2021. For context, on average 17 children die in Barnsley every year (Barnsley ECDOP (2020)). They leave behind devastated parents, siblings, grandparents and other family members. Some of these deaths are expected, others are unexpected, but all are tragic and have a profound impact on those left behind. A small proportion of these deaths are also witnessed by other children. At present the only support offered to all these families is a leaflet signposting to charities, but no other offer of formal support. We also know that many of the national charities have significant waiting lists and the offer is mainly via telephone only so does not offer a holistic approach with the family. It is also estimated that each year 80 parents die in Barnsley, leaving around 140 dependent children (aged 0 to 17) (Child Bereavement UK). It is estimated that the current school age population of children and young people (5-16) in Barnsley who have been bereaved of a parent or sibling at some point in their childhood is around 1040 (Child Bereavement UK). A recent survey of Barnsley residents highlighted a lack of support in the borough either paid for or 12 months + waiting list. Out of 204 responses 48% said they received no support and 29% felt like they didn't have enough support. Those that did receive support was mainly (55%) from other sources such as friends and family & Private counsellors; 20% coming from health & social care; 15% from work; 13% from schools; 10% from online sources and 8% from other community groups.</p>
<p>6.</p>	<p>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</p>
	<p>Governing Body is asked to note the report for information.</p>
<p>7.</p>	<p>APPENDICES / LINKS TO FURTHER INFORMATION</p>
	<p>N/A</p>

<p>Agenda time allocation for report:</p>	<p>10 mins</p>
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PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T) See 3.5
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2) See 3.6
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		Y
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		/NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		/NA

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

QUALITY & PATIENT SAFETY COMMITTEE

14 December 2021

Quality Highlights Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
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2.	PURPOSE											
	<p>Provide the January 2021 Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 17 December 2020. The information provided is in addition to the monthly performance report and ongoing risk management via the Assurance Framework and Risk Register.</p>											
3.	REPORT OF											
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Quality and Patient Committee	17 December 2020	To raise as highlights to the Governing Body										
5.	EXECUTIVE SUMMARY											
	<p>At the Quality and Patient Safety Committee meeting on 17 December 2020, it was agreed that the following five quality issues are highlighted to the Governing Body and rated:</p> <ul style="list-style-type: none"> • Green – BHNFT Management of OPEL 4 position • Green – Minimising Harm due to Covid • Green – LeDeR Programme • Green – Safeguarding People Policy/ Information Security Policy • Red – Locked Rehabilitation Provision 											

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

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

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	Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)
3.	Governance Considerations Checklist		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		Y
	Jayne Sivakumar, Chief Nurse		
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		N
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA
3.4	Improving quality (s14R, s14S)		
	Has a Quality Impact Assessment (QIA) been completed if relevant?		NA
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?		NA
	See Appendix A		

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

Appendix A Quality Highlights Report

Issue	Consideration	Action
BHNFT Management of OPEL 4 Position	<p>QPSC was updated on how BHNFT had responded when its Operational Pressures Escalation (OPEL) status moved to level 4 recently due to the number of COVID positive patients within the hospital both on the wards and in Critical Care along with considerable staff shortages.</p>	<p>QPSC formally acknowledged and expressed thanks for the hard work that the Trust had undertaken during this period to maintain a safe environment for patients and staff.</p>
Minimising Harm due to Covid	<p>Barnsley as part of an ICS initiative is taking part in a group that is focusing on minimising harm to four patient cohorts.</p> <ul style="list-style-type: none"> • Patients who are currently on elective waiting lists and have been waiting for some time; • Patients who had been on an elective waiting list but had been removed for the list and referred back to Primary Care without their procedure having been carried out; • Patients who have 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; • The management of potential new referrals by GPs and alternatives to referrals / patients whom are not presenting to services. <p>QPSC received a report on the progress of this workstream.</p>	<p>QPSC noted for assurance the content and progress described within the report.</p> <p>QPSC also approved the adoption of the SYB ICS Cancer Alliance Harm Minimisation Principles.</p>
Learning Disabilities Mortality Review (LeDeR) Programme	<p>QPSC received an update on the positive progress of the completion of outstanding LeDeR reviews. This should result in the backlog being cleared before 31 December 2020.</p>	<p>QPSC noted the current position in relation to LeDeR and thanked the reviewers for their hard work.</p>
CCG Policies	<p>QPSC received the updated Safeguarding People Policy, and the updated Information Security Policy for consideration and approval.</p>	<p>Q&PSC approved the proposed updates to both Policies.</p>

Issue	Consideration	Action
<p>Locked Rehabilitation Provision</p>	<p>QPSC was informed that work is progressing within the CCG to improve the approach regarding access to out of area locked rehabilitation beds. The CCG is investigating whether the current pathway provides positive outcomes for patients due to concern that some patients are being referred for locked rehab when they do not fit the criteria but there is no alternative provision available/commissioned. Initial work has identified concerns with transition arrangements from CAMHS, particularly for Looked After Children.</p>	<p>QPSC noted the update and agreed that they required further assurances on this issue.</p>

GOVERNING BODY REPORT

14 January 2021

Covert Administration of Medication in Care Homes Policy

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR		
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>
	<input checked="" type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>
	<i>Information</i>	<input type="checkbox"/>	<input type="checkbox"/>
2.	PURPOSE		
	The purpose of this report is to introduce a new policy on the covert administration of medication in care homes, so that the CCG is assured that it is fulfilling its statutory duties and to minimise the risk of reputational risk and litigation.		
3.	REPORT OF		
		Name	Designation
	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse
	Author	Jo Harrison	Specialist Clinical Portfolio Manager
4.	SUMMARY OF PREVIOUS GOVERNANCE		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	Group / Committee	Date	Outcome
	Quality and Patient Safety Committee	22/10/2020	Approved
5.	EXECUTIVE SUMMARY		

	<p>5.1 Covert administration of medication is a serious interference with a person’s autonomy and right to self- determination under Article 8 of the European Convention of Human Rights. It should always be the intervention of last resort when all less restrictive methods of supporting a person to take their medication have failed</p> <p>5.2 In some cases, the covert administration of medication is the only way to maintain the health and well-being of a person.</p> <p>5.3 This policy should be applied in direct conjunction with the CCG’s policies on the Mental Capacity Act and Consent.</p> <p>5.4 This policy applies specifically to residents in Barnsley care homes.</p>
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:
	Approve the policy for operational use and publication on the CCG’s public website.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix A – Covert Administration of Medication in Care Homes

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

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care	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		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>
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T) See 3.5
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U) x
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2) See 3.6
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership? <i>Via QPSC</i>		Y
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

Covert Administration of Medication for Patients in Care Homes.

Version:	Final 2.0
Approved By:	Quality and Patient Safety Committee
Date Approved:	
Name of originator/author:	Erica Carmody Catherine Ellwood Jo. Harrison, Specialist Clinical Portfolio Manager
Name of responsible committee/individual:	QPSC
Name of executive lead:	Jayne Sivakumar (Chief Nurse)
Date issued:	
Review Date:	
Target Audience:	General Practice and Care Home Staff.

THIS POLICY HAS BEEN SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT

Amendment Log

Version No	Type of Change	Date	Description of change
V0.1	Initial draft iteration	01.12.2016	
V0.2	Specialist review	03.02.2017	Additional information regarding Mental Capacity Act Removal of duplicate information Update of flow charts to match policy text Reformatting Addition of cover sheet and contents page Completion of Equality Impact Assessment.
V0.3	Additional information and formatting	16.02.2017	Additional information to support understanding of acronyms used Reformatting of flow charts
V1.0	Iteration of final version		Additional information added to flow charts appendices 1 and 2 at request of Q&PSC. Policy agreed by Q&PSC for dissemination and implementation.
V2.0	Review	21/06/2019	1.2 MCA Section 5 limitations added 2.1 Statement added re: restraint 3. Process requirements strengthened for compliance with legislation 3.5 Information about LPA/CAD added for reference 4. CQC and OPG information added Appendix 3 added : Covert medication care plan
V3.0	Review	16/07/2020	Appendix 5 added: Practical guidance for Administration of Medication to Residents with swallowing difficulties

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1. Introduction

- 1.1 The giving or withholding of medication should not be the primary method of influencing or controlling a resident's behaviour. **Other recognised skills, such as de-escalation or distraction techniques should always be the first choice in attempting to manage behaviour that challenges.**
- 1.2 The covert administration of medicines should only be used in exceptional circumstances, when that means of administration is judged necessary and proportionate, in accordance with the principles of the Mental Capacity Act 2005 and the limitations in Section 5 of the Act and the Deprivation of Liberty Safeguards, 2008. (NICE QS85).
- 1.3 The scope of this policy extends to the use of oral medications in all but emergency and life-saving situations.
- 1.4 This policy should still be applied in situations such as infection outbreaks / epidemics / pandemics. (NB: It is acknowledged at such times that assessing capacity may be more difficult due to lack of face to face contact. At such times, advice can be sought from the Local Authority or CCG Safeguarding / MCA Lead).

2. The Legal Framework

- 2.1 Covert administration of medication is a serious interference with a person's autonomy and right to self-determination under Article 8 of the European Convention of Human Rights. In all cases where the administration of covert medication is care planned an application to the Supervisory Body must be made for a Deprivation of Liberty Safeguards (DoLS) authorisation, or a review of any existing authorisation that may be in place. This is particularly important for medication that has a sedative effect, as this can be viewed as restraint.

3. The Process

NB – if a resident is accepting medication but has swallowing difficulties, this is not to be seen as a refusal. Please refer to Appendix 5: Practical guidance for Administration of Medication to Residents with swallowing difficulties

- 3.1 If a resident is refusing medication, the care home worker must provide them with relevant information which may enable the resident to reconsider their decision. This must be in a format that the person finds easier to understand. If the resident continues to refuse medication, the care home worker must try to ascertain the reason for medication refusal and record this on the Medicine Administration Record (MAR) chart and daily care records. The care home worker must then inform the Registered Manager.

- 3.2 The delegated person (e.g. shift leader/ in charge) must contact the prescriber for advice. If the medication being refused falls within part of a defined course of treatment, the prescriber needs to be informed after the first refusal.
- 3.3 Following refusal of medication that is essential to health and well-being, or for all other medications, refusal for two consecutive days or more, a mental capacity assessment in relation to consenting to the administration of medication should be completed. This should be done by the prescriber, who should also undertake a full medication review to support appropriate clinical management and ensure that only those medications that are currently necessary are prescribed.
- 3.4 If it is assessed that the resident has capacity to make an independent decision, medicines **must not** be administered covertly.
- 3.5 If the resident is assessed as lacking capacity to consent to the administration of medication a BEST INTEREST discussion MUST take place. This must include the prescriber (decision maker), multi-disciplinary team involved in the resident's care, anyone with authority to make decisions on their behalf, the Relevant Person's Representative (if subject to a Deprivation of Liberty Safeguards (DoLS) Authorisation), those close to the resident and any Advocate, to decide if the medication is to be administered covertly. This must be thoroughly documented (via the covert medication plan (appendix 3)).

NB: The only person's with delegated authority to make a decision on behalf of a person who lacks capacity are those who hold a valid Lasting Power of Attorney (LPA) or who are a Court Appointed Deputy (CAD) for Health and Welfare. They must show proof of this at the time the decision needs to be made by producing an LPA form which is stamped 'VALIDATED-OPG – otherwise the prescriber remains the decision maker. To check if someone has LPA/CAD go to <https://www.gov.uk/find-someones-attorney-or-deputy>

If it is felt that the LPA/CAD is not acting in the person's best interests or there is any concern / dispute about their decision making an application to Court of Protection would need to be considered.

- 3.6 If the situation is urgent, a best interests decision will need to be made by the person administering the medication at the care home and the prescriber via a discussion when it is not safe or appropriate to delay or avoid administration of the medication. However, a formal meeting should be arranged as soon as possible afterwards (no longer than within 5 working days). Examples of such situations are life critical medications (e.g. for Epilepsy/Diabetes/CVD etc. and short course antibiotics)
- 3.7 If the patient has cognitive impairment, seeking guidance from the Memory Team & Support Services should be considered in terms of exploring approaches that might work best for the individual.

- 3.8 It is important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that the need for continued covert administration is regularly reviewed.
- 3.9 Medications should not be altered to make them easier to swallow or to hide them without input from a pharmacist or prescriber. Inappropriate changes to the form of the medication may affect the way that it works. Appropriate information regarding stability of medication when administered covertly should be obtained from the GP, practice pharmacist, or CCG/PCN * care home pharmacist. This information should be documented on the care plan and the Administration of Covert Medication Form at Appendix 4. This should then be attached to the front of the Medicine Administration Record (MAR chart).
- * CCG Clinical Commissioning Group
* PCN Primary Care Network
- 3.10 Regular review dates (at least 6 monthly) MUST be set to review the resident's mental capacity to make decisions regarding medication -Best Interest decisions made on their behalf and covert administration of medication management plans. Any change of medication or treatment regime MUST also trigger a review where such medication is covertly administered. A medication review may also be triggered by conditions set at any Deprivation of Liberty Safeguards Authorisation review.

4. Further guidance

Further guidance can be found at:

AG, Re [2016] EWCOP 37 (6 July 2016)

<http://www.bailii.org/ew/cases/EWCOP/2016/37.html>

National Institute for Health and Care Excellence (NICE). March 2015.
Medicines Management in Care Homes. Quality Standard QS85

<https://www.nice.org.uk/guidance/qs85>

Office of the Public Guardian

<https://www.gov.uk/government/organisations/office-of-the-public-guardian>

CQC: Brief guide to covert medication in mental health services

https://www.cqc.org.uk/sites/default/files/20180406_9001398_briefguide-covert_medication_mental_health_v2.pdf

Equality Impact Assessment 2013

Title of policy or service	Covert administration of medication for patients in care homes.	
Name and role of officers completing the assessment	Erica Carmody, Clinical Practice Pharmacist/Medication Review Pharmacist Catherine Ellwood, Medicines Management Technician Jo Harrison, Specialist Clinical Portfolio Manager	
Date assessment started / completed	16/07/2020	

1. Outline	
<p>Give a brief summary of your policy or service.</p> <ul style="list-style-type: none"> • Aims • Objectives • Links to other policies, including partners, national or regional 	<p>The policy aims to provide guidance for prescribers and those administering medication in the care home environment regarding clinical and legal considerations to be taken into account when administering medications covertly.</p> <p>Due regard has been taken of the requirements of the Mental Capacity Act (2005), recent case law (AG, Re [2016] EWCOP 37. July 2016) and National Institute for Health and Care Excellence (NICE). March 2015. Medicines Management in Care Homes. Quality Standard QS85.</p>

2. Gathering of Information					
This is the core of the analysis; what information do you have that might impact on protected groups, with consideration of the General Equality Duty					
	What key impact have you identified?			What action do you need to take to address these issues?	What difference will this make?
	Positive impact	Neutral impact	Negative impact		
Human rights	Y				
Age	Y				
Carers		Y			
Disability	Y				

Sex		Y			
Race		Y			
Religion or belief		Y			
Sexual orientation		Y			
Gender reassignment		Y			
Pregnancy and maternity		Y			
Marriage and civil partnership (only eliminating discrimination)		Y			
Other relevant group		Y			

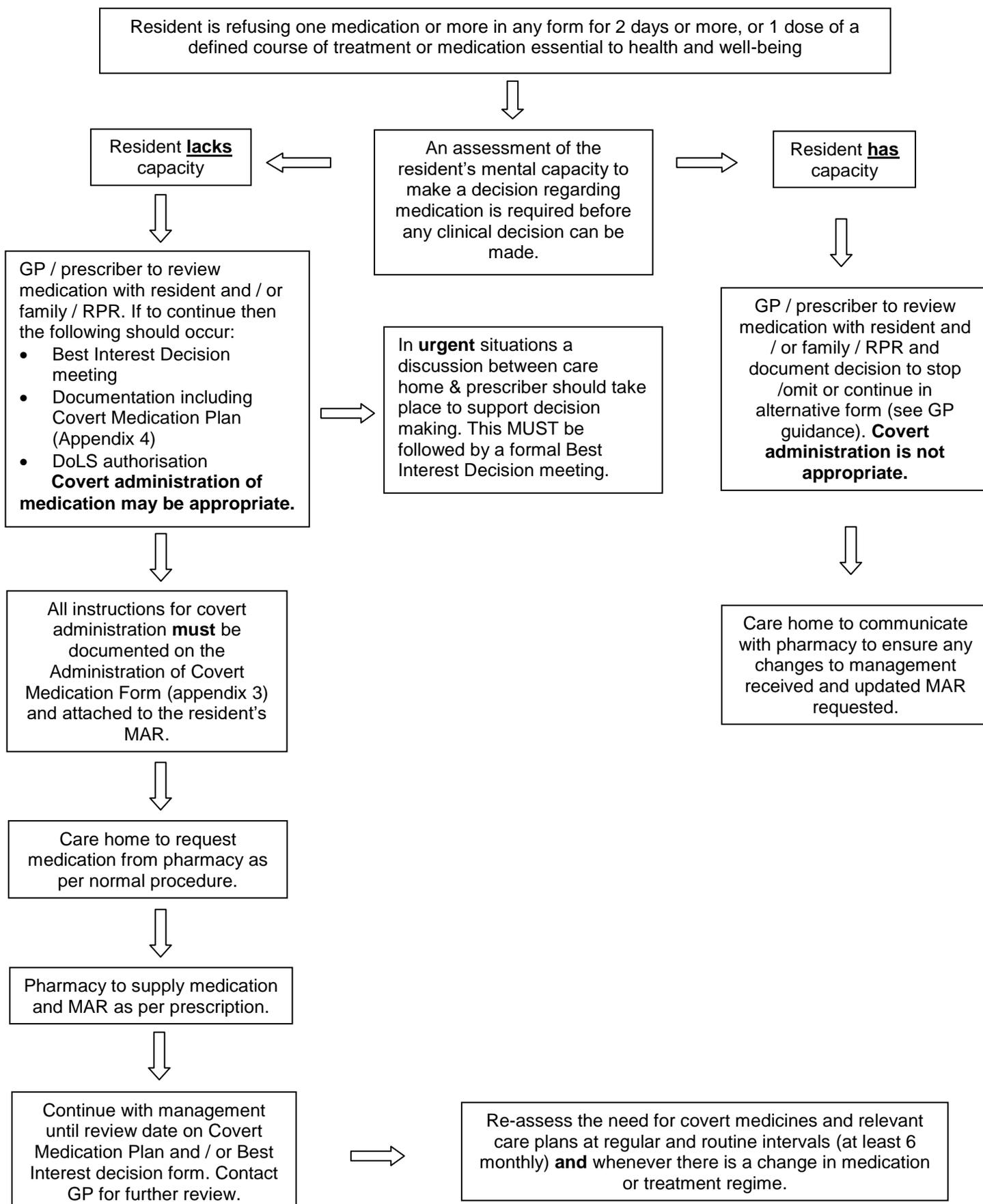
Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action Plan				
Issues Identified	Actions required	How will you measure impact / progress?	Timescale	Officer responsible
Nil	Nil	Not required	N/A	N/A

4. Monitoring, review and publication			
When will the policy and EIA be reviewed and by whom?	The EIA will be reviewed when the policy is reviewed. This will be in 2 years or sooner if there is a change in legislation.		
Lead Officer	Jo Harrison Colin Brotherstone-Barnett	Review date:	February 2019

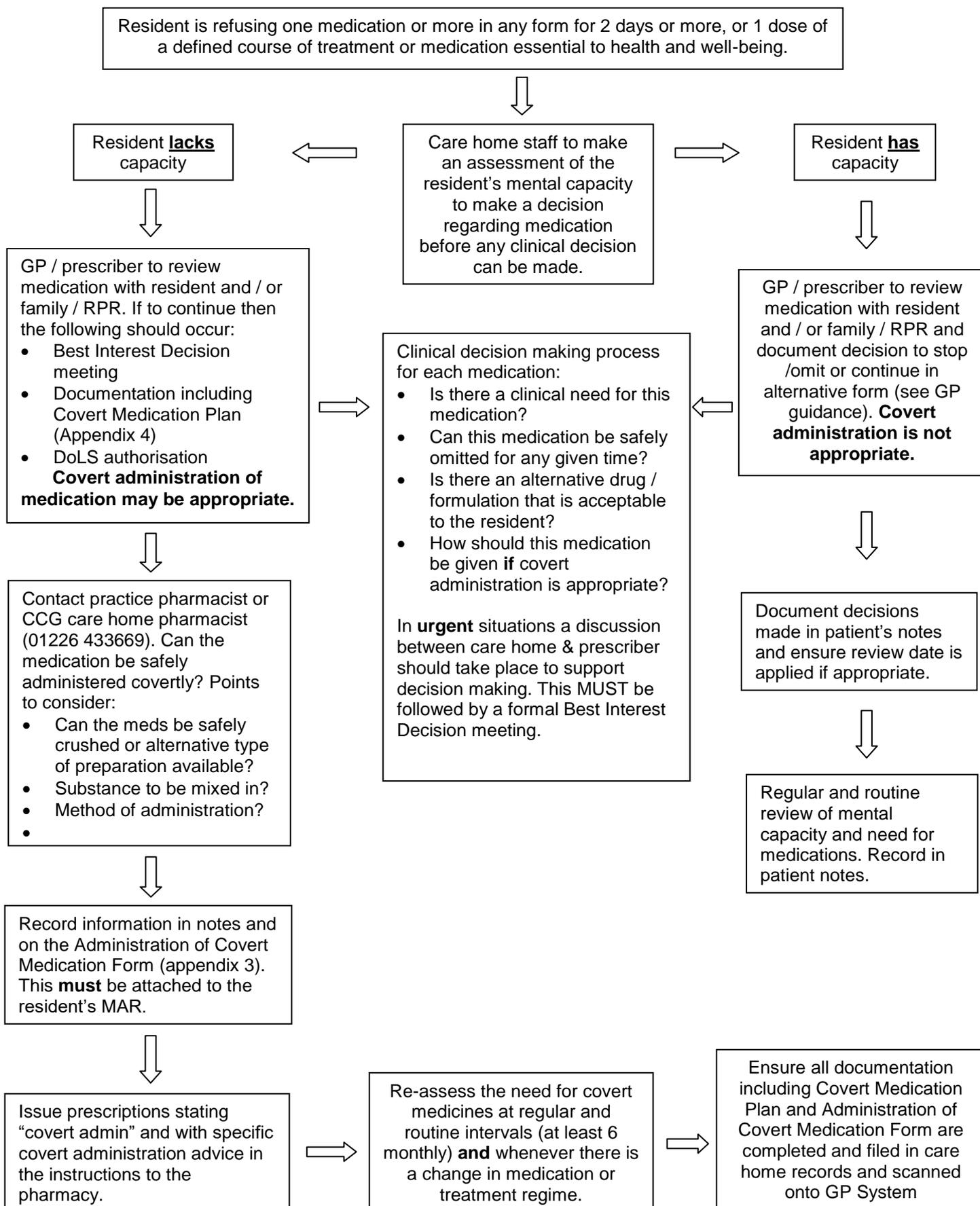
Appendix 1

Covert Medication: Care Homes Flowchart.



Appendix 2

Covert Medication: GP Flowchart.



Covert Medication Plan

Part 1: Proposed oral medication and rationale for covert administration (following a full medication review and possible discontinuation of any medications no longer required)					
1. Name of resident		2. D.o.B.		3. Name of care home / room number	
4. Prescribed medication and dosage (list) NB: If the medication is to be modified in any way (e.g. crushed or combined with food) a qualified pharmacist must give advice					
5. Medication / dosage			Medication / dosage		
Treated condition			Treated condition		
Instructions for administration			Instructions for administration		
Medication / dosage			Medication / dosage		
Treated condition			Treated condition		
Instructions for administration			Instructions for administration		
Medication / dosage			Medication / dosage		
Treated condition			Treated condition		
Instructions for administration			Instructions for administration		

<p>Medication / dosage</p> <p>Treated condition</p> <p>Instructions for administration</p>	<p>Medication / dosage</p> <p>Treated condition</p> <p>Instructions for administration</p>
<p>Medication / dosage</p> <p>Treated condition</p> <p>Instructions for administration</p>	<p>Medication / dosage</p> <p>Treated condition</p> <p>Instructions for administration</p>
<p>6a. Prescriber Name:</p>	<p>6b. CCG Pharmacist Name:</p>
<p>7a. Has a mental capacity assessment been carried out?</p> <p style="text-align: center;">YES / NO (<i>delete as applicable</i>)</p> <p>If YES:</p> <p>Name of assessor:</p> <p>Role:</p> <p>Date of assessment:</p> <p>If NO this process must be stopped until one has been carried out</p>	<p>7b. If so, does the assessment determine a reasonable belief that the person lacks capacity to consent / agree to taking the prescribed medication?</p> <p style="text-align: center;">YES / NO (<i>delete as applicable</i>)</p> <p>If YES proceed to next section</p> <p>If NO the process must be stopped as this indicates that the person may have capacity to make the decision</p>
<p>8a. What are the benefits of taking the prescribed medication? (list)</p>	<p>8b. What are the risks / burdens of taking the prescribed medication? (list)</p>

<p>8c. What are the benefits of not taking the prescribed medication? (list)</p>	<p>8d. What are the risks / burdens of not taking the prescribed medication? (list)</p>
<p>9. In your clinical opinion do the benefits outweigh the risks? YES / NO (<i>delete as applicable</i>)</p> <p>If NO please reconsider this decision</p>	
<p>10. Are there any realistic alternatives to the prescribed medication? YES / NO (<i>delete as applicable</i>)</p> <p>If YES please state why these have been discounted?</p>	
<p>11. What unsuccessful alternative approaches have been tried to encourage the person to agree to take the medication?</p> <p>Why were alternative approaches unsuccessful?</p>	
<p>12. Are you satisfied that covert administration is the only alternative? YES / NO (<i>delete as applicable</i>)</p> <p>If NO – reconsider decision</p>	
<p>Part 2: Best Interest decision</p>	
<p>14. Does the person have an appointed Lasting Power of Attorney or Court Appointed Deputy for Health and Welfare? YES / NO (<i>delete as applicable</i>)</p> <p>If YES the LPA / CAD can make the decision in the person’s best interests – go to 15</p> <p>If No the prescriber is the decision maker and must take the views of those involved into account – go to 16</p>	

<p>15. Name of LPA / CAD:</p> <p>Office of the Public Guardian (OPG) reference number:</p> <p><i>NB: If no proof of LPA/CAD is given at the time of the decision the prescriber will be the decision maker</i></p>		
<p>16. People involved in this decision</p>	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>
	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>
	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>	<p>Name:</p> <p>Relationship:</p> <p>Sign:</p>
<p>17. Based on the information and appraisal of the risks and benefits in section 8 it is decided that it IS / IS NOT (<i>delete as applicable</i>) in the above named person's best interests to have medication covertly administered.</p>		
<p>18. Date of decision:</p>		
<p>19. This decision will be reviewed in weeks / months. (Regular review dates (at least 6 monthly) MUST be set to review the resident's mental capacity to make decisions regarding medication, Best Interest decisions made on their behalf and covert administration of medication management plans. Any change of medication or treatment regime MUST also trigger a review where such medication is covertly administered. A medication review may also be triggered by conditions set at any Deprivation of Liberty Safeguards Authorisation review).</p>		

PART 3: Review (must be carried out by a Prescriber)	
Date of Review:	
<p>20a. Has a mental capacity assessment been carried out?</p> <p style="text-align: center;">YES / NO (<i>delete as applicable</i>)</p> <p>If YES:</p> <p>Name of assessor:</p> <p>Role:</p> <p>Date of assessment:</p> <p>If NO this process must be stopped until one has been carried out</p>	<p>20b. If so, does the assessment determine a reasonable belief that the person lacks capacity to consent / agree to taking the prescribed medication?</p> <p style="text-align: center;">YES / NO (<i>delete as applicable</i>)</p> <p>If YES proceed to next section</p> <p>If NO the process must be stopped as this indicates that the person may have capacity to make the decision</p>
<p>Have there been any changes to existing medication needs? YES / NO (<i>delete as applicable</i>)</p> <p>If NO the above plan can continue until the next review in weeks/ months</p> <p>If YES complete a full new plan</p>	

Administration of Covert Medication Form

This document should be completed for any covert administration of medication after a Best Interest Decision has been made. This form **must** be attached to the resident's MAR chart. This must be reviewed at least 6 monthly or whenever there is a change in medication or treatment regime.

Name of medication to be administered.	Specific instructions for administration. Include any cautions such as temperature or types of food to avoid.	Name of pharmacist / GP providing instruction for administration.	Date of commencement.	Date of review.	Authorised by:

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

Appendix 5

Good Practice Guidance for Care homes

Practical guidance for Administration of Medication to Residents with swallowing difficulties

The guidance applies to residents:

- Who find it difficult to swallow tablets or capsules
- Who have been assessed by speech and language as requiring a modified diet and fluids
- Who require medication to be administered via a feeding tube

This guidance does not cover the management of patients who are refusing medication.

For patients where oral medication usage is further complicated by psychological conditions such as learning disabilities, severe mental illness and dementia a multidisciplinary team should be involved in a best interest decision about the need to continue the medication, and how any medication administration should be managed.

Patients with dysphagia should be referred to the speech and language team.

Protocol for patient unable to swallow tablets:

- Arrange a meeting with the resident and all the care staff involved with the resident, to establish the extent of swallowing difficulties. Consider if the resident can swallow similar sized food or if they can manage liquids (without a thickening agent).
- Consult with prescriber, explaining the problems associated with administering each medication and request a medication review. A copy of this communication should be kept in the care plan.
- The prescriber will then arrange for a suitable medication review which may involve liaison with a pharmacist.
- The prescriber will amend the prescription to enable safe administration. This will usually be:
 - a switch to a liquid (if available and suitable) or
 - guidance with dosage instructions on how to administer the medication e.g. “may be added to food to facilitate swallow” or “may be crushed and mixed with food to facilitate swallow” or
 - a switch to an alternative medication.

Procedure for Administration:

- The preferred option (if the medication is suitable to be administered with food) is to administer the tablet or capsule whole in yoghurt or apple sauce.
Consider whether the resident can manage to swallow a similar sized piece of food to the tablet or capsule and refer to speech and language therapist for further advice if needed.
Tablets less than 4mm diameter can usually be safely swallowed in yoghurt.

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

- Some medicines are available as a licensed liquid; if the resident can safely manage liquids the GP may switch the medication to a liquid. Many liquid medicines however may not be suitable for patients requiring thickened fluids.
- If a liquid medication is not available some capsules can be opened and sprinkled on yogurt and some tablets can be crushed and mixed with yogurt. Sometimes this may result in an unpleasant taste that the resident cannot tolerate.
- Residents must consent to having their medication administered in this manner.
- Residents who do not have capacity must have a best interest's decision to administer in this way.
- Instruction to alter the tablet or capsule must be on the label and documented in the patient's care plan.
- The procedure for administration should be clearly documented; this needs to be individually tailored to include the vehicle the medication is administered in e.g. water, juice, jam, yogurt at room temperature.
- Medication must be prepared immediately prior to administration.
- Each medicine must be administered separately.

The following are summaries on processes of administration

Dispersing Tablets in water:

- Place the tablet(s) in a small quantity of water, allow to disperse this can take a few minutes; alternatively, the water can be agitated with a spoon to speed up the process.
- Each different medication should be separately dissolved and administered.

Crushing Tablets:

- A tablet crusher must be used for this process. A separate tablet crusher must be used for each different tablet and for each service user which must be thoroughly cleaned and dried in between each administration process.
- Crush the tablet using a tablet crusher; add the crushed tablet to a small amount of a suitable soft food, alternatively add a little water or squash to the crusher for the resident to take as a liquid.
- Each different medication should be separately crushed and administered.

Opening capsules:

- Open capsule and sprinkle contents into either a small volume of soft food water or squash
- Each different medication should be separately administered via a feeding tube:
- Feeding tubes should be flushed with water before and after each medication is administered. If a liquid medicine is thick or syrupy, dilution may be required. Some patients are fluid restricted; this needs to be taken into account.

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

- When administering crushed or opened capsules via a feeding tube, add the powder to 15-30ml water and mix well. Draw into a 50ml oral syringe and administer. If you have used a tablet crusher, rinse this with water and administer the rinsing also.

Suggested protocol for administering medicines via feeding tubes:

1. Stop the feed (leaving a break if necessary)
2. Flush the tube with 30ml water
3. Prepare the first medicine for administration and give it.
4. Flush with 10ml water
5. Repeat stages 3 and 4 with subsequent medicines
6. Flush with 30ml water
7. Re-start the feeding (leaving a break if necessary)

CARE STAFF CAN ONLY ADMINISTER MEDICINES IN THIS MANNER ON THE INSTRUCTION OF THE PRESCRIBER

A WRITTEN INSTRUCTION TO CRUSH OR DISPERSE TABLETS OR TO OPEN CAPSULES MUST BE DOCUMENTED IN THE PATIENT'S CARE PLAN. (Nursing staff should refer to Nursing & Midwifery Council (NMC) guidance)

See Appendix 6 for Good Practice for Care Homes, permission to administer medication in food to facilitate swallowing

See Appendix 7 for Administration of Medication

Good Practice Guidance for Care Homes			
Permission to administer medication in food to facilitate swallowing			
Name:		Date of Birth:	
Address:		Date:	
Completed by:		Position:	
Assessing Capacity: Does the person have impairment, or a disturbance in the functioning, of their mind or brain? Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?		Yes/No (if yes a best interests decision must be documented) Yes/No (if yes a best interests decision must be documented)	
Functional tests of capacity To be able to make a decision a person must be able to: <ul style="list-style-type: none"> • understand the information relevant to the decision, • retain that information, • use or weigh that information as part of the process of making the decision, or • Communicate the decision. 		Describe how assessed	
If a person has capacity to consent, verbal permission to add medication to food must be gained prior to each administration. Person to sign that they agree that with the principal of administering medicine with food to facilitate swallowing, and that medication may be unlicensed in this manner		Name: Signature: Date:	
If person is lacking capacity to consent to medication being administered in food. A best interest's decision involving the prescriber, person with lasting power of attorney , family and care home representative must be made e.g. why this medication is necessary or what benefit is there for the patient?		Name and signatures of persons involved in decision	
What medication is being considered for administration in food to facilitate swallowing?			
Have alternative options been considered?		list	
A Barnsley CCG pharmacist must be involved to give advice if administration involves crushing tablets, opening capsules or combining medicines in any way with food or drink.		Name of Pharmacist: Date:	
Review Date:			

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

Appendix 7

Administration of Medication Form

This document should be completed for any administration of medication to aid swallowing after a Best Interest Decision has been made. This form **must** be attached to the resident's MAR chart. This must be reviewed whenever there is a change in medication or treatment regime.

Name of medication to be administered.	Specific instructions for administration. Include any cautions such as temperature or types of food to avoid.	Name of pharmacist / GP providing instruction for administration.	Date of commencement.	Date of review.	Authorised by:

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

Appendix F - Equality Impact Assessment

Title of Policy or Service:	Barnsley Clinical Commissioning Group	
	Covert Administration of Medication Policy	
Name and Role of Officer(s) Completing the Assessment:	Erica Carmody	
Date of Assessment:		
Type of EIA Completed:	Initial EIA 'Screening' <input type="checkbox"/> or 'Full' EIA process ✓	<i>(select one option)</i> <i>Full</i>

1. Outline	
Give a brief summary of your policy or service <ul style="list-style-type: none"> • including partners, 	This policy aims to support BCCG in the discharge of its duties and responsibilities as an NHS Commissioner and to gain assurance that the principles of the MCA 2005 Code of Practice, and DoLS 2008 Code of Practice are being applied to situation where a decision about covertly administering medication is considered.

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

national or regional	
What Outcomes do you want to achieve	The organisation meets governance and standards required relating to the relevant legal frameworks.
Give details of evidence, data or research used to inform the analysis of impact	The Policy is based on National Legislation, Policies And Guidance.
Give details of all consultation and engagement activities used to inform the analysis of impact	None

Identifying impact:

- **Positive Impact:** will actively promote the standards and values of the CCG;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact: causes or fails to mitigate unacceptable behaviour. If such an impact is identified, the EIA should ensure, that as far as possible, it is eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

2. Gathering of Information
 This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive or negative) give details below:	
	Positive Impact	Neutral impact	Negative impact	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	Yes	<input type="checkbox"/>	<input type="checkbox"/>	Protects the Human Rights of vulnerable people over the age of 16 in Barnsley.	Implementation of the Policy should ensure the CCG meets the positive obligations required under the MCA/DoLS Legislation.
Age	Yes	<input type="checkbox"/>	<input type="checkbox"/>	Ensures everyone over the age of 16 falls within scope as per legislation.	Those who refuse medication and do not have capacity will receive a best interests review
Carers	Yes	<input type="checkbox"/>	<input type="checkbox"/>	Takes into account a person's representative in terms of making decisions on behalf of or expressing wishes and feelings on behalf of a	Increase the number of carers included within decision making.

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

				person who may lack capacity.	
Disability	Yes	<input type="checkbox"/>	<input type="checkbox"/>	A greater number of disabled people have medication prescribed. The Policy helps to support those who may be at risk.	Those who refuse medication and do not have capacity will receive a best interests review
Sex	Yes	<input type="checkbox"/>	<input type="checkbox"/>	A greater proportion of elderly patient receiving medications are female. The Policy helps to support those who may be at risk.	Those who refuse medication and do not have capacity will receive a best interests review
Race	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Religion or Belief	<input type="checkbox"/>	Yes			
Sexual Orientation	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Gender Reassignment	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Pregnancy and Maternity	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Marriage and Civil Partnership (only eliminating discrimination)	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Other Relevant Groups	<input type="checkbox"/>	Yes	<input type="checkbox"/>		



Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

HR Policies only:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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IMPORTANT NOTE: If any of the above results in ‘negative’ impact, a ‘full’ EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.

Having detailed the actions you need to take please transfer them to the action plan below.

3. Action Plan				
Issues/Impact Identified	Actions Required	How will you Measure Impact/Progress	Timescale	Officer Responsible
No actions required				

4. Monitoring, Review and Publication				
When will the Proposal be Reviewed and by Whom?	Lead/Reviewing Officer:		Date of next Review:	

Once completed, this form **must** be emailed to the Equality Lead barnsleyccg.equality@nhs.net for sign off:

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

<p>Equality Lead signature:</p> <p>Date:</p>	<p></p> <p>05/01/2021</p>
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GOVERNING BODY

14 January 2021

RISK AND GOVERNANCE EXCEPTION REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR		
	<i>Decision</i> <input type="checkbox"/>	<i>Approval</i> <input type="checkbox"/>	<i>Assurance</i> <input checked="" type="checkbox"/>
		<i>Information</i> <input type="checkbox"/>	
2.	PURPOSE		
	<ul style="list-style-type: none"> To assure the Governing Body re the delivery of the CCG's annual strategic objectives To assure the Governing Body that the current risks to the organisation are being effectively managed and monitored appropriately To assure Governing Body that the Equality and Engagement Committee Terms of Reference have been subject to annual review 		
3.	REPORT OF		
		Name	Designation
	Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance
	Author	Paige Dawson	Governance, Risk & Assurance Facilitator
4.	SUMMARY OF PREVIOUS GOVERNANCE		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	Group / Committee	Date	Outcome
	N/A		
5.	EXECUTIVE SUMMARY		
5.1	Governing Body Assurance Framework		
	<p>The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. Two of the key priority areas (3 - Cancer and 6 – Financial Balance & Efficiency Plans) are rated as red meaning that there is currently a significant risk that the deliverables in these two areas 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 an exception of the Corporate Risk Register (Appendix 2).

There are currently 9 red (extreme) risks on the CCG's Risk Register which have been escalated to the Assurance Framework as gaps in assurance against risks on the Assurance Framework:

- Ref CCG 18/04 (rated score 16, 'extreme') - If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG.
- Ref 18/02 (rated score 16 'extreme') - If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.
- Ref CCG 14/10 (rated score 16 'extreme') – Risks resulting from not being able to attract and retain a suitable and sufficient Primary Care clinical workforce.
- Ref CCG 14/15 (rated score 15 'extreme') – Potential impact on quality & patient safety of incomplete D1 discharge letters.
- Ref CCG 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.
- COVID 3 - Flu season 2020/21 - 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.

	<ul style="list-style-type: none"> • COVID 4 - QIPP - There is a risk that if the CCG does not develop a robust QIPP plan supported by effective delivery and monitoring arrangements, the CCG will not achieve its statutory financial duties and NHS England business rules. <p>Updates:</p> <ul style="list-style-type: none"> • Both Finance and Performance Committee and Quality and Patient Safety Committee have approved a new risk in relation to CHC (detailed in appendix 2). • In addition at its meeting on 3rd December the Equality & Engagement Committee agreed to reduce the risk score in respect of risk 13/13b (risk of not engaging effectively with the public) from 3x4=12 to 2x4=8 in the light of the CCG again receiving a 'green star' rating in NHSE's annual assessment of our arrangements. <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>
<p>5.3</p>	<p>Committee Terms of Reference</p> <p>At its meeting on 3rd December the Equality and Engagement Committee undertook its annual review of its Terms of Reference. Committee agreed to correct a few minor typos. In addition the membership was changed slightly, so that the Chief Nurse is named as Vice Chair of the Committee, and the Deputy Chief Nurse is added as an additional member.</p>
<p>6.</p>	<p>THE GOVERNING BODY IS ASKED TO:</p>
	<ul style="list-style-type: none"> • Review the Assurance Framework and Risk Register • Note the new risk in relation to CHC • Consider whether all risks are being appropriately Managed • Identify any potential new risks or risks for removal • Note and approve the changes to the Equality and Engagement Committee TOR.
<p>8.</p>	<p>APPENDICES / LINKS TO FURTHER INFORMATION</p>
	<ul style="list-style-type: none"> • Appendix 1 – GBAF • Appendix 2 – Corporate Risk Register
<p>Agenda time allocation for report:</p>	<p>10 minutes</p>

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register	
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework	
	1.1 Urgent & Emergency Care	✓
	2.1 Primary Care	✓
	3.1 Cancer	✓
	4.1 Mental Health	✓
	5.1 Integrated Care @ System	✓
	5.2 Integrated Care @ Place	✓
	6.1 Efficiency Plans	✓
	7.1 Transforming Care for people with LD	✓
	8.1 Maternity	✓
	9.1 Digital and Technology	✓
	10.1 Compliance with statutory duties	✓
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	ALL
2.	Links to statutory duties	
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act	
	Management of conflicts of interest (s14O)	
	Duty to promote the NHS Constitution (s14P)	✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	
	Duty as to improvement in quality of services (s14R)	
	Duty in relation to quality of primary medical services (s14S)	
	Duties as to reducing inequalities (s14T)	
	Duty to promote the involvement of each patient (s14U)	
	Duty as to patient choice (s14V)	
	Duty as to promoting integration (s14Z1)	
	Public involvement and consultation (s14Z2)	
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)	
3.1	Clinical Leadership	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	NA
3.2	Management of Conflicts of Interest (s14O)	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)	
	Have any financial implications been considered & discussed with the Finance Team?	NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	NA
3.4	Improving quality (s14R, s14S)	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	NA
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	NA

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

PRIORITY AREA 1: URGENT & EMERGENCY CARE				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY			
<ul style="list-style-type: none"> Increased clinical assessment of calls to NHS 111 & CAS Implementation of 111 First Approach to reduce attendance to ED where suitable alternative service exist (including front door clinical streaming/booking to alternative services) Delivery of ambulance targets / conveyance with zero tolerance of delays over 30 minutes Delivery of 4 hour A&E standard Improved patient flow and reduce length of stay Free up hospital beds - Reduce non-elective activity Enhance Same Day Emergency Care, increasing the proportion patients discharged on the day of attendance Reduce A&E by default selections on the DOS 				Highest quality governance		If partners locally and across the ICS do not engage constructively together, to develop a model for urgent care at a South Yorkshire and Bassetlaw and Barnsley level, in line with best practice and national guidance there is a risk that urgent care services are unable to meet the growing demand, constitution standards for urgent care are not achieved and the quality of patient care is negatively impacted			
				High quality health care				✓	
				Care closer to home				✓	
				Safe & sustainable local services				✓	
				Strong partnerships, effective use of £		✓			
				Links to SYB STP MOU					
				8.4. Urgent and Emergency Care					
Committee Providing Assurance			FPC	Executive Lead		JW	Clinical Lead	JH & MS	
Risk rating	Likelihood	Consequence	Total					Date reviewed	Dec-20
Initial	3	4	12					Rationale: Likelihood currently judged to be 'possible' given current pressures and challenges across the urgent care system and the developing nature of plans to deliver outcomes of the national urgent care review. Consequence is judged as major due to the potential impact on patient care.	
Current	3	4	12						
Appetite	3	4	12						
Approach	Tolerate								
Key controls to mitigate threat:				Sources of assurance				Rec'd?	
Operational planning 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	
Gaps in assurance				Positive assurances received					
Gaps in control				Actions being taken to address gaps in control / assurance					
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)		
PRIORITY AREA 2: PRIMARY CARE										
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.				Delivery supports these CCG objectives: Highest quality governance ✓ High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ Links to SYB STP MOU B.3. General Practice and primary care		PRINCIPAL THREATS TO DELIVERY 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				
Risk rating	Likelihood	Consequence	Total						Date reviewed	Dec-20
Initial	3	4	12						Rationale: Likelihood has been scored at 3 (possible) but will be kept under review. Consequence has been scored at 4 (major) because there is a risk of significant variations in quality of and access to care for patients if the priorities are not delivered.	
Current	3	4	12							
Appetite	3	4	12							
Approach	TOLERATE									
Key controls to mitigate threat:				Sources of assurance				Rec'd?		
All practices are required to complete the National Workforce Data Return. The APEX tool has been decommissioned and replaced by the National reporting. ARR's roles identified in the PCN workforce plan and recruitment plans in place				All practices have now completed the HEE tool to allow the CCG to create a workforce baseline. ARR's recruitment of SPLW, CP, PAs, Care Coordinators and H&W Coordinators				Ongoing		
Additional investment above core contracts through PDA delivers £4.2 to Barnsley practices to improve sustainability and attract workforce to the Barnsley area				Ongoing monitoring of PDA (contractual / QIPP aspects via FPC, outcomes via PCCC).				Ongoing		
Optimum use of BEST sessions A contract is in place with BHF for the BEST programme which enables the CCG to support the programme				BEST programme and Programme co-ordination being led by BHF				Ongoing		
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				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.				Ongoing		
BHF - Existence of strong federation supports Primary Care at Scale				BHF contract monitoring, oversight by PCCC				Ongoing		
Practices increasingly engaging with voluntary and social care providers (e.g. My Best Life) Social Prescribing - My Best Life is a successful programme supporting the people of Barnsley to work towards self care. This service has now extended to include high intensity users. Social prescribing link workers are now delivering a young peoples Social Prescribing service as part of the PCN additional roles recruitment.				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.				Ongoing		
Programme Management Approach of GPFV & Forward View Next steps				GPFV assurance returns submitted quarterly to NHSE. Regular updates on progress are reported to PCCC as per PCCC work plan.				Ongoing		
Care Navigation roll out - First Port of Call Plus				This has been delivered and the contract has now ended				Complete		
Engagement and consultation with Primary Care (Membership Council, Practice Managers etc.)				NHS England 360 Stakeholder Survey results shared with stakeholders and published on the CCG website. Results show that BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement.				Ongoing		
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.				BCCG is represented on the group. BCCG is represented on all workforce groups. Reporting is via PCCC for Primary care.				Ongoing		
Gaps in assurance				Positive assurances received						
None identified										
Gaps in control				Actions being taken to address gaps in control / assurance						
RR 14/10: If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce there is a risk that: (a) Some practices may not be viable, (b) Take up of PDA or other initiatives could be inconsistent (c) The people of Barnsley will receive poorer quality healthcare services (d) Patients services could be further away from their home.				The CCG and BHF work with member practices to address any gaps/ variance and to develop a workforce plan going forward 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.						

PRIORITY AREA 3: CANCER				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY		
<ul style="list-style-type: none"> Preventing cancer incidence Reduced Inequalities especially those diagnosed at emergency admission. Improved cancer diagnosed rates at stage 1 or 2 Early Diagnosis - Implement rapid assessment and diagnosis pathways for all tumour sites Improve care and treatment - embed new cancer waiting times system Improve Patient Experience along pathways and LWBAC Increasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of life Deliver Survivorship Program (LWABC) including recovery package and stratified pathways Commissioning for Value adopted if appropriate Achieve 10 waiting time standards including the 62 day referral-to-treatment cancer standard and 28 day faster diagnosis standard and pre-covid position. 				Highest quality governance		✓		
				High quality health care		✓		
				Care closer to home		✓		
				Safe & sustainable local services		✓		
				Strong partnerships, effective use of £		✓		
Links to SYB STP MOU								
8.6. Cancer								
				1. Risk to delivery of the 62 day wait NHS Constitution standard if clear pathways from cancer diagnosis to treatment are not developed; capacity in place to meet the demand and services are able to respond to the impact of Covid restrictions on delivery of the Cancer Waiting Times. 2. Risk to delivery of early diagnosis if: (a) the CCG does not effectively promote to the people of Barnsley the national screening programme (b) Practices do not consistently apply NICE guidance for cancer diagnosis and referral and deliver the PCN DES . 3. Risk that, if the CCG does not have a clear local strategy for delivering cancer priorities and performance, Barnsley people morbidity and mortality from cancer will be impacted negatively for people at risk of cancer; Living With and Beyond Cancer (LWABC) and improving 62 day target and delivering 10 CWT standards . 4. Risk that the incidence of cancer is not reduced, and of poorer outcomes post treatment, if steps to promote healthy lifestyles for Barnsley people are not successful.				
Committee providing assurance		FPC	Executive Lead		JW	Clinical Lead		Dr H Kadarsha
Risk rating	Likelihood	Consequence	Total			Date reviewed		Dec-20
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							
Key controls to mitigate threat:				Sources of assurance		Rec'd?		
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 & 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>62 Day Waits</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 & Performance committee and via CA board reporting arrangements. CCG meets BHNFT cancer lead weekly to monitor performance and gain assurance about improvement actions to address minimising COVID impact and P3 restoration. Steering group meeting 4 weekly and produces monthly programme assurance and risk register that is approved by steering group and shared with CA. This group monitors programme delivery and updates shared with CCG SRO monthly . CCG attends BHNFT CPIG group and raises assurance points that are addressed via the action log process. Reduction in performance due to large number endoscopy backlog breaches and Urology. Escalated to CCG via Finance & Performance committee and mitigating actions provided for assurance . P3 Restoration plan agreed with BHNFT by CCG. DON gaining assurance about maintaining quality from BHNFT and STHT during restoration period.</p>	<p>Ongoing</p>
<p>Prevention</p>		
<p>Cervical started June 2020 Bowel restarted early September and Breast screening 5 days mid September .CCG raised at BHNFT CQB that breast screening staff capacity is a risk and impacting on restoration. Extended Cervical screening running again via I-HEART .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>Early Diagnosis</p>		

<p>Timed pathways: All timed pathway been affected - Lung, Lower & upper GI & urology (red rating): not meeting 28 day STT FDS. Endoscopy started extra slots and having an impact but still have 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 in 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 >65 should receive a formal diagnosis.</p>	<p>Highest quality governance</p> <p>High quality health care</p> <p>Care closer to home</p> <p>Safe & sustainable local services</p> <p>Strong partnerships, effective use of £</p> <p>Links to SYB STP MOU</p> <p>8.5. Mental Health</p>	<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>

Committee providing assurance			FPC & QPSC	Executive Lead	PO	Clinical Lead	Dr M Smith	
Risk rating	Likelihood	Consequence	Total					Date reviewed
Initial	4	3	12					Dec-20
Current	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
Appetite	4	3	12					

Approach	Tolerate	A M J J A S O N D J F M	<p>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</p> <p>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.</p>
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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><i>Note (1) - Adult Joint Commissioning group minutes go to F&PC for information. It reports into the Health & Wellbeing Board which is attended by the CCG CO and Chair and minutes go to GB.</i></p> <p><i>Note (2) - the Childrens & Young Peoples Trust ECG minutes go to F&PC for information. It reports via TEG to H&WB which is attended by the CCG Chair and CO and minutes go to GB. Specific issues may be raised with GB via quarterly Children's Services updates.</i></p>		
Gaps in assurance	Positive assurances received	

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

NHS Barnsley CCG Governing Body Assurance Framework 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 & 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.</p>				Highest quality governance		✓		<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. The effectiveness of commissioning at place level across the full range of CCG priorities could be detrimentally affected if uncertainty re the future of commissioning across the system leads to disengagement or loss of capacity or direction locally. Effective governance of the ICS, changing role of the ICS eg allocation of funding to CCGs and providers</p>	
				High quality health care		✓			
				Care closer to home		✓			
				Safe & sustainable local services		✓			
				Strong partnerships, effective use of £		✓			
Links to SYB STP MOU				8.7 Workforce; 8.8 Digital & IT; 8.9. Development of Integrated Care in Place & System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review					
Committee Providing Assurance		ICS CPB JCC of CCGs	Executive Lead		CE		NB		
Risk rating	Likelihood	Consequence	Total				Date reviewed	Dec-20	
Initial	3	3	9				<p>Rationale: Likelihood has been scored at 3 (possible) because individual organisation will be required to deliver on their statutory duties and may prioritise these over partnership commitments. Consequence has been scored at 3 (moderate) because whilst we would not be able to harness the full benefits of integrated health and care the commissioning and provision of health and care services for Barnsley people would continue.</p>		
Current	3	3	9						
Appetite	3	4	12						
Approach	Tolerate								
Key controls to mitigate threat:				Sources of assurance				Rec'd?	
Governance review of the ICS currently underway				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
Gaps in assurance	Positive assurances received	
	SYB response to the NHS Long Term Plan collectively developed across partnership.	
	Workshops with ICS and CCG Chairs and AOs held in December 2019 and January 2020 to agree the way forward with commissioning reform Jan 2020	
Gaps in control	Actions being taken to address gaps in control / assurance	

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"> • Development of the primary care network and localities • Development of neighbourhood action plans that deliver better use of estates, support co-production and integration • Population health management including PHMU, integrated care outcomes framework and local profiles and needs assessments that support neighbourhood prioritisation • Development of a place-based workforce strategy • Integrated commissioning with BMBC • Service specification for the out-of-hospital model of care • Strategic outline case for integrated care in Barnsley • Set out how the local health system will specifically reduce health inequalities by 2023/24 and 2028/29 <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>				Highest quality governance		✓		<p>There is a risk that if the following threats are not effectively managed and mitigated the key deliverables will not be achieved:</p> <ul style="list-style-type: none"> • Financial pressure on individual organisations leads to reduced involvement/investment in the partnership working • Constraints within the current legislative and regulatory framework limit progress with partnership working despite the clear direction of travel set out in the 5YFV and NHS LTP. NHS England is consulting on possible legal changes but these are unlikely to come into effect for at least 3 yrs • Political uncertainty in part due to Brexit. • Maturity of the local provider partnership, financial and operating pressures in the system affect their ability to implement transformational change • Capacity to constructively engage all relevant stakeholders in the development of integrated care and to deliver the cultural and behavioural change required (both staff and service users) • Failure to demonstrate the impact and benefits of new ways of working in order to generate support and increase engagement • Limited local leadership capacity, particularly for Primary Care Networks • Ability of candidates to recruit into new primary care network roles <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>
				High quality health care		✓		
				Care closer to home		✓		
				Safe & sustainable local services		✓		
				Strong partnerships, effective use of £		✓		
<p>Links to SYB STP MOU</p> <p>8.7 Workforce; 8.8 Digital & IT; 8.9. Development of Accountable Care in Place & System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review</p>								
Committee Providing Assurance		Governing Body	Executive Lead		JB	Clinical Lead	NB	
Risk rating	Likelihood	Consequence	Total			Date reviewed	Dec-20	
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	Tolerate							
Key controls to mitigate threat:				Sources of assurance			Rec'd?	
Oversight of process by CCG Governing Body				Routine reporting of progress into Governing Body meetings (public and private) and discussions at development sessions			Ongoing	
Primary care engagement				Series of BEST events focussed on emerging guidance for primary care networks and the right model for Barnsley			Completed	
Engagement with the Membership Council and Local Medical Committee to gain support for integrated care objectives and primary care network proposals				Membership Council agreed to strategic direction at the meeting held on 3 July 2018			Completed	
Local partnership governance arrangements				The CCG is a member of the Integrated Care Partnership and Delivery Groups and leads the Strategic Estates Group and Workforce Transformation Group. 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
Gaps in assurance	Positive assurances received	
Gaps in control	Actions being taken to address gaps in control / assurance	
18/02; If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.	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"> System agreement to be open and transparent re. recovery plans – plans to be shared 	
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"> Modelling now being undertaken locally, regionally and nationally to understand impact Close monitoring of service demand against these models to give early signs for service escalation Developing a tool to support prioritisation based on medical, social and economic vulnerability that can support phased recovery of services for maximum health benefits 	

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"> Free up hospital beds Best value across all CCG expenditure Reduce avoidable demand Reduce unwarranted variation in clinical quality and efficiency Financial accountability and discipline for all trusts and CCGs Deliver financial balance in 2020/21 				Highest quality governance		✓	
				High quality health care		✓	
				Care closer to home		✓	
				Safe & sustainable local services		✓	
				Strong partnerships, effective use of £		✓	
Links to SYB STP MOU							
8.2. Managing demand and demand management							
8.1. Efficiency programmes							
Committee Providing Assurance				FPC		Executive Lead	
				RN		Clinical Lead	
				Various			
Risk rating	Likelihood	Consequence	Total			Date reviewed	Jan-21
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	Tolerate						
Key controls to mitigate threat:				Sources of assurance		Rec'd?	
Structured project management arrangements in place to support delivery				Monthly reports to Finance & Performance Committee and Governing Body		Ongoing	
QIPP Delivery Group continues to be in place to maintain oversight of the QIPP programme a system wide efficiency group is also in place to ensure costs can be taken out of the system across partners				Ongoing engagement with primary care, secondary care and internal management to support delivery of schemes, with a view to taking costs out of the system and ensure effective use of the Barnsley £.		Ongoing	
Clinical Forum provides clinical oversight of projects						Ongoing	
Continued development and review of the CCG's Medicines Optimisation QIPP 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.		Ongoing	
Gaps in assurance				Positive assurances received			
				Discussions with partners remain positive in moving to a new style of contract and expectations that costs need to be taken out of the system to ensure that the allocation in Barnsley is utilised effectively to achieve the best outcome for the people of Barnsley.			
Gaps in control				Actions being taken to address gaps in control / assurance			

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

Immediate action is required to identify and model through plans to determine the expected impact in 2020/21 to close the gap in the current financial plan. Development sessions are planned with SMT and the Governing Body to ensure plans can be progressed at pace and maximum impact can be delivered for the remainder of 2020/21. Budget reviews has led to a small contingency being created to mitigate the unidentified QIPP and further risk on Prescribing and CHC budgets. The forecast position continues to be reviewed and updated with risks being captured and reported to the Finance and Performance Committee and Governing Body.

PRIORITY AREA 7: TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM CONDITIONS				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY																				
Transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals by: -Reduce inappropriate hospitalisation and lengths of stay to be as short as possible - Improve access to healthcare and deliver annual physical health checks (eg cervical screening) -Invest in community teams -Ensure all children with learning disabilities, autism or both receive Community Care, Education and Treatment Review (CETR) if appropriate - Ensure all adults with learning disabilities, autism or both receive Community Care and Treatment Review (CTR) as appropriate -Increase uptake on annual health checks and learn from learning disability mortality reviews				Highest quality governance High quality health care Care closer to home Safe & sustainable local services Strong partnerships, effective use of £		There is a risk that if the CCG and its partners are unable to provide focussed case management and wrap around services the following negative consequences may result: -People with a learning disability or autistic spectrum conditions will enter hospital inappropriately -There will be difficulty discharging current patients -Potential prohibitively high cost of meeting needs -Inability of current provider market to meet needs -Difficulty in ensuring that the quality of care is high -Insufficient funding to ensure the appropriate level of care within the community																				
				Links to SYB STP MOU																						
Committee providing assurance				FPC & QPSC		Executive Lead																				
Risk rating				PO / AR		Dr M Smith																				
<table border="1"> <thead> <tr> <th>Likelihood</th> <th>Consequence</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Initial</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Current</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Appetite</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Approach</td> <td colspan="2">Tolerate</td> <td></td> </tr> </tbody> </table>				Likelihood	Consequence	Total	Initial	4	3	12	Current	4	3	12	Appetite	4	3	12	Approach	Tolerate					Date reviewed Dec-20 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.	
Likelihood	Consequence	Total																								
Initial	4	3	12																							
Current	4	3	12																							
Appetite	4	3	12																							
Approach	Tolerate																									
Key controls to mitigate threat:				Sources of assurance		Rec'd?																				
A Complex Case Manager for Transforming Care patients has been in post from May 2019. The postholder will 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.				JCU reports to Finance & Performance Committee with any Quality issues escalated to Quality & Patient Safety Committee. Quarterly update reports to CCG Governing Body Quarterly meetings with NHS England Spec Comm, who commission the existing placements for this cohort of patients, to determine progress made, working towards discharge.		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																				
Gaps in assurance				Positive assurances received																						
Gaps in control				Actions being taken to address gaps in control / assurance																						
Plans are to be established to improve the uptake of Annual physical Health checks for people with LD																										

PRIORITY AREA 8: MATERNITY				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY	
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 High quality health care Care closer to home Safe & sustainable local services Strong partnerships, effective use of £		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	
				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	Dec-20
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.	
Current	4	3	12			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.'	
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.				Highest quality governance High quality health care Care closer to home Safe & sustainable local services Strong partnerships, effective use of £		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.	
				Links to SYB STP MOU			
Committees providing assurance		PCCC & SMT	Executive Lead		JB	Clinical Lead	JH
Risk rating	Likelihood	Consequence	Total			Date reviewed	Dec-20
Initial	3	4	12			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	Tolerate						
Key controls to mitigate threat:				Sources of assurance		Rec'd?	
Barnsley IT Strategy Group				Monthly meetings to review SCR progress and refresh Digital Roadmap. Minutes to GB		Ongoing	
BBS IT Delivery Group and BBS Digital Strategy Group established				Monthly meetings to review progress of the delivery of key projects and programmes. Updates to SMT, GB and PCCC		Ongoing	
GP IT and Corporate IT service commissioned from BBS IT Services, the successor to eMBED. The new shared service is now establishing working protocols. Shared staffing allows for technical and network experience to be available to the CCG. Additional staffing to be secured if Digital First EOIs are successful as bids include resource.				CCG representatives attend the BBS IT Delivery Group and BBS Digital Strategy Group. KPIs and other performance monitoring data is provided and reviewed. 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"> • Delivery of all the CCG's statutory responsibilities • Deliver statutory financial duties & VFM • Improve quality of primary & secondary services (inc reductions in HCAI, ensuring providers implement learning from deaths, and reductions in medication errors); • Involve patients and public; • Promote Innovation; • Promote education, research, and training; • Meet requirements of the Equality Act; • Comply with mandatory guidance for managing conflicts of interest • Adhere to good governance standards. 				Highest quality governance		✓						
				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'				There is a risk that if the CCG fails to deliver its statutory duties, due to weaknesses in its corporate governance and control arrangements, it will result in legal, financial, and / or reputational risks to the CCG and its employees.								
Committee Providing Assurance		Audit Committee	Executive Lead					RW	Lay / Clinical Leads			
MG,MT,NBa, NBe, CM												
Risk rating	Likelihood	Consequence	Total								Date reviewed	Dec-20
Initial	2	5	10								Rationale: Likelihood is 'unlikely' as arrangements now well established. Consequence is catastrophic due to very significant quality, financial & reputational impact of failure.	
Current	2	5	10									
Appetite	3	4	12									
Approach	Tolerate											
Key controls to mitigate threat:				Sources of assurance				Rec'd?				
Overall: Constitution, Governance Handbook, Prime Financial Policies, and suite of corporate policies				Audit Committee provides oversight, supported by internal & external audit reports & opinions, LCFS work etc				Ongoing				
Governing Body & Committee Structure underpinned by clear terms of ref and work plans				GB members sit on Committees. All Committee minutes taken to GB and significant issues are escalated. Committees produce annual assurance reports for the GB.				Ongoing				
Management Structure - responsibilities clearly allocated to teams and individuals				Management action monitored by regular senior management team meetings. SMT decisions with a financial consequence reported through F&PC.				Ongoing				
Finance: Budgetary control, contract monitoring & QIPP monitoring arrangements. Scheme of Delegation requires SMT approval for spending commitments <£100k and GB approval over this level.				Financial Plan signed off by GB each year. Monthly finance report to FPC and GB; internal & external audit reviews and opinions; GB formally adopt annual report & accounts.				Ongoing				
Performance monitoring arrangements				Integrated Performance Reports to FPC provides assurance across all NHS Constitution pledges. Summary reports to GB.				Ongoing				
Quality: comprehensive and well established arrangements in place to monitor, assure and improve the quality of all commissioned services including Clinical Quality Boards, Quality Assurance visits, benchmarking, Primary Care Quality Improvement Tool, outcomes from CQC inspections in both primary and secondary care, review of serious incidents and never events, complaints & compliments, review of FFT, nurse leads for safeguarding adults & children who represent the CCG on the local safeguarding boards.				Reporting of all relevant information to the Quality & Patient Safety Committee, with assurance to Governing Body through Quality Highlights reports and sharing of minutes.				Ongoing				

<p>Patient & Public Involvement: strategy in place, well established Patient Council and development of a local/regional citizen's panel, Healthwatch Barnsley holds independent role on engagement and equality committee and primary care commissioning committee, co-ordination of activity with partners, appropriate engagement & involvement re service changes, membership of consultation institute, active patient reference groups locally, funding provided to Barnsley Council to provide community engagement activity and to support a robust and sustainable third sector.</p>	<p>Oversight by Equality & Engagement Committee. Assurance to Governing Body via minutes and bi-monthly PPI Summary reports. In previous years Internal Audit Reviews and NHSE assurance process also provided assurance re robustness of our arrangements. Compliance with statutory guidance on patient and public participation in commissioning health and care is assessed via the NHSE 'improvement and assessment framework'. (rated green in 2017/18, 2018/19 and 'Green Star' in 2018/19).</p>	<p>Ongoing</p>
<p>Equality: EDS2 used to ensure compliance with PSED requirements; Equality Action Plan monitored via E&D Group and E&E Committee; E&D Lead; E&D training provided to all staff; EQIA policy in place and EQIAs attached to GB papers where appropriate; Staff survey results considered & acted upon; HR policies approved & embedded.</p>	<p>Progress monitored by Equality, Diversity & Inclusivity Group and reported quarterly to Equality & Engagement Committee. Assurance to GB via E&E Committee Minutes and annual assurance report. Summary of key actions on CCG website each year.</p>	<p>Ongoing</p>
<p>Conflicts of Interest: standards of business conduct policy in place & compliant with statutory guidance; registers of interests maintained & published; declared conflicts managed in meetings and / or during procurements; online training provided to key staff; oversight by Audit Committee; Conflicts of Interest Guardian in place; PCCC has delegated authority where GB cannot make decisions.</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 & policies in place, SIRO / Caldicott Guardian identified, training provided for all staff, information asset register in place, committee report & business case template prompts consideration of IG issues. GDPR / compliant processes in place. DPO service provided by third party provider.</p>	<p>DSP Toolkit (formerly IG Toolkit) compliance achieved every year. Reporting via IG Group==>QPSC==>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 & Safety and Business Continuity Group established to oversee compliance with statutory Fire & Health & Safety & Business Continuity requirements</p>	<p>Annual Report & update reports taken to Audit Committee.</p>	<p>Ongoing</p>
<p>MAST: Statutory & Mandatory training programme in place for all staff, inc GB members, as well as IPR reviews, development sessions for Governing Body inc conflicts of interest, risk management & assurance etc</p>	<p>L&D team provides dashboard which is considered by management team on a regular basis.</p>	<p>Ongoing</p>
<p>Gaps in assurance</p>	<p>Positive assurances received</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 & Risk Management arrangements (Sep 2019). The CCG received a 'significant assurance' opinion from internal audit on its conflicts of interest arrangements (Dec 2019). The CCG received a 'substantial assurance' opinion from internal audit on the Integrity of the General Ledger and Financial Reporting (Jan 2020).</p>	
<p>Gaps in control</p>	<p>Actions being taken to address gaps in control / assurance</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

PRIORITY AREA 11: DELIVERY OF ENHANCED HEALTH IN CARE HOMES				<i>Delivery supports these CCG objectives:</i>		PRINCIPAL THREATS TO DELIVERY					
Delivery of all 17 elements and sub elements of the Barnsley Care Homes Delivery Plan. This includes the elements of the Enhanced Health in Care Homes (EHCH) Framework and the Covid-19 Pandemic specific support. 1. Engagement with care homes on all requisites of the delivery plan 2. EHCH Primary Care Network (PCN) Specification 3. Named Clinician for each care home 4. Coordinated health and social care MDT support 5. Specialist Support 6. Out of Hours support 7. Infection Prevention and Control (IPC) including Personal Protective Equipment (PPE) 8. Mutual Aid 9. Testing / Swabbing 10. Medicines 11. Equipment 12. Discharge to Assess (D2A) and Intermediate Care (IMC) 13. Secondary Care support 14. Personalised care 15. Workforce support 16. Technology 17. Integrated Care System link-in				Highest quality governance			There is a risk that the CCG will 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				
				High quality health care		✓					
				Care closer to home		✓					
				Safe & sustainable local services		✓					
				Strong partnerships, effective use of resources		✓					
				Links to SYB STP MOU							
<i>Committee Providing Assurance</i>				Q&PSC		<i>Executive Lead</i>		JS		<i>Clinical Lead</i>	
Risk rating	Likelihood	Consequence	Total					Date reviewed		Dec-20	
Initial	3	4	12					Likelihood assessed as 3 'possible' taking into account learning from Phase 1 responses, service delivery, issues and risks; discussions about the risk and issues			
Current	3	4	12								
Appetite	3	4	12								

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

RISK REGISTER – January 2021

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

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	9	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	18	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	6	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	3	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

The initial risk rating is what the risk would score if no mitigation was in place. The residual/current risk score is the likelihood/consequence (impact) of the risk sits when mitigation plans are in place

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
COVI D 1	5, 6	Disruption to health and social care – hidden harm During the C19 peak healthcare seeking behaviours changed along with service delivery models resulting in lower urgent and emergency care presentations and fewer referrals to healthcare services. This 'hidden harm' may cause a double burden that may be caused by people not presenting or delaying presenting with new or existing conditions.	5	5	25	07/07/20 <ul style="list-style-type: none"> Modelling now being undertaken locally, regionally and nationally to understand impact Close monitoring of service demand against these models to give early signs for service escalation Developing a tool to support prioritisation based on medical, social and economic vulnerability that can support phased recovery of services for maximum health benefits 	Director of Commissioning CCG Gold Command F&PC	COVID-19	5	5	25	Sep-20		Oct-20

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 2	1,5,6	Backlog and demand surge A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an 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.	5	5	25	14/07/20 <ul style="list-style-type: none"> System agreement to be open and transparent re. recovery plans – plans to be shared 	Director of Commissioning CCG Gold Command F&PC	COVID-19	5	5	25	Sep-20		Oct-20
COVI D 3		Flu season 2020/21 A possible influenza epidemic that will be additive to the challenges above. The size and severity of the influenza epidemic	5	5	25	20/07/20 <ul style="list-style-type: none"> Local flu group mobilised. JW confirmed there was a bid for capital to support this year's flu programme, specifically about supporting GP 	Chief Operating Officer CCG Gold Command	COVID-19	4	5	20	Sep-20	Oct 20 * Barnsley Flu Group is meeting regularly and a flu plan is in place aiming to meet aspirational	Oct-20

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			
		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.				<p>practices to deliver to at risk groups.</p> <ul style="list-style-type: none"> • Waiting on detail from national team on over 50's element of the programme: a bigger task than previous years. • 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. • These issues are being picked up at local, regional and national flu delivery calls. 	F&PC					<p>targets and which been discussed in Peer Review with Rotherham CCG.</p> <p>* 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 approaches.</p> <p>* NHSE have informed approx £52K for Barnsley flu plan delivery and an application & approval process is being developed by the CCG.</p> <p>* NHSE have advised sufficient vaccine stock is nationally available and published a process for obtaining</p>		

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
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	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	Chief Operating Officer (Finance & Performance Committee)	Contract and Performance Monitoring	5	4	20	11/20	November 2020 Increased COVID related activity is impacting on A&E and unplanned care activity. Plans against priority areas are being refined to ensure clear focus on reducing activity in hospital and providing earlier support in the community. Aug 2020	12/20

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			
		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.				<p>improvements to urgent care services and achieving related targets. The Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising ambulatory care pathways and implementing a new model at the front of A&E..</p> <p>Engagement with regional and SYB programme to implement 'Think 111' (Talk before you walk) model in partnership with Integrated Urgent Care providers</p> <p>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</p>							A number of out of hospital work streams are ongoing including Intermediate Care, Respiratory and Diabetes services aimed at providing better support in the Community. Plans to improve links between 111 and community/ Primary Care services is also intended to avoid hospital attendance and admission.	

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			
						developments. 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	10/20	Oct 2020 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	11/20

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			
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	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	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	4	4	16	12/20	Dec 2020 No further updates. Oct/Nov 2020 2020-21 PCN workforce plan submitted to NHSE for the Additional Role recruitment by the	01/20

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			
		<p>or other initiatives could be inconsistent</p> <p>(c) The people of Barnsley will receive poorer quality healthcare services</p> <p>(d) Patients services could be further away from their home.</p>				<p>sustainable services in Barnsley.</p> <p>NHS England has published an Interim People Plan to 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 & 2 technicians in March 2019.</p>							<p>PCN. The remaining 3 years plan is to be submitted for review by the CCG prior to NHSE by end November 2020.</p>	

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
						The PDA requires Practices to submit a workforce baseline assessment to the CCG on a quarterly basis. This will be monitored via the Primary Care Quality Improvement Tool to identify any capacity issues or pressure points.								
14/15	1, 5, 6	There are two main risks: 1. Scant or absent information relating to why medication changes have been made. Poor communication of medication changes, even if changes are appropriately made for therapeutic/safety reasons, creates a patient safety risk when post discharge medicines reconciliation is being undertaken by the GP practice. The risk being that the GP practice may either accept inappropriate	4	4	16	Ongoing discharge medication risks escalated to BCCG Chief Officer and Chief Executive of BHNFT resulted in 2 quality risk meetings (August and November 2016). Area Prescribing Committee (APC) monitor concerns and will report 2017 audit to the Quality & Patient Safety Committee. A working Group (with reps from Practice managers Group & BHNFT) looking at D1 Discharge Summary Letters.	Head of Medicines Optimisation (Quality & Patient Safety Committee)	Risk Assessment & audit of discharge letters	3	5	15	10/20	Oct 20 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 nd July 2020. This showed an improvement; 61.4% of D1 forms had all medicines accurately	11/20

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			
		<p>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> <p>2. Clinically significant safety alerts, such as contraindicated combinations of medication, are being frequently triggered by primary care prescribing systems during post discharge medicines reconciliation when adding medicines to the Patients Primary Care Record. This indicates that either the hospital is not reconciling medicines using the GP Practice</p>										<p>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.</p>		

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
		Summary Care Record or that the reconciliation is not sufficiently robust.												

	2	<p>b) Financial Risks Increased costs to CCG due to having to obtain care from specialist providers</p> <p>Delayed discharges will affect CCG's efficiency plans</p> <p>c) Performance Risks Delayed discharges impact upon patient flow which could affect delivery of 4 hour A&E standard and elective waiting times.</p> <p>Increase in non-elective admissions to hospital because of patients being left without care in the community.</p>				<p>from neighbourhood nursing service/ palliative care services in Barnsley</p> <p>e) Care packages to be spot purchased from any provider</p> <p>f) CHC EOL team to contact care providers on Barnsley borders to identify if they could pick up packages just over the borders.</p>						<p>preferred place of care. BMBC Contracts and Compliance seeking a legal view on this. Designated premise is the fall-back position. One problem arose with a neighbouring CCG not being able to put a package in place in time and patient RIP in hospital. Contact made with CCG CHC team. It was ascertained that it is their policy to only procure providers on their framework and they cannot spot purchase. Matter escalated via Bronze 6/11/20. Chief Nurse will address with DCCG Chief Nurse.</p> <p>October 2020 CHC have worked closely with partners on D2A process for EOL. Otherwise no further updates. Operational lead /</p>	
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													team leader attend sit rep meeting at 10am each morning to raise any concerns /issues re EOL.	
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 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</p>	<p>Chief Finance Officer</p> <p>Governing Body</p> <p>(Finance & Performance Committee)</p>	Risk Assessment	4	4	16	12/20	<p>December 2020 Plans continue to be monitored with financial risk and delivery of efficiency being flagged to the Finance and Performance Committee and Governing Body.</p> <p>November 2020 Allocations for month 7-12 have now been received with significant requirements for the CCG to delivery efficiency in order to achieve financial balance. Plans continue to be developed to ensure that the CCG can achieve financial duties.</p> <p>September 2020 The month 7-12 financial framework,</p>	01/21

					<p>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 & Accounts subject to statutory external audit by KPMG, reported via Annual Governance (ISA260) Report, and Annual Audit Letter.</p> <p>Monthly monitoring reporting to NHS England</p> <p>Develop a joint approach to future efficiency to ensure costs are taken out of the system to allow financial balance.</p>						<p>national modelling of expenditure and NHS block contracts limits the CCGs scope to deliver efficiency across all areas and services commissioned. The CCG needs to develop plans to deliver significant efficiency to ensure financial balance can be achieved. The CCG has not yet submitted a balanced financial plan and work continues to ensure statutory duties and business rules can be achieved.</p>	
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New CHC risk added:

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			
20/03	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	16	<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 consistency to staff and patients in relation to the cost</p>	<p>Chief Nurse</p> <p>Finance & Performance Committee</p> <p>And</p> <p>Quality & Patient Safety Committee</p>	SMT discussion	3	4	12	12/20		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			
		implications on meeting the KPI's as set by NHSE.				of care packages and rationale for the level of care provided.								

GOVERNING BODY

14 January 2021

Home Working Policy**PART 1A – SUMMARY REPORT**

1.	THIS PAPER IS FOR		
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>
		<input checked="" type="checkbox"/>	<i>Assurance</i>
			<i>Information</i>
2.	PURPOSE		
	This paper presents a draft Home Working Policy for Governing Body's approval.		
3.	REPORT OF		
		Name	Designation
	Executive Lead	Richard Walker	Head of Governance & Assurance
	Author	Esther Short	HR & OD Business Partner
4.	SUMMARY OF PREVIOUS GOVERNANCE		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	Group / Committee	Date	Outcome
	Senior Management Team	20.11.2020	Agreement in principle for the development of this policy
5.	EXECUTIVE SUMMARY		
	<p>Barnsley CCG already includes home working as an option within its Flexible Working Policy. The majority of CCG staff are currently working from home in response to the Covid-19 pandemic, and it is likely that some may wish to continue with this arrangement for at least some of their working week once the emergency has been contained and a return to Hilder House is possible.</p> <p>Whilst any such requests will always need to be considered on their merits and in the light of business need, there are clear potential benefits to the CCG in providing the option of home working to its staff. For example it:</p> <ul style="list-style-type: none"> allows greater flexibility for staff with child care or caring responsibilities, thereby supporting the recruitment and retention of staff 		

	<ul style="list-style-type: none"> • can improve efficiency for some staff by reducing time lost in travel etc • reduces pressure on space in the office and car park • reduces the need for business travel with a commensurate reduction in expenses claims and the CCG's carbon footprint. <p>In view of this the HR Business Partner has drafted the attached draft Home Working Policy, which provides a more comprehensive and robust framework for considering home working requests than is set out in the existing flexible working policy. The draft policy has been through a wide ranging engagement process encompassing CCG Senior Management Team, CCG staff, staff side, the Local Counter Fraud Specialist, and the Equality Diversity & Involvement Lead. Comments and suggestions received through this engagement process have been incorporated into the draft policy.</p>
6.	GOVERNING BODY IS ASKED TO:
	<ul style="list-style-type: none"> • Approve the Draft Home Working Policy.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix A – Daft Home Working Policy

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

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care		7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)	See 3.2	Duties as to reducing inequalities (s14T) See 3.5
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2) See 3.6
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

**BARNSELY CLINICAL COMMISSIONING
GROUP**

HOME WORKING POLICY

Version:	1
Approved By:	Governing Body
Date Approved:	
Name of originator / author:	HR & OD Business Partner
Name of responsible committee/ individual:	Equality and Engagement Committee
Name of executive lead:	Chief Officer
Date issued:	September 2020
Review Date:	3 years from date of implementation
Target Audience:	All employees.

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK
POLICY

**THIS POLICY HAS BEEN SUBJECT TO A FULL EQUALITY IMPACT
ASSESSMENT**

DOCUMENT CONTROL

Version No	Type of Change	Date	Description of change
DRAFT		November 2020	With the CCG for consultation.

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

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BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

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BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

PART 1

1. POLICY STATEMENT

1.1 NHS Barnsley Clinical Commissioning Group (CCG) is committed to promoting flexible working in order to facilitate effective and efficient working. A key component of our flexible working policy is home working. This policy outlines the circumstances under which the CCG will allow employees to work from home.

2. SCOPE

2.1 This policy applies to those members of staff that are directly employed by the CCG and for whom the CCG has legal responsibility. Seconded staff are covered by the policy of their employing organisation. For those staff covered by a letter of authority / honorary contract or work experience, this policy is also applicable whilst undertaking duties on behalf of the CCG or working on the CCG premises and forms part of their arrangements with the organisation. As part of good employment practice, agency workers are also required to abide by the CCG policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for the CCG.

3. DEFINITIONS

3.1 Home working is about using the employee's home as a base for work instead of the employee coming into a workplace. There are a number of categories of home workers:

- Occasional home workers
- Regular home workers
- Home based routine workers – employee requested
- Home based routine workers – service driven

These arrangements are described below.

3.2 ***Occasional home working***

Occasional home workers are normally based at a CCG site but may spend a small amount of time (up to 20% or no more than 1 day each week over a calendar year) working from home. Occasional home working can be ad hoc and associated with the delivery of a specific piece of work. For example, an employee with a deadline to meet for a piece of research or executive report may agree with their line manager to complete the work at home rather than in the office.

The benefit of occasional home working for managers and employees is

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

the opportunity to be flexible about the work base where specific conditions are required for a piece of work. There may also be an improvement in employee retention and easier recruitment by offering an attractive working arrangement which improves work/life balance.

This designated way of working may also be a consideration for managers where a recommendation has been made that occasional home working may be supportive to an employee with disclosure of a disability or to facilitate a return to work of an employee following a period of long term absence.

3.3 ***Regular home working***

Regular home working is where the employee works from home rather than a CCG site for a large proportion of their working time (normally between 20% and 80% or between 2 and 4 days each week over a calendar year). These employees may not have a designated desk space at the CCG so may be required to use a desk within a designated team space when working on site. Employees will still be required to attend meetings and training at other sites or venues as appropriate.

The potential benefits of regular home working for the CCG include:

- Potential savings on office space by reducing the number of employees who require a permanent desk space
- Support for the employees travel plan and other environmental initiatives, by reducing the number of vehicles on the road
- Improved employee concentration at home, leading to enhanced productivity
- Improved employee retention and easier recruitment by offering an attractive working arrangement which improves work/life balance
- Increased opportunities for people with disabilities to work for the CCG

The benefits of regular home working for employees include:

- Savings on the travel time and cost associated with regular days in the office
- Improved work/life balance by exercising more control over the hours and place that you work
- Greater flexibility to accommodate child care or other caring responsibilities.

3.4 ***Home based routine workers – employee requested***

Home based routine workers are those who visit users/customers or

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

attend meetings at a variety of locations, but who require a base at points throughout the day, particularly at the start and end of the day. Generally these employees are in the office for less than 20% of their working week. These employees will request to be based from home and provided with the equipment they need to do their job remotely if required (See Part 2, Section 5). They will still be required to attend meetings and training at CCG sites as appropriate, but will not usually maintain a permanent office base.

The benefits of home based routine working can be applied equally to that of regular home workers. In addition, this arrangement will reduce travel and "down time" between appointments by providing the opportunity to plan journeys and visits more efficiently.

3.5 ***Home based routine workers – service requested***

As stated above at 3.4 but this is where there is a request from the Service for the employee to be a home based routine worker rather than requested by the employee.

Arrangements for service driven changes to the work base will be managed in line with Staff Side consultation and the CCG's Organisational Change Policy. Employees do not need to apply for this type of home working as it is service driven.

4. ROLES AND RESPONSIBILITIES

4.1 Overall accountability for ensuring that there are systems and processes to effectively ensure compliance with this policy lies with the Chief Officer. Responsibility is delegated to the following:

<i>Chief Officer</i>	<ul style="list-style-type: none">• Maintaining an overview of the corporate ratification and governance process associated with the policy.• Ensuring that the policy is applied fairly, consistently and in a non-discriminatory manner.
<i>Human Resources</i>	<ul style="list-style-type: none">• Leading the development, implementation and review of the policy.• Providing advice and guidance to managers and employees in relation to the policy.• Monitoring home working levels within the

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK
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	organisation.
<p style="text-align: center;"><i>Appointing Officers/ Line Managers</i></p>	<ul style="list-style-type: none"> • Ensuring they understand and adhere to their obligations in relation to the policy. • Ensuring the policy is applied fairly and consistently to all employees. • Considering the request for home working in accordance with the set procedure. • Providing the appropriate support and information to the employee throughout the course of the application. • Ensuring the health and safety implications for home working arrangements have been considered and addressed, including ensuring risk assessments have been undertaken and seeking advice from the Occupational Health Provider where required • Liaising with IT to establish the relevant technological solution for home working opportunities. • Ensure that all equipment for home working is encrypted to the required standards, has an asset tag and that all employees have access to a network drive or other secure back up devices to back up and store confidential information • Reviewing home working levels at agreed intervals, at least annually, to ensure the level is still valid/ effective. • Ensure employees are aware of this policy including referring new employees to the policy as part of their induction process. • Ongoing communication with the employee to ensure they are aware of and engaged with developments at work
	<ul style="list-style-type: none"> • Ensuring they understand their responsibilities in relation to this policy. • Completing the necessary application forms to request to work from home if applicable • Being prepared to discuss their home

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All Employees	<p>working request with their line manager in an open and constructive manner.</p> <ul style="list-style-type: none"> • Being flexible where a mutually agreed compromise is required. • Agreeing to regular reviews, at least annually, to ensure the working from home level continues to be valid and meets the needs of the organisation as well as personally. • Informing their manager of any changes to the agreed working arrangements and / or if they notice or start to experience any muscular aches or pains, etc. which may be associated with working at home. • Following best practice guidance in relation to setting up their home working environment and maintaining physical movement and mobility to promote own good health
Staff Side	<ul style="list-style-type: none"> • Ensure they are familiar with the policy and procedure. • Advise and represent employees who are a member of a recognised Trade Union.

5. EQUALITY

5.1 NHS Barnsley CCG aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and The Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

5.2 NHS Barnsley CCG embraces the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

6. MONITORING & REVIEW

- 6.1 This policy and procedure will be reviewed at least every three years by the Equality and Engagement Committee, in conjunction with HR, Managers and Trade Union representatives. Where review is necessary due to legislative change, this will happen immediately.

PART 2

PROCEDURE

Home working arrangements can be driven either by service needs, requests from individual employees or both. This section describes the criteria for effective home working and the application and selection procedure.

1. CRITERIA

- 1.1 All proposals for a home working arrangement, whether service or employee driven, must satisfy the following criteria:

- The work can be done without access to office-based IT
- The work can be done through virtual face-to-face contact (via MS Teams or similar) with colleagues, internal and external customers for the duration of the time spent working from home
- The work can be done from home without increasing the workload of others
- The work can be conducted with minimal supervision.

In addition, individuals who wish to work from home should also:

- Provide a satisfactory health and safety self-assessment of their proposed work space, advice will be available from the Health & Safety Lead should an employee require this (Appendix 2)
- Have access to stable broadband with sufficient capacity in their local area
- Have met all their essential development needs and therefore possess the skills and confidence to work without immediate access to support from colleagues and their line manager
- Be performing satisfactorily. Applicants must be meeting or exceeding any local performance standards and it may not be appropriate for those involved in the capability or disciplinary process to work from home.

2. SUITABILITY OF HOME WORKING

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

2.1 Job Roles

Not all jobs are suitable or can be or can be adapted for home working, however any job may be considered on its own merits. Jobs that will not be suitable include those that provide a direct service to the public at a fixed location. Jobs that involve project work or identifiable output, or those which provide services within the community, may in particular lend themselves to home working. Consideration should also be given to the impact on and inter-relationship with other jobs, access by the public, access to/by colleagues, access to required information, technology, costs and savings etc.

The following job characteristics may lend themselves to home working:

- Defined output tasks
- Discrete projects or functions
- Relatively autonomous jobs
- Jobs requiring frequent travelling
- Jobs requiring high periods of concentration

2.2 Employee Characteristics

Having established the suitability of the job for home working the suitability of the employee needs to be considered.

Home working does not suit everyone. Office dynamics and informal information flows may have a significant impact on the employee's performance. Some employees may develop better in a traditional office environment, and those without very much experience in their role are likely to need closer supervision which would not be possible if they were working from home. Individuals may also have a distorted view of home working with little recognition or understanding of the potential drawbacks, and it is important that both the advantages and the disadvantages are considered.

A trial period may be appropriate in order to gauge suitability before any longer term arrangements are put in place.

3. APPLICATION PROCESS

3.1 *Application for employee requested home working*

Employees wishing to work from home on an occasional basis (see section 3 of the policy) should discuss with their line manager. Employees wishing to work from home on a regular basis or as a home based routine worker (see section 3 of the policy) should complete a

BARNSELY CLINICAL COMMISSIONING GROUP'S EMPLOYMENT BREAK POLICY

written application (Appendix A) in the first instance.

The line manager will be responsible for considering the request in a fair and consistent manner. They should consider whether the role is eligible to work from home, whether the employee's personal characteristics are suitable for home working and if so, agree the proportion of time that can be agreed as home working, subject to service delivery needs.

Requests for home working should be responded to by the line manager within 10 working days of receipt of the request. If the line manager is not able to accept the application at this stage, they should provide the employee with a written response to their request including details of the reasons for rejecting the application.

Any requests for home working should be viewed in a positive light and the CCG will, wherever possible and practicable, agree to the employee's request subject to business need.

If the request is accepted in principle, a health and safety self-assessment (Appendix 2) of the home working environment must be carried out before a Home Working Agreement (Appendix 3) can be drawn up.

3.2 Appeals

If an employee feels that their application for home working has been treated unfairly, they have the right to appeal the decision. Appeals must be submitted in writing to the next most senior manager within 10 working days of being notified in writing that the request has been declined and should include the grounds for appeal.

An appeal panel should be convened and an appeal hearing held within 15 working days of receipt of the appeal. The panel should not include anyone involved in making the original decision.

The outcome of the appeal should be confirmed to the employee in writing within 5 working days of the appeal hearing taking place.

3.3 Assessing the Home Environment

An employee who works from home is afforded the same protection under health and safety legislation as an employee who is office based. It is therefore vital to ensure the home working environment is suitable before any home working agreement is reached. The employee needs to take personal responsibility for the health and safety aspect of home

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working. An employee needs an environment at home which offers the following:

- Suitable "office" space, ideally a separate room but at least a dedicated space
- Freedom from interruptions and distractions
- Security and confidentiality
- Ability to meet Health and Safety requirements

Employees wishing to adjust their routine working arrangements to accommodate dependent care responsibilities should discuss with their line manager in the first instance and defer to the Flexible Working Policy. If an application for home working has been accepted in principle by the line manager, the employee concerned should complete a Health and Safety Home Worker Self-Assessment Checklist (see Appendix 2) and submit this to their line manager.

If this assessment identifies any particular risks it will be the responsibility of the line manager, executive lead and employee to discuss ways in which the risks may be minimised or eliminated. The home environment must be deemed to be safe to work in before a home working agreement can be drawn up. In exceptional circumstances, a CCG health and safety representative may need to visit an employee's home to help assess the environment before a decision can be made. This would be with the employee's agreement.

An application for home working will be refused if there is not sufficient assurance that risks can be minimalised or eliminated or if there is not space to accommodate all equipment necessary to effectively perform their duties at home.

3.4 Home Working Agreement

Where a request to work from home has been agreed, a home working agreement should be issued to the employee (see Appendix 3) by the line manager. The employee will be asked to sign and return a copy of the home working agreement and this will be retained on their personal file.

Any home working arrangement should stipulate whether this has been agreed on a trial basis. All home working agreements should be reviewed annually. This will allow both parties to assess whether the arrangement is still appropriate.

A home working agreement can be terminated or amended, by either party, by giving 12 weeks' notice. This may be varied in exceptional circumstances.

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Where the agreement relates to occasional or regular home working, the employee will return to office based working on termination. Where the agreement relates to home based routine working, advice should be sought from Human Resources as the termination of the home working agreement may have wider consequences to the contract of employment.

4. Management of Home Working Agreements

4.1 Management arrangements must be agreed at the outset, before the home working arrangement begins. As a minimum, the following must be agreed:

- Security and confidentiality arrangements
- Contingency arrangements should the IT system or home networks be unavailable.

5. Provision of Equipment

5.1 Where appropriate, the CCG may provide, install and maintain equipment to assist with home working. Factors taken into consideration in determining appropriateness may include the frequency of home working and whether the need for home working has been generated by the CCG or the employee.

The following items of equipment may be appropriate:

Type	Equipment
Occasional home working	All CCG employees will have access to a lap top if occasional home working is required. The employee will retain an office/work station at their normal place of work or other desk sharing arrangements depending on the team.
Regular home working	Employees will be provided with the IT equipment they need to do their job in their home. For example a laptop, mouse, screen and keyboard if required with remote access to the CCG's systems.
Home based routine working (either employee requested	As above plus a desk and chair, or contributions towards, if required. Consideration needs to be given as to if

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or service driven)	additional equipment is also required that is necessary for the employee to do their job
--------------------	--

In relation to maintaining the equipment it may be necessary for the employee to bring the equipment in to the CCG in order to carry out the relevant maintenance. The CCG will not be responsible for maintaining a home worker's own equipment e.g. electrical sockets and other parts of the home worker's domestic electrical system, which are their own responsibility.

Any CCG equipment installed at the employee's home remains the property of the CCG and can be recalled at any time.

The CCG will provide IT helpdesk support during standard working hours but this does not include a home visit. The CCG will also take responsibility for the repair/replacement of damaged or stolen equipment, provided the employee has taken appropriate precautions to safeguard the equipment.

Upon the termination of the home working agreement, employees must return all CCG equipment to the CCG.

It will be the responsibility of the home worker to ensure that they have appropriate stationery and paper to work from home.

6. Sickness Absence Reporting

6.1 Normal rules governing management and reporting of sickness absence will apply for any home working arrangement. It is particularly important that staff who become ill during a period of home working should notify their line manager as soon as possible.

7. Insurance and tax

7.1 Whilst working from home is unlikely to have an impact, employees are advised to notify their landlord/mortgage and insurance companies of the fact that they will be working from home.

If the area being used for home working is also used by other occupants of the property there may be no implications for Council Tax. If the area is solely used for business and not available to other occupants at other times, then this may be a change of definition and the employee should check their individual circumstances with their local council.

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Employees who choose to work from home are not normally entitled to tax relief on additional outgoings. However, if there is a requirement from the CCG for an employee to work from home, there may be tax relief on a proportion of the costs for heating, lighting etc. It is the responsibility of the home worker to clarify their position with the Inland Revenue and to claim the tax relief back from the Inland Revenue directly.

8. Health and Safety

- 8.1 All staff, have a statutory responsibility under the Health and Safety at Work Act 1974. They are required to take 'reasonable care' of their own health and safety and to 'others' who may be affected by their acts or omissions. Employees are also required to co-operate with the CCG as necessary, to comply with statutory obligations, and abide by all CCG policies. This duty is also placed on persons working from home.

It will be the responsibility of the home worker to conduct the workplace self-assessment and to communicate the assessment findings to their line manager. The manager may need to question further any risk issues that arise as a result of the assessments.

- 8.2 For occasional and regular home workers, it will be the responsibility of the home worker to ensure that they have a suitable desk and chair for display screen use prior to being considered for home working.

Once home working has been agreed it will be the responsibility of the home worker to maintain the workstation and surroundings in a safe condition. For example, this should be free of trailing cables, no liquid in the vicinity of the display screen equipment and kept clean and tidy.

- 8.3 The Working Time Directive continues to apply to employees working from home. More information can be found in the Hours of Work Policy.
- 8.4 Employees working at home must inform their manager in the event of accidents, incidents or dangerous occurrences. Initial reports should be by telephone, followed by appropriate action such as entering the incident on the Datix incident reporting system within 48 hours of the incident occurring if relevant.

9. Work Space

- 9.1 The basic requirements for work space at home must comply with the health and safety requirements outlined in this procedure. Whilst it is not necessary to have a separate room that can be used as an office, it is essential that you have enough space to accommodate your

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workstation. You must have enough room to work freely without interruption from others and to ensure that your work files are not accessible by other members of the household.

10. Information Security

- 10.1 Employees who work from home are required to comply with all IT security and confidentiality requirements of the CCG. This includes acceptance and adherence to the Internet Acceptable Use Policy.

The home worker will have a direct responsibility for all CCG information material held at their home and must ensure that it is secure and not accessible to non-authorized people (e.g. other members of the household).

Any physical documents that require filing should be filed securely on the CCG premises.

Following Cabinet Office advice it is important that internet devices e.g. Alexa placed in or around the designated working environment are switched off if an employee is working with / making calls that may contain personal or confidential data to comply with DPA / GDPR.

11. Contractual Terms

- 11.1 If the employee is an occasional or regular home worker, there will be no requirement to issue a variation to the substantive contract of employment.

The contracts of employment for home based routine workers will need to reflect the fact that their normal place of work is their home. It should be noted that employees whose normal place of work is home may still be expected to attend one of the CCG's offices from time to time (e.g. to attend team meetings or training).

All other terms and conditions of employment remain unchanged by a home working application. Employees are also expected to adhere to all CCG policies and procedures whilst home working.

- 11.2 Expenses

Car Mileage would be paid in line with Agenda for Change terms and conditions. For occasional and regular home workers, car mileage expenses will only be paid for those miles travelled which are over and above the number of miles which the home worker would previously

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have incurred by having to travel into the office and return home on a daily basis, i.e. their normal commuting journey.

For home based routine workers, car mileage expenses would be payable for work-related journeys beginning and ending at the home base.

12. Business Continuity

- 12.1 In emergency situations, for example, where it becomes impossible for an employee to work at their normal base, employees may be offered the option of working from home temporarily until the emergency situation can be rectified.

Working from home due to business continuity reasons will not require an application for home working. The arrangement would be reviewed on a regular basis in line with the CCG's business continuity plans. It is anticipated that in emergency situations, such as a national pandemic, employees may also have to combine home based working with dependent care.

If, after the emergency situation has ended, an employee wishes to continue to work from home for a proportion of their contracted hours, they will need to follow the application process detailed in this procedure.

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APPENDIX 1

HOME WORKING APPLICATION FORM

Name	
Job Title	
Current Working Pattern	
Type of home working applying for	Regular home working / Home based routine working (<i>delete as appropriate</i>)
Working arrangements you are proposing	
Address at which home working will take place	
Do you feel your home working would have an impact on the service you provide or the colleagues in your team? If so, how could this be minimised?	

Signed (Employee)	
Name (please print)	
Date	

Once complete, please submit this form to your line manager for consideration.

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APPENDIX 2

HOME WORKER HEALTH & SAFETY SELF-ASSESSMENT

This form should be used by the employee to undertake an initial assessment of the suitability of that part of their home which has been identified as the intended location for home working. It must then be signed by both the employee and the line manager.

Name of intended home worker		
Home address		
Area in home intended to be used as workspace		
Job Title		
Summary of equipment used in the home to undertake the role		
Date of self-assessment		
	Yes/No or N/A	Comments
Is the size of the room adequate for the intended purpose and is there sufficient space to move around safely?		
Is there a source of natural light and can the light be sufficiently controlled by blinds or curtains?		
Is adequate ventilation available?		
Does the heating system provide a comfortable temperature which is appropriate for the tasks?		
Are the floors and floor covering in good		

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condition and do not present a trip hazard?		
Is the work area kept tidy and waste paper disposed of regularly?		
Are procedures in place that family members of others who are in the home do not have access to confidential information?		
Are proposed work surfaces large enough for the intended tasks?		
Is a suitably adjustable chair available?		
Are there sufficient fixed electrical sockets to cope with essential electrical equipment?		
Are electrical and telephone sockets appropriately located to avoid the need for trailing cables across the room(s) so they do not pose a trip hazard?		
Is a suitable smoke alarm fitted and tested regularly?		
Is there a clear and unobstructed escape		

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route for you in case of emergencies?		
Do you carry out significant manual handling activities associated with your home working?		
Is home working permitted in terms of your insurance and mortgage/tenancy?		
Is there any requirement for additional health and safety equipment (i.e. footrest, monitor/ keyboard/mouse etc.)?		
Signed (Employee)		
Name (please print)		
Date		
Approved (Line Manager)		
Name (please print)		
Date		

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APPENDIX 3

HOME WORKING AGREEMENT

Name	
Home Address	
Job Title	
Total hours of work	
Agreed working pattern	
Agreed review date	

- I have read and understood the CCG's Home Working policy and request a home working arrangement in line with the hours and times of work set out in my application form.
- I confirm that I have completed a health and safety home worker self-assessment on my home work environment and I will implement and maintain any control measures required as a result of this. I will notify my manager of any changes which may affect the validity of the assessment.
- I understand that I will still be required to attend meetings and training at CCG sites. I understand that the equipment I have been provided with remains the property of the CCG. I will use this equipment in line with established guidelines and agree to return it when my home working arrangement ends if requested.
- This Agreement will be monitored and reviewed in accordance with the CCG's Home Working Policy.

Signed (Employee)	
Name (please print)	
Date	
Approved (Line Manager)	
Name (please print)	
Date	

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APPENDIX 4

HOME WORKING HEALTH AND SAFETY GUIDE

Expectations while working from home

There is a general duty of care on both the employer and employee to ensure the safety of all persons while at work; this duty also includes those staff that work from home. Therefore the guidance which is contained in the CCG's Policies and Procedures continues to apply when working from home. If you are unsure how a particular policy or procedure can affect you while you work from home, please speak with your line manager.

Electrical Safety

User checks

If electrical equipment is to be plugged or frequently moved, regular user safety checks should be conducted, with the equipment disconnected. Employees should look for:

- Damage to the lead including fraying, cuts or heavy scuffing;
- Damage to the plug, e.g. to the cover or bent pins;
- Tape applied to the lead to join leads together;
- Coloured wires visible where the lead joins the plug (the cable is not being gripped where it enters the plug);
- Damage to the outer cover of the equipment itself, including loose parts or screws;
- Signs of overheating, such as burn marks or staining on the plug, lead or piece of equipment;
- Cables trapped under furniture.

Extension leads

An extension lead or adaptor will have a limit to how many amps it can take, so be careful not to overload them to reduce the risk of a fire.

Appliances use different amounts of power; the information can generally be located on the plug or within the instruction manual of the equipment – a television may use a 3amp plug and a vacuum cleaner a 5amp plug for example.

Fire Safety

It is recommended by the fire authority to fit at least one smoke alarm on every level of your home.

- Smoke alarms are cheap and easy to install.
- Always look out for one of these symbols, which show the alarm is approved and safe.

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- If the alarm goes off by mistake, never disconnect or take the batteries out of your alarm.
- Testing smoke alarms tests the smoke sensor as well as the battery. It is recommended that you should test your smoke alarm every month and replace the batteries annually unless your smoke detector states otherwise.

Equality Impact Assessment

Title of policy or service:	Home Working Policy	
Name and role of officer/s completing the assessment:	HR & OD Business Partner	
Date of assessment:	September 2020	
Type of EIA completed:	Initial EIA 'Screening' <input checked="" type="checkbox"/> <i>or</i> 'Full' EIA process <input type="checkbox"/>	<i>(select one option - see page 4 for guidance)</i>

1. Outline	
<p>Give a brief summary of your policy or service</p> <ul style="list-style-type: none"> • Aims • Objectives • Links to other policies, 	<p>NHS Barnsley Clinical Commissioning Group (CCG) is committed to promoting flexible working in order to facilitate effective and efficient working. A key component of our flexible working policy is home working</p>

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including partners, national or regional	
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Identifying impact:

- **Positive Impact:** will actively promote the standards and values of the CCG.
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact: causes or fails to mitigate unacceptable behaviour. If such an impact is identified, the EIA should ensure, that as far as possible, it is eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information This is the core of the analysis; what information do you have that might <i>impact on protected groups, with consideration of the General Equality Duty.</i>					
(Please complete	What key impact have you identified?			For impact identified (either positive or negative) give details below:	
				How does this impact and what action, if any, do you need to take to address	What difference will this make?

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each area)	Positive Impact	Neutral impact	Negative impact	these issues?	
Human rights	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Provides an additional opportunity for employees to achieve career and personal life balance	
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Carers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Sex	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Gender reassignment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	

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Pregnancy and maternity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	“	
Marriage and civil partnership (only eliminating discrimination)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
Other relevant groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	“	
HR Policies only:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Procedure legally compliant and in line with NHS practice	

IMPORTANT NOTE: If any of the above results in ‘**negative**’ impact, a ‘full’ EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.

Having detailed the actions you need to take please transfer them to the action plan below.

3. Action plan				
Issues/impact identified	Actions required	How will you measure impact/progress	Timescale	Officer responsible

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No actions have been highlighted	No actions have been highlighted	N/A	N/A	N/A
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4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	Lead / Reviewing Officers:	HR & OD Business Partner	Date of next Review:	September 2023

Governing Body

14 January 2021

Integrated Performance Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>									
	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>									
	<i>Information</i>	<input checked="" type="checkbox"/>										
2.	PURPOSE											
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 30 November 2020.</p> <p>This report also provides details of all Covid-19 expenditure incurred and approved in line with Governing Body delegation.</p>											
3.	REPORT OF											
	<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>Roxanna Naylor</td> <td>Chief Finance Officer</td> </tr> <tr> <td>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										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
4.1	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1" 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>Finance and Performance Committee</td> <td>07/01/2021</td> <td>Considered the paper and noted the actions</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Finance and Performance Committee	07/01/2021	Considered the paper and noted the actions			
Group / Committee	Date	Outcome										
Finance and Performance Committee	07/01/2021	Considered the paper and noted the actions										

5.	EXECUTIVE SUMMARY
5.1	<p>2020/21 - Month 8 Finance Update</p> <p>The detailed finance report, attached at Appendix 2, provides an assessment of the current financial performance of the CCG up to 30 November, together with the forecasts for the year end. The report contains the headline messages along with monthly financial monitoring.</p> <p>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.</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 £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).</p> <p>Further information on the CCG's financial performance targets is set out in section 2 of Appendix 2.</p> <p>The position as at 30 November is that planned efficiency 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).</p> <p>As risks and mitigations emerge the Governing Body will be updated through this report which is a standing agenda item of the committee.</p>
5.2	<p>Covid-19 Finance Update</p> <p>As previously reported the total allocation is £1,768,000 for the period October 2020 to March 2021 for Covid-19 related expenditure.</p> <p>Expenditure to date is being contained within this financial envelope and no further commitments against this funding have been made.</p> <p>Section 4 of Appendix 2 provides the details of covid-19 expenditure with a forecast position to 31 March 2021.</p> <p>Updates will be provided to the Governing Body through the remainder of 2020/21 including any emerging financial risks associated with the pandemic.</p>
5.3	<p>Performance Update</p> <p>The summary performance report (attached at Appendix 1) provides the Finance</p>

	<p>and Performance Committee with an overview of performance across key areas of CCG responsibilities and include NHS constitution standards and key operational performance indicators up to month 8 (Nov 2020) 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 however to November there have been reductions in the number of patients waiting longer than the standards. Urgent care related measures such as A&E waits and ambulance response times continue to be below standard and have been impacted by increased activity levels.</p> <p>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.</p> <p>IAPT performance has also continued to improve although the access rate remains slightly below the target level.</p>
<p>6.</p>	<p>THE GOVERNING BODY IS ASKED TO:</p>
	<p>Note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2020/21 • Finance update to Month 8
<p>7.</p>	<p>APPENDICES / LINKS TO FURTHER INFORMATION</p>
	<p>Performance Section</p> <ul style="list-style-type: none"> • Appendix 1 – IPR M8 2020/21 <p>Finance Section</p> <ul style="list-style-type: none"> • Appendix 2 – Month 8 Finance update
<p>Agenda time allocation for report:</p>	<p>10 Minutes</p>

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register	
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:	
	1.1 Urgent & Emergency Care	✓
	2.1 Primary Care	✓
	3.1 Cancer	✓
	4.1 Mental Health	✓
	5.1 Integrated Care @ System	✓
	5.2 Integrated Care @ Place	✓
	6.1 Efficiency Plans	✓
	7.1 Transforming Care for people with LD	✓
	8.1 Maternity	✓
	9.1 Digital and Technology	✓
	10.1 Compliance with statutory duties	✓
	11.1 Delivery of Enhanced Health in Care Homes	✓
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	18/04, 13/3, 13/31, 15/12, 17/05
2.	Links to statutory duties	
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:	
	Management of conflicts of interest (s14O)	
	Duty to promote the NHS Constitution (s14P)	✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	
	Duty as to improvement in quality of services (s14R)	
	Duty in relation to quality of primary medical services (s14S)	
	Duties as to reducing inequalities (s14T)	
	Duty to promote the involvement of each patient (s14U)	
	Duty as to patient choice (s14V)	✓
	Duty as to promoting integration (s14Z1)	
	Public involvement and consultation (s14Z2)	
3.	Governance Considerations Checklist	
3.1	Clinical Leadership	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	NA
3.2	Management of Conflicts of Interest (s14O)	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	NA
3.3	Discharging functions effectively, efficiently, & economically (s14Q)	
	Have any financial implications been considered & discussed with the Finance Team?	Y
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	NA

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



Performance & Delivery Report

2020/21 : Position statement
using latest information
for the January 2021 meeting
of the Governing Body

Performance Indicator	Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Total Monthly Position	
			Monthly Position		YTD Position		Barnsley Hospital	Yorkshire Ambulance Service
NHS Constitution								
Referral To Treatment waiting times for non-urgent consultant-led treatment	All patients wait less than 18 weeks for treatment to start	92%		Provisional 76.09%	Nov-20	Provisional 72.56%		Published Oct-20 72.54%
	No patients wait more than 52 weeks for treatment to start	0		328	Nov-20	826		184
Diagnostic test waiting times	Patients waiting six weeks or more for a diagnostic test	1%		Provisional 50.62%	Nov-20			Published Oct-20 48.47%
			Q2 20/21					
A&E Waits	Patients are admitted, transferred or discharged within 4 hours of arrival at A&E	95%	86.16%	77.94%	Nov-20	86.53%		76.91%
			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%	95.50%	Oct-20	97.07%		95.86%
	2 week (14 day) wait from referral with breast symptoms (cancer not initially suspected)	93%	98.17%	96.26%	Oct-20	98.00%		98.13%
Cancer Waits: From Diagnosis to Treatment	1 month (31 day) wait from diagnosis with suspicion of cancer to first treatment	96%	97.71%	98.28%	Oct-20	97.23%		100.00%
	1 month (31 day) wait for second/subsequent treatment, where treatment is anti-cancer drug regimen	98%	96.58%	100.00%	Oct-20	96.66%		100.00%
	1 month (31 day) wait for second/subsequent treatment, where treatment is radiotherapy	94%	94.70%	100.00%	Oct-20	93.31%		
	1 month (31 day) wait for second/subsequent treatment, where treatment is surgery	94%	88.14%	94.12%	Oct-20	90.43%		100.00%
Cancer Waits: From Referral to First Treatment	2 month (62 day) wait from urgent GP referral	85%	82.86%	87.30%	Oct-20	80.35%		90.09%
	2 month (62 day) wait from referral from an NHS screening service	90%	50.00%	*	Oct-20	65.00%		*
	2 month (62 day) wait following a consultant's decision to upgrade the priority of the patient	(85% threshold)	90.32%	76.92%	Oct-20	80.28%		75.00%
Cancer Waits: Faster diagnosis standard	Cancer 28 day waits - Told within 28 Days	75%	60.51%	65.99%	Oct-20	64.08%		

Performance Indicator		Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Total Monthly Position	
				Monthly Position		YTD Position		Barnsley Hospital	Yorkshire Ambulance Service
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		8mins 14secs	Nov-20				8mins 14secs
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		24mins 36secs	Nov-20				24mins 36secs
	Category 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		2hrs35mins25secs	Nov-20				2hrs35mins25secs
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		3hrs23mins35secs	Nov-20				3hrs23mins35secs
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		13.62%	Oct-20	8.13%		20.90%	13.62%
	Ambulance Handover - reduction in the number of delays over 1 hour in clinical handover of patients to A&E	Local Reduction		3.81%	Oct-20	1.34%		6.00%	3.81%
	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		8.06%	Oct-20	8.42%		2.25%	8.06%
	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		0.45%	Oct-20	0.50%		0.11%	0.45%
IAPT	Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.83%		1.58%	Nov-20	10.76%			
	Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50%		62.75%	Nov-20				
	Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95%		99.80%	Nov-20				
	Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75%		93.32%	Nov-20				

NHS Barnsley Clinical Commissioning Group

Finance Report 2020/21

Month 8



1 Headline Messages and contents

Headline Messages	Contents	
<ul style="list-style-type: none"> 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. However this position is predicated on the assumptions outlined within this report. The forecast position on CCG expenditure before mitigation show an overspend of £304k, outstanding allocations for Hospital Discharge Programme costs total £648k and this is not included in the CCG overspend position of £304k. Allocations are expected to be received in Month 10 for these costs. The CCG has also received the Primary Care funding expected totalling £263k, leaving the balance of technical adjustments outstanding at £797k which relates to the Additional Roles Reimbursement scheme. The Finance and Performance Committee considered detail on risks and mitigations with the current projections in the ‘Most Likely’ scenario indicating a potential net risk of £50k. Should the forecast position materialise in the ‘worst case’ prediction further efficiency plans and other underspend positions of £505k would need to be developed and delivered to ensure financial duties and targets are achieved. The CCG continues to work to identify further opportunities against this risk to ensure that financial duties and targets can be achieved. 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. Private provider arrangements remain unclear for the period September to March 2021 and therefore the CCG continues to forecast these costs based on budgets included within the financial plan. Further guidance is expected on the financial reporting of these contracting for Month 9. Primary Care prescribing data has been received for Month 5 and continues to show pressures with an overspend position. The forecast overspend at this stage is estimated to be approx. £384k. The Head of Medicines Optimisation is working closely with the Finance and Contracting team to ensure this position is reviewed and action is taken immediately, particularly where efficiency forecasts are being reported less than the agreed position. 	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 £178k against the budget agreed with the Chief Nurse in October. 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 pulling together a plan of action to address actions outstanding 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. Prescribing and Continuing Health Care QIPP plans are currently forecasting a shortfall against the targets agreed, however work continues to address this to ensure the maximum delivery is achieved.
- Section 4 details total covid spend to date with details of a forecast position to 31 March 2021.

NHS Act Section	Duty	2020/21 Target £'000	2020/21 Actual Performance £'000	2020/21 Actual Achievement
223H (1)	Expenditure not to exceed income	487,920	487,920	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	487,881	487,881	YES
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	YES
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	YES
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	4,882	4,035	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) £
PROGRAMME EXPENDITURE						
Acute	159,628	159,625	(3)	244,438	244,435	(3)
Patient transport	1,605	1,605	(0)	2,407	2,407	0
Mental Health	24,829	24,841	12	37,555	37,578	22
Community Health	32,937	32,809	(128)	50,226	50,095	(130)
Continuing Health Care	18,551	18,610	59	27,821	27,999	178
Primary Care Other	41,400	41,299	(102)	61,786	62,297	511
Primary Medical Services (Co-Commissioning)	27,591	27,478	(113)	41,386	41,324	(62)
Other Programme Costs	2,279	2,238	(41)	3,418	3,410	(8)
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	308,819	308,505	(314)	469,037	469,546	509
Corporate Costs - EMBED/DSCRO	115	115	0	173	173	0
Corporate Costs - IFR	30	30	0	44	44	0
NHS Property Services/Community Health Partnerships	536	560	24	804	887	83
Depreciation Charges	13	0	(13)	20	0	(20)
TOTAL CORPORATE COSTS	694	705	11	1,041	1,104	63
Coronavirus Costs - Acute	1,624	1,624	(0)	4,873	4,873	0
Coronavirus Costs - MH	468	254	(213)	820	967	148
Coronavirus Costs - PrimCare	1,394	1,353	(41)	1,832	1,846	14
Coronavirus Costs - CHC	3,412	3,710	299	3,800	4,078	278
Coronavirus Costs - Community	546	741	195	546	741	195
Coronavirus Costs - Other Prog.	26	54	28	26	38	13
TOTAL CORONAVIRUS COSTS	7,469	7,736	267	11,897	12,544	648
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	316,983	316,946	(36)	481,975	483,194	1,220
RUNNING COSTS						
Pay	1,763	1,399	(364)	2,644	2,249	(396)
Non Pay	1,092	970	(121)	1,638	1,765	128
Coronavirus Costs	20	22	1	20	20	0
TOTAL RUNNING COSTS	2,875	2,391	(484)	4,302	4,035	(268)
CCG Reserves	(526)	0	526	1,753	1,753	0
NHS England Planning Guidance Reserves/required reserves	263	0	(263)	263	0	(263)
In Year (Over)/underspend	0	905	905	0	(304)	(304)
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	(263)	905	1,168	2,016	1,449	(567)
TOTAL EXPENDITURE	319,595	320,243	648	488,293	488,678	385
Programme	288,946	288,946	0	443,677	443,677	0
Primary Care Co-Commissioning	27,591	27,591	0	38,667	38,667	0
Running Costs	2,875	2,875	0	4,889	4,889	0
RESOURCE ALLOCATIONS	319,412	319,412	0	487,233	487,233	0
SURPLUS/(DEFICIT)	(183)	(831)	(648)	(1,060)	(1,445)	(385)

	YTD BUDGET	£	YTD ACTUAL	£	YTD VARIANCE OVER / (UNDER)	£	TOTAL ANNUAL BUDGET	£	FORECAST OUTTURN	£	FORECAST VARIANCE OVER / (UNDER)	£
Summary of Surplus/Deficit												
Original Planned Deficit		446		446		0		1,060		1,060		0
Allocation Received for Primary Care		-263		-263		0				-263		-263
Adjusted Net Deficit		183		183		0		1,060		797		-263
Hospital Discharge Programme - Month 7				248		248				248		248
Hospital Discharge Programme - Month 8				400		400				400		400
Total Technical Adjustments		183		831		648		1,060		1,445		385
SURPLUS/(DEFICIT) after technical adjustments		0		-830		-647		-1,059		-1,443		-384

3.2 Resource Allocation – Detailed Summary

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		RECURRENT £000	NON RECURRENT £000	TOTAL £000
Description	Month	£	£	£
Allocations -Final allocation after place-based pace of change	M1	416,113		416,113
Allocations - Other funding after pace of change	M1	1,532		1,532
Delegated Allocations - Final allocation after place-based pace of change	M1	39,771		39,771
Reduction for central indemnity scheme	M1	(1,142)		(1,142)
IR PELs transfer	M1	188		188
Month 12 IR changes	M1	(8)		(8)
2018/19 FYE - IR Final Changes	M1	(8)		(8)
Transfer pf ventilators to NHS Emgland	M1	(34)		(34)
SCH IR/PEL	M1	53		53
CCG core services additional funding from 2020/21 to 2023/24	M1	301		301
Transfer 8 months Programme Allocation to central reserve	M2		(278,758)	(278,758)
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
LD Complex Case Funding 20/21 (Bid 11 CKWB TCP)	M8		6	6
Winter Pressures	M8		93	93
Adjustment to Month 7-12 Baseline for error in Envelope calucations	M8		10	10
Flash Glucose Offer to Patients with Learning Disability	M8		8	8
Impact and Investment Fund	M8		112	112
Care Homes Premium	M8		105	105
Increase in practice funding	M8		46	46
Children's & Young People's Palliative and End of Life Care Match Funding 20/21	M8		14	14
Retrto Non-Covid for month 06	M8		1,604	1,604
Retro Covid for month 06	M8		830	830
Covid retro transfer to running cost Mth 1-5	M8		(5)	(5)
Retro transfer to running cost Mt 1-5	M8		(513)	(513)
Retrto Non-Covid for month 6	M8		(16)	(16)
Retro Covid for month 6	M8		(250)	(250)
TOTAL RESOURCE ALLOCATION		456,766	25,578	482,344

RESOURCE ALLOCATIONS - RUNNING COSTS		RECURRENT £000	NON RECURRENT £000	TOTAL £000
Description	Month	£	£	£
2020/21 Allocation	M1	4,882		4,882
Transfer 8 months Running Costs allocation to central reserve	M2		(3,255)	(3,255)
Prospective 4 months running costs Non-recurrent Adjustment	M2		(517)	(517)
Transfer 2 months Running Costs allocation from central reserve	M5		814	814
Prospective 2 months running costs Non-recurrent Adjustment	M5		(259)	(259)
Transfer 6 months Running Costs allocation from central reserve	M7		2,441	2,441
Covid retro transfer from programme			5	5
Retro transfer from Programme			513	513
Covid retro transfer from programme			16	16
Retro transfer from Programme			250	250
TOTAL RESOURCE ALLOCATION		4,882	7	4,889

SUMMARY	£'000	£'000	£'000
Programme	418,137	25,540	443,677
Primary Care Co-Commissioning	38,629	38	38,667
Running Costs	4,882	7	4,889
TOTAL RESOURCE ALLOCATION	461,648	25,585	487,233

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	2,721,260	5,582,001
Support to stay home	846,622	399,445	1,246,067
Primary Care reimbursements - PPE/Hotsite/Bank Holiday cover/locum cover	774,055	108,244	882,299
Covid 19 home visiting service	325,896	325,046	650,942
Other minor costs	46,257	43,290	89,547
Contingency to cover further costs	-	502,445	502,445
Total	5,277,699	4,489,260	9,766,959
Breakdown of total expenditure:			
Covid	2,416,958	1,768,000	4,184,958
Hospital Discharge Programme	2,860,741	2,721,260	5,582,001

Comments:

The table above includes details of all expenditure claimed during the year 2020/21. This also includes a forecast of continued expenditure in relation to the Hospital Discharge Programme and ongoing covid-19 expenditure to be contained within the £1.768m received as part of the financial planning process. There is approximately £502k available to manage any further costs associated with responding to the pandemic, should national funding not be available.

**Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group
 FINANCE & PERFORMANCE COMMITTEE held on Thursday 5 November 2020 at
 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	- Director of Strategic Planning & Performance
Nigel Bell	- Lay Member Governance
Dr Jamie MacInnes	- Elected Member Governing Body

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant
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APOLOGIES:

Patrick Otway	- Head of Commissioning (MH, Children, Specialised)
Dr Andrew Mills	- Membership Council Member

Agenda Item		Action & Deadline
FPC20/113	QUORACY	
	The meeting was declared quorate.	
FPC20/114	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda. Agreed Action: <ul style="list-style-type: none"> • Dr J MacInnes reported that his practice Dove Valley was a member of the Barnsley Healthcare Federation. 	LW
FPC20/115	MINUTES OF THE PREVIOUS MEETING HELD ON 1 OCTOBER AND 15 OCTOBER 2020 – Approved.	
FPC20/116	MATTERS ARISING REPORT	
	FPC20/90 IPR The Chief Finance Officer reported that the Chief Nurse and the	

	<p>CHC team had developed a trajectory for the backlog due to Covid-19. There may be some risks to this as there are now some issues within the team which will impact on delivery.</p> <p>The report was received and noted.</p>	
FPC20/117	UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE – No update to report.	
FPC20/118	UPDATE ON CONTRACTING CYCLE	
	<p>The Chief Finance Officer presented the update on contracting cycle report to the Committee attention was drawn to the First4Care contract and due to the rising demand in covid cases at BHNFT the trust have asked for increased hours from the weekend 17 October – 8 November 2020, this would be provided within contracted annual hours, but would leave the provision short over the winter months. Further conversations with the Trust around how to fund this were to be had and it was noted this should come from external national resource such as the Hospital Discharge Programme.</p> <p>An update was given on the One Health Group, it was reported that activity was still low, the backlog was being dealt with and the contract was still showing an underspend against the planned activity.</p> <p>The Committee were asked to note the contents of the report including:</p> <ul style="list-style-type: none"> • BREATHE service procurement • Barnsley Integrated Diabetes Service • Patient Transport Service updated guidance • One Health Group 	
FPC20/119	APPROVAL AND OR UPDATE ON PROCUREMENTS	
	<p>It was reported that there were currently two tenders out for procurement and one due out:</p> <ul style="list-style-type: none"> • Health provision for Children and Young People in Barnsley Special Schools with Special Educational Needs and Disability Service. The tender closes on the 5th November 2020. • Barnsley REspiratory Assessment and THERapy (BREATHE) in the Community Service. The tender closes 2nd November 2020. • Mental Health Support Teams. A market engagement event was held on the 26th October 2020. The tender will be issued in November 2020. <p>It was reported to members that a meeting had been held that day</p>	

	<p>to discuss the Breathe procurement and due to the current level 4 of the NHS set by NHS England and covid impact it had been queried whether this would impact the procurement and if this would be extended. It had been proposed to extend the procurement to 5.2.21, the process would not stop but would extend the deadline for submission of bids, once the deadline for bids has closed the process to award the contract and mobilise the service should be progressed as quickly as possible.. The Accountable Officer agreed he would explore with the Integrated Care Partnership Group and the providers on what can be offered in the meantime with the resource available, particularly in response to the national requirement to have post assessment covid clinics in place, but felt with covid etc this was not the time for providers to be completing procurement bids despite the process commencing earlier in the year and therefore the decision to extend the procurement by 3 months and contract to 30 June 2021 had been taken as an urgent decision.</p> <p>Dr J Harban the Elected Member of the Governing Body for Contracting and clinical lead for respiratory requested that it was noted he did not support this decision, given the lead in time for submission of bids. Dr J MacInnes Elected GB Member had reservations but supported the decision.</p> <p>The Committee were asked to note this decision and that this would be ratified by Governing Body. The Committee received and noted the report.</p>	
<p>FPC20/120</p>	<p>FINANCIAL PLAN</p>	
	<p>The Chief Finance Officer presented the financial plan to the Committee which sets out the budgets set based on known commitments and agreed efficiency programmes. The plan currently shows a deficit position of £1,060k due to further national funding expected but not yet received. Confirmation has been received that this funding will be made available as expenditure is incurred and therefore the CCG assumes a balanced budget can be delivered. The Committee were asked to note the significant risk included in plans with an assessment of unmitigated risk included within the financial plan submission of £2.4m.. The CCGs efficiency programme requires £4,441k to be delivered and the budgets impacted with an efficiency requirement £962k remains unidentified and plans are currently being reviewed to identify how this can be delivered.</p> <p>The Finance and Performance confirmed agreement to the plans at the extra ordinary meeting on 15 October and agreed to further support efficiencies across CHC and Prescribing.</p> <p>Detail of the expenditure relating to covid-19 was also included within the report and will be reviewed in full during month 7 in order</p>	

	<p>that costs can be contained within the allocation received from the ICS. Robust financial monitoring against these budgets and delivery of plans is critical to allow the CCG to deliver an in year balanced budget position. The budgets included in Appendix 1 will be reviewed further to support the financial position and where flexibility emerges budgets will be transferred to create a risk reserve for other emerging risks and pressures.</p> <p>The Finance and Performance Committee would be informed of any emerging risks and flexibilities through the Integrated Performance Report which is a standing agenda item of the committee.</p> <p>The Committee were asked to note the contents of the report including:</p> <ul style="list-style-type: none"> • Approve Appendix 1 as the budgets to be set for the CCG for Month 7-12 noting the further work to be undertaken across budgets. 	
<p>FPC20/121</p>	<p>INTEGRATED PERFORMANCE REPORT</p>	
	<p><u>Finance</u></p> <p>The Chief Finance Officer presented the finance section of the report to Committee highlighting that month 6 top up had not yet been received required is £2.4m which includes £0.8m covid expenditure and £1.6m non covid expenditure to allow the CCG to achieve a breakeven position. It was also note that an audit of covid cost was expected in the future.</p> <p><u>Performance</u></p> <p>The Director of Strategic Planning and Performance updated members on the performance section of the report it was noted that recovery was started to be seen but now covid patients were beginning to impact on services. It was reported that there had been some improvement in the waiting times performance on the cancer pathways including 2 week wait, referral to diagnosis and referral to treatment. IAPT performance has also improved although the access rate remains slightly below the target level. It was reported that the performance figures were from August/September so may see more shift next month.</p> <p>The Committee were asked to note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2020/21 • Finance update to Month 6 including Covid-19 expenditure and expenditure approved at CCG Gold Command in line with Governing Body delegation 	

FPC20/122	FULL ASSURANCE FRAMEWORK	
	<p>The Director of Strategic Planning and Performance presented the Assurance Framework to the Committee. The assurance framework had been refreshed and the draft went to SMT in October and would go to Governing Body in November. There were 6 risks (2 red risks and 4 amber risks) 3 of these were shared with other Committees.</p> <p>The Committee were asked to:</p> <ul style="list-style-type: none"> • Review the risks on the 2020/21 Assurance Framework for which the Finance and Performance Committee is responsible • Note and approve the risks assigned to the Committee • Review and update where appropriate the risk assessment scores for all Finance and Performance Risks • Identify any new risks that present a gap in control or assurance for inclusion on the Assurance Framework • Agree actions to reduce impact of high risks • Identify any sources of positive assurance to be recorded on the Assurance Framework to reassure the Governing Body that the risk is being appropriately managed. 	
FPC20/123	FULL RISK REGISTER	
	<p>The Director of Strategic Planning and Performance presented the Risk Register to the Committee. There were 4 red risks for the Committee and all had been reviewed. The committee were asked to revise the score of risk 13/31 which as a current score of 12 to move to 16.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • The Committee agreed the change in score from 12 to 16 on risk 13/31. <p>The Committee were asked to:</p> <ul style="list-style-type: none"> • Review the Finance and Performance Committee Risk Register for completeness and accuracy • Note and approve the risks assigned to the Committee • Review the risk assessment scores for all Finance and Performance risks • Identify any other new risks for inclusion on the Risk Register • Agree actions to reduce impact of extreme and high risks • Consider and approve increase in risk score of 13/31. 	JW

FPC20/124	MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD – No minutes available.	
FPC20/125	MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD – No minutes available.	
FPC20/126	MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP 6 JULY 2020	
	The Lay Member Governance agreed to speak with the Chief Nurse around the safeguarding discussion section within the minutes. Agreed Actions: <ul style="list-style-type: none"> • Lay Member Governance to speak with Chief Nurse re safeguarding. <p>The Committee received and noted the minutes.</p>	NBell
FPC20/127	MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP – No minutes available.	
FPC20/128	MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS	
	The Director of Strategic Planning and Performance presented the report the Committee. The Finance & Performance Committee were asked to note the following decisions to commit expenditure taken by Management Team during October 2020: <ul style="list-style-type: none"> • Approved future, potential payments of the CCG’s share of any future voids in relation to the new, purpose built facility at Mayman Lane, Batley, for people with complex and challenging behaviours (est £1034 pw). <p>The Committee received and noted the report.</p>	
FPC20/129	2021 MEETING DATES – noted and diary appointments had been sent out.	
FPC20/130	ANY OTHER BUSINESS - No items were raised under this heading.	
FPC20/131	AREAS FOR ESCALATION TO GOVERNING BODY	
	<ul style="list-style-type: none"> • Covid/Financial Position • Breathe 	
FPC20/132	REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED	
	Business was conducted in a timely manner, but there were a few minor IT glitches.	
FPC20/133	DATE AND TIME OF NEXT MEETING	

	Thursday 3 December 2020 at 10.30 am via MS Teams.	
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Adopted

**Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group
FINANCE & PERFORMANCE COMMITTEE held on Thursday 3 December 2020 at
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
Nigel Bell	- Lay Member Governance
Dr Andrew Mills	- Membership Council Member
Dr Jamie MacInnes	- Elected Member Governing Body

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant
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APOLOGIES:

Patrick Otway	- Head of Commissioning (MH, Children, Specialised)
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Agenda Item		Action & Deadline
FPC20/134	QUORACY	
	The meeting was declared quorate.	
FPC20/135	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda.	
FPC20/136	MINUTES OF THE PREVIOUS MEETING HELD ON 5 NOVEMBER 2020 – Approved with a slight amendment to page 3 item FPC20/119 to now read: Dr J Harban the Elected Member of the Governing Body for Contracting and clinical lead for respiratory requested that it was noted he did not support this decision, given the lead in time for submission of bids. Dr J MacInnes Elected GB Member had reservations but supported the decision.	

	Agreed Actions: <ul style="list-style-type: none"> • Update minutes from November. 	LW
FPC20/137	MATTERS ARISING REPORT	
	<p>FPC20/126 Minutes of the Children’s Executive Group 6.7.20</p> <p>Action now complete Lay Member Governance met with Chief Nurse and was assured there were no safeguarding issues and the Chief Nurse agreed to report the inaccuracy within the minutes to the group.</p> <p>FPC19/151 IPR – MSK</p> <p>This action was currently on hold.</p> <p>Agreed Action:</p> <ul style="list-style-type: none"> • Ask David Lautman for an update in relation to MSK. <p>The Committee received and noted the report.</p>	?
FPC20/138	INTEGRATED PERFORMANCE REPORT	
	<p><u>Finance Update</u></p> <p>The Chief Finance Officer presented an update on the finance position it was reported that all budgets had been reviewed and agreed with budget holders which were set out in appendix 2 with details of a small risk contingency being created to cover any prescribing or continuing healthcare risk. . Appendix 2 includes the forecast position and budget detail for the month end 31 October 2020. Due to the nature of reporting and financial framework during the year finalisation of the budget position for 2020/21 has only being completed in the recent weeks. The forecast position reported for Month 7 shows a deficit position due to technical adjustments still outstanding from NHS England and Improvement (NHSEI). Once these transactions are complete the CCG will achieve business rules with a balanced budget position. Confirmation of the Month 6 retrospective top up remains outstanding, confirmation is expected before closure of the month 8 reporting position. There is a risk that if this funding is not received the CCG may not deliver on its statutory requirement to deliver an in year breakeven position. Any potential risks of not receiving this resource will be reported to the Finance and Performance Committee as soon as information is received.</p> <p>It was reported that there was an emerging risk around CHC and this had been reported to the Chief Nurse and an action plan had been requested. There had been some staffing issues within the CHC team and the impact of the pandemic has had a significant impact on the number of reviews outstanding and actions being</p>	

	<p>taken forward to ensure delivery of the efficiency required whilst also ensuring patient care and quality is not compromised. The Committee were asked if they felt assured on the plans in place and it was agreed to wait for the action plan. It was also agreed that the Chief Officer would discuss this further with the Chief Nurse to ensure she was supported to deliver the requirements of any outstanding actions.</p> <p><u>Performance Update</u></p> <p>The Chief Operating Officer presented the performance data noting that information included in the performance report continues to show the adverse impact of COVID19 upon delivery of some constitutional standards including those which have been consistently delivered previously such as referral to treatment times and waiting times for diagnostic waits and also the urgent care related measures such as A&E waits and Ambulance Handover.</p> <p>There had also been a deterioration in waiting times performance on some cancer pathways including 2 week wait and referral to treatment and needed to keep working to recover this position. Performance at Barnsley Hospital in relation to waiting times remains strong.</p> <p>IAPT performance has also improved although the access rate remains slightly below the target level but may see some referrals via the covid assessments.</p> <p>The Committee were asked to note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2020/21 • Finance update to Month 7 including Covid-19 expenditure and outstanding allocations in order for the CCG to deliver financial balance. 	
<p>FPC20/139</p>	<p>MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS</p>	
	<p>The Chief Operating Officer presented the report to the Committee. The Finance & Performance Committee is asked to note the following decisions to commit expenditure taken by Management Team during November 2020:</p> <ul style="list-style-type: none"> • SMT approved 2 x Band 3 Stoma staff to support delivery of QIPP in excess of £100k per annum. These positions were agreed on the assumption they would be funded from efficiencies delivered. Approved to March 2022 <p>The Committee were asked to note the report.</p>	

FPC20/140	ANY OTHER BUSINESS	
	No items were raised under this heading.	
FPC20/141	ITEMS FOR ESCALATION TO GOVERNING BODY	
	<p>Following the earlier discussion it was agreed to take CHC to the private January Governing Body and ask the Chief Nurse to present at update on this and the long term plan for the CHC team.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • Chief Nurse to bring an update to the Private January GB. 	RN to inform JS
FPC20/142	REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED	
	The meeting was crisp and the agenda was short.	
FPC20/143	DATE AND TIME OF NEXT MEETING	
	Thursday 7 January 2021 at 10.30am via Microsoft Teams.	

Adopted

GOVERNING BODY

14 January 2021

PRIMARY CARE COMMISSIONING COMMITTEE HIGHLIGHTS REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	Decision	<input type="checkbox"/>	Approval									
		<input type="checkbox"/>	Assurance									
		<input checked="" type="checkbox"/>	Information									
		<input type="checkbox"/>										
2.	PURPOSE											
	The purpose of this report is to provide Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 26 November 2020.											
3.	REPORT OF											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Lay Member Lead</td> <td>Chris Millington</td> <td>Chair PCCC</td> </tr> <tr> <td>Author</td> <td>Julie Frampton</td> <td>Head of Primary Care</td> </tr> </tbody> </table>				Name	Designation	Lay Member Lead	Chris Millington	Chair PCCC	Author	Julie Frampton	Head of Primary Care
	Name	Designation										
Lay Member Lead	Chris Millington	Chair PCCC										
Author	Julie Frampton	Head of Primary Care										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	The matters raised in this paper have been subject to prior consideration in the following forums:											
	<table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>PCCC</td> <td>26.11.2020</td> <td>Highlights agreed</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	PCCC	26.11.2020	Highlights agreed			
Group / Committee	Date	Outcome										
PCCC	26.11.2020	Highlights agreed										
5.	EXECUTIVE SUMMARY											
	<p>This report provides the January 2021 Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 26 November 2020.</p> <p>It was agreed at the meeting that the following would be highlighted:</p> <ol style="list-style-type: none"> The Primary Care team did not pick up the end date of the APMS contract for BHF Brierley Medical Centre early to discuss the options for re-procuring with the PCCC. This contract had the option to extend for 1 year which was recommended to PCCC on 26th. Had PCCC not agreed to the 1 year extension the team would have procured via the Emergency Contractor Framework which Barnsley Healthcare Federation is listed as a provider for 											

	Barnsley and is also the current contract holder.
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:
	<ul style="list-style-type: none"> Note the above which is provided for information and assurance.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> Minutes of the 24 September 2020 meeting.

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

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<i>place ✓ beside all that apply</i>):		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care	✓	7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):		
	Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		Y
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		Y
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

**Minutes of the PUBLIC Primary Care Commissioning Committee meeting
held on Thursday, 24 September 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

GP CLINICAL ADVISORS: (NON-VOTING)

Dr Madhavi Guntamukkala	Governing Body Member
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IN ATTENDANCE:

Julie Frampton	Head of Primary Care
Leanne Whitehead	Executive Personal Assistant
Victoria Lindon	Assistant Head of Primary Care Co-Commissioning, NHSE
Carrie Abbott	Public Health, BMBC
James Barker	Chief Executive, BHF

APOLOGIES:

Chris Edwards	Chief Officer
Dr Nick Balac	CCG Chairman
Roxanna Naylor	Chief Finance Officer
Julie Burrows	Director of Public Health, BMBC
Sue Womack	Manager, Healthwatch Barnsley
Ruth Simms	Assistant Finance Manager
Dr Mark Smith	Governing Body Member

MEMBERS OF THE PUBLIC:

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

Agenda Item	Note	Action	Deadline
PCCC 20/09/01	APOLOGIES		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 20/09/02	QUORACY		
	The meeting was declared quorate.		
PCCC 20/09/03	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	Dr M Guntamukkala reported the following declarations of interest which would be added to the register:		

	<ul style="list-style-type: none"> • Senior GP in a Barnsley Practice (Apollo Court Medical Practice & The Grove Medical Practice) • Practices provide services under contract to the CCG • Spouse – Dr M Vemula is also partner GP at both practices 		
PCCC 20/09/04	MINUTES OF THE LAST MEETING		
	The minutes of the meeting held on the 30 July 2020 were verified as a true and correct record of proceedings.		
PCCC 20/09/05	MATTERS ARISING REPORT		
	<p>20/07/20 GP Patient Survey</p> <p>The Head of Primary Care had had discussions with the Assistant Head of Primary Care Co-Commissioning, NHSE around the regional results of the GP Patient Survey to consider any learning opportunities, the outcome of which was attached to the report.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • It was noted that a thorough analysis of all the results would be carried out and a full report including an action plan would be presented at a future meeting of the Committee. It was noted that this action was ongoing. 	JF	
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 20/09/06	PRIMARY CARE NETWORKS PRESENTATION – James Barker		
	James Barker, Chief Officer, Barnsley Healthcare Federation attended the meeting to present an update on the work that had been taking place with the PCN's over the last few months. James reported that BHF had been working very closely with the CCG and the business development managers and had been included on the silver command calls during this period. It was noted that during the Covid-19 pandemic all practices had remained open, a Blue Clinic had been opened which was to provide medical support to patients with Covid symptoms, and this service was being run from Oaks Park Medical Centre as part of the iHeart services that had been a successful service and provided support to over 1000 patients. It was noted that the service had been busy during September and was supported by the home visiting team. It was expected that the service would be busy during the winter, and BHF were working with the CCG to ensure plans are		

	<p>place around this.</p> <p>It was reported that practices planned to continue offering triage via telephone call, video calls and face to face. Dr M Guntamukkala congratulated BHF on the phenomenal job they had done over the last few months which showed that the Barnsley Healthcare Systems worked well together.</p> <p>James reported that plans to expand the workforce were being worked on. BHF were looking to appoint 79wte across a number of roles and were confident that this could be done as a number of roles had already been offered out. The Assistant Head of Primary Care Co-Commissioning, NHSE asked about training and development for the new roles; this would be done by employment through BHF and embedding staff into practices and the use of BEST sessions for training.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • Present the PCN update to a future Patient Council meeting. <p>The Committee received and noted the presentation update and congratulated the teams on all the work that had taken place.</p>	<p>JB/CM</p>	
<p>QUALITY AND FINANCE</p>			
<p>PCCC 20/09/07</p>	<p>FINANCE UPDATE</p>		
	<p>The Head of Primary Care presented an update to members in relation to Finance. It was reported that the CCG remains in a top up arrangement for months 1-6 of 2020/21 due to the impact of the Covid-19 pandemic.</p> <p>National guidance on allocations and financial framework for months 7-12 were expected imminently. The Finance and Contracting Team were working through the financial position and developing a full budget and forecast position. This detailed information would be provided to the Committee during November 2020 following budgets being approved by the Governing Body.</p> <p>Early indications suggest there were likely to be significant pressures across all budgets including delegated primary care and it was likely that there would continue to be a requirement for the CCG to fund a shortfall against delegated budgets from within CCG programme costs. The current overspend of £583,071 would be included as part of the CCGs top up allocation expected to be received</p>		

	to month 6. The Committee were asked to: <ul style="list-style-type: none"> • Note the update on the financial framework for 2020/21 and financial position including forecast to month 6. 		
PCCC 20/09/08	CQC UPDATE		
	The Head of Primary Care reported that there had not been any inspections or desk top evaluations performed by the CQC for any of the Barnsley GP practices. The CQC had confirmed that there were no concerns and no issues to report with regard to those practices that highlighted for the Emergency Support Framework during the C-19 pandemic. The Committee were asked to: <ul style="list-style-type: none"> • Note the report which is provided for information and assurance. 		
CONTRACT MANAGEMENT			
PCCC 20/09/09	CONTRACTUAL ISSUES REPORT		
	The Head of Primary Care presented the report to the Committee noting that the CCG had received an application to vary the Royston Group Practice GMS contract due to Dr Krishnasamy's resignation. It was noted that this removal did not require an amendment to the contract due to it being a GMS contract. It was reported that rent reimbursement for C85004 Penistone Group Practice had been reviewed, approved and actioned. The CCG continued to fund the increased expenditure through CCG programme budgets. The Committee were asked to: <ul style="list-style-type: none"> • note the report for information and assurance. 		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 20/09/10	The Head of Governance & Assurance presented the risk register to the Committee for assurance. It was noted that the assurance framework had been paused due to Covid. A review was currently being carried out on the assurance framework and would be brought back to the Committee shortly.		

	<p>The Head of Governance & Assurance reported that there had been no changes or additions made to the risk register.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • The Lay Member for Governance suggested an update to the PCN Staffing risk in light of a future update from James Barker in relation to the recruitment process for the PCN. <p>The Committee were asked to:</p> <ul style="list-style-type: none"> • Review and agree that the risks were being appropriately managed and scored. 	RW	
OTHER			
PCCC 20/09/11	REFLECTION OF CONDUCT OF THE MEETING The Committee agreed that the meeting had been conducted appropriately.		
PCCC 20/09/12	QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA		
	<p>There were no questions received from the members of the public.</p> <p>Carrie Abbot in attendance at the meeting asked whether the primary care standing operating procedures around Covid were being worked on and if the right information was being sent to primary care? The Head of Primary Care reported Sarah Pollard was working with Public Health on this and all relevant information was circulated to primary care via the bulletin which also included community pharmacists.</p> <p>Carrie also enquired about flu vaccinations and whether there were any issues around obtaining these? The Head of Primary Care reported that regular meetings were taking place around flu and that practices were aware of their obligations. Practices were confident with the plans that had been put in place and they would endeavour to reach all cohorts of patients.</p>		
PCCC 20/09/13	ITEMS FOR ESCALATING TO THE GOVERNING BODY It was agreed to escalate the following items to the Governing Body:-		
	<ul style="list-style-type: none"> • Outline of the work BHF have been doing 		
PCCC	DATE & TIME OF NEXT MEETING		

20/09/14	Thursday, 26 November 2020 at 2:30 – 3:30pm via MS Teams.		
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ADOPTED

**Minutes of the NHS Barnsley Clinical Commissioning Group
QUALITY & PATIENT SAFETY COMMITTEE
Thursday 22 October 2020, 13:00pm-15:00pm
Via Microsoft Teams**

MEMBERS:

Jayne Sivakumar	- Chief Nurse (Chair)
Mike Simms	- Secondary Care Clinician
Dr Mark Smith	- Practice Member Representative Contracting Lead from the Governing Body
Chris Millington	- Lay Member for Public and Patient Engagement and Chair of Primary Care Commissioning
Chris Lawson	- Head of Medicines Optimisation
Dr Guntamukkala	- Elected GB 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
Amy Hodgson	- Quality Administration Assistant (Minutes)

APOLOGIES:

Dr Adebowale Adekunle	- GP Governing Body Member
Dr Shahriar Sepehri	- Membership Council Representative

Agenda Item	Note	Action	Deadline
Q&PSC 20/10/01	HOUSEKEEPING		
	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.		
Q&PSC 20/10/02	APOLOGIES & QUORACY		
	Apologies were received as above. The meeting was declared quorate.		
Q&PSC 20/10/03	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	The committee considered the declarations of interest report, no new declarations of interest were declared. The new appointed Governing Body Member, BCCG, Dr Guntamukkala to be added to the register.	RW	

	Actions agreed: The Head of Governance and Assurance to add the new appointed Governing Body member, Dr Guntamukkala to the Declarations of Interest register.	RW	December 2020
Q&PSC 20/10/04	MINUTES OF THE MEETING HELD ON 02 JULY 2020		
	The minutes of the previous meeting held on 20 August 2020 were approved as an accurate record.		
Q&PSC 20/10/05	MATTERS ARISING REPORT		
	<p>The Chair confirmed that all items were complete apart from the following:</p> <ul style="list-style-type: none"> <p>Minute reference Q&PSC 20/08/06 – Quality and Patient Safety Update - The Head of Commissioning (Mental Health) to follow-up the concerns raised by YAS regarding access to SWYPFT's Intensive Home Based Treatment Team out of hours. The Quality Manager, BCCG reported that work is now progressing as part of the Mental Health Urgent and Emergency Care work stream for each locality to ensure the NHS 111 DOS is robust and that there are appropriate dispositions in place. Barnsley has a number of areas where there are no valid dispositions. The SYB ICS MH team is providing support.</p> <p>Minute reference Q&PSC 20/08/08 – Learning Disabilities Mortality Review (LeDeR) - The Head of Governance and Assurance to meet with the Specialist Clinical Portfolio Manager to articulate the risks and mitigation on the risk register. The Specialist Clinical Portfolio Manager has provided a draft copy of the LeDeR risks to be added to the risk register via Risk, Governance and Assurance Facilitator</p> <p>Minute reference Q&PSC 20/08/12 – Quality and Patient Safety Committee Terms of Reference - The Head of Governance and Assurance to make reference to this review and minor changes in the Governance and Assurance monthly report.</p> <p>Minute reference Q&PSC 20/08/13 – Individual Funding Requests Policy - The Lead Commissioning and Transformation Manager, BCCG to submit Individual Funding Requests</p> 	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Ongoing</p>	

	<p>Policy to Governing Body for ratification subject to outcome of discussion with Specialist Clinical Portfolio Manager regarding MCA and DoLS. The Specialist Clinical Portfolio Manager advised she has been unable to meet with the Lead Commissioning and Transformation Manager.</p> <ul style="list-style-type: none"> <p>Minute reference Q&PSC 20/08/18 – Any Other Business - The Quality Manager to circulate the Covert Medicines Policy to members for virtual sign off. Quality Manager confirmed that the policy had been circulated again along with the Quality and Equality Impact assessments. There have been no comments raised by members. The Chair requested a further copy of the policy and associated documentation.</p> <p>Minute reference Q&PSC 20/02/03 – Patient Story – Pharmacy Incident - Governing Body Member would check with the Pharmacy as to whether the incident had been raised with them and to check whether any learning had been identified. This action will be picked up with Governing Body Member, Dr Adebowale Adekunle outside of the meeting.</p> <p>Minute reference Q&PSC 20/07/06 - Quality & Patient Safety Update – Safeguarding – Cherry Trees Care Home - Police investigation closed no charges were made against the people involved in the case. BMBC will commence a safeguarding review which will feed into a further meeting on 24 August 2020. The CCG will receive a formal update following this meeting to provide assurance to the committee. Post meeting update – The Specialist Clinical Portfolio Manager provided the following update. The Safeguarding investigation has concluded and an action plan is in place. The home is still being monitored but there are no embargos in place.</p> <p>Minute reference Q&PSC 20/07/08 - Current Issues/Concerns – Sheffield Health and Social Care Trust - The CCG’s Safeguarding Adult Lead will be involved in the Quality Monitoring process and will provide regular updates to the committee. The Chair requested an update outside of the meeting.</p> 	<p>Ongoing</p> <p>Complete</p> <p>Complete</p> <p>Complete</p>	
QUALITY AND GOVERNANCE			

Q&PSC 20/10/06	QUALITY AND PATIENT SAFETY REPORT		
	<p>The Quality Manager, BCCG presented the Quality and Patient Safety report highlighting the following:</p> <p><u>BHNFT</u> Serious Incidents are at the same level as reported in the same period last year. Maternity incidents –There has been a delay in the completion of some investigations due to Covid as investigators are asked to undertake clinical duties. A meeting has been arranged for 3 December 2020 to review the information obtained so far. The Trust’s initial review of the incidents revealed no particular themes, but there was learning from some of the individual incidents which will be taken forward. There have not been any further maternity incidents reported since July 2020.</p> <p>Patient Experience - the Trust has notified the CCG that they are looking to introduce new patient engagement initiative: coffee and chat sessions for patients and carers. These will provide a wider range of patient experience feedback. The CCG has offered to support the sessions.</p> <p><u>Cancer Services</u> Work is continuing to help ensure patients attend their appointments.</p> <p>A highlighted risk is that the waits are increasing. In relation to cancer services, The Lay Member for Public and Patient Engagement and Chair of Primary Care Commissioning, BCCG stated that there is a need for more cervical screening in the community.</p> <p><u>SWYPFT</u> At the last SWYPFT Clinical Quality Board on 1 October 2020, it was reported that the Trust’s recovery plans were still being developed.</p> <p>Adult Community Speech And Language Therapy (SALT) - The current risk is that the waiting list for dysphasia patients will increase as the team does not have capacity to reduce the list and the Trust has not been successful in recruiting a locum on a full time basis. A business case has been submitted to the CCG for additional speech and language therapists. The Committee were provided with details of additional actions being taken, including management of communication about the service no longer taking new referrals for dysphasia patients. The Chair advised that she needed to liaise with The Head of</p>	JS	December

	<p>Contracting, BCCG about this change.</p> <p>The Chair informed members that the Quality Manager, BCCG is auditing the waiting lists for non-consultant led services to ensure that there are not similar issues with these. This work is being monitored through the SWYPFT Clinical Quality Board.</p> <p><u>YAS</u> There has been a Covid outbreak in the Emergency Operations Centre (EOC) in Wakefield. This has affected their capacity to manage incoming calls and to assist with the investigation of incidents. As a result of this there has been an Infection Prevention Control (IPC) review of the working arrangements in the EOC. The outbreak is now reducing.</p> <p><u>Care Homes</u> Specialist Clinical Portfolio Manager, BCCG provided an update regarding care homes and Continuing Healthcare. There are concerns around visiting and contact with relatives. The CCG needs to know how the care homes are arranging contact with loved ones.</p> <p>Outbreaks are being monitored and services are put in place quickly when there is an outbreak.</p> <p>There was a detailed discussion about some care homes not allowing residents back into their home after they had been to the Emergency Department due to concerns about their Covid status.</p> <p>There has been a focus on training in care homes particularly around PPE, social distancing and swabbing residents. Training is still available to care homes to keep the skills up.</p> <p><u>Continuing Health Care</u> The Continuing Health Care Team is focusing on their recovery plan. Figures are being reviewed to understand the position in more detail.</p> <p>Recruitment is going on around additional support for the team.</p> <p><u>Primary Care Update</u> The Primary Care and Transformation Manager, BCCG updated members regarding primary care. It was highlighted that the Quality Dashboard gives a good overview of what is happening in practices along with other intelligence. At the moment there is</p>		2020
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	<p>no practice which needs additional monitoring.</p> <p><u>Out of Hours/Extended Access</u> Primary Care receives a monthly SQP report from Barnsley Healthcare Federation with information for the services they provide. A monthly meeting is held to review complaints, compliments, incidents, feedback. In relation to patient experience they are continuously looking at how data can be gathered. The Primary Care Transformation Manager and Quality Manager to discuss what is in the Barnsley Healthcare Federation contract around reporting of serious incidents, and report back to members.</p> <p>The Chair asked what the process is for employees to raise serious incidents and if the process has been seen by the CCG. The Primary Care Transformation Manager and Quality Manager to discuss what is in the Barnsley Healthcare Federation contract around reporting of serious incidents, and report back to members.</p> <p>The Primary Care Transformation Manager left the meeting at 14:25pm</p>	TH/HF	December 2020
	<p>Actions agreed: The Chair to liaise with the Head of Contracting, BCCG regarding the comms for the change to the service offer for dysphasia patients provided by the Adult Community SALT team.</p> <p>The Primary Care Transformation Manager and Quality Manager to discuss what is in the Barnsley Healthcare Federation contract around reporting of serious incidents, and report back to members.</p>	JS	December 2020
		TH/HF	December 2020
Q&PSC 20/10/07	COVID 19 EMERGING RESPONSE		
	<p>The Chair stated that in Barnsley Hospital there were 67 Covid positive patients and 9 on ITU. The bronze operational cell has been stepped up to provide support for care homes, community services, Right Care Barnsley, intermediate care, primary care and social care. All partners are at the meeting which focuses on the operational response to the pandemic and what needs to be done on a daily basis.</p> <p>From a data and information perspective the CCG is in a good position to understand what is coming in terms of Covid 19 and how the CCG can manoeuvre its services in the areas that are needed.</p> <p>There is a number of staff off sick with Covid 19 or who are self-isolating across the patch which is</p>		

	<p>causing some significant operational issues. An increasing number of staff from across all partners are off sick with non-Covid issues. Groups and systems are in place to manage this.</p> <p>Regarding safeguarding adults and children, it was highlighted that nothing was stepped down and nothing will be stepped down during the second wave of Covid.</p>		
Q&PSC 20/10/08	EXCELLENCE IN CARE BOARD AND IMPROVEMENT PANEL		
	<p>The Chair reported that this piece of work is to enable the shared responsibility and accountability for improving the standards of care in health and social care provision across Barnsley.</p> <p>The Care Home Quality Board operated prior to Covid, but as other groups were in place through Covid, the Board has not met since. The Terms Of Reference (TOR) for the Excellence in Care Board and Improvement Panel has been prepared and the Board will be led by the local authority but with the CCG firmly at the table to help improve the standards of care across care homes. A Health and Social Care Quality Improvement panel will feed into the Board, which will bring together individuals from a range of organisations to share information and to assess the risks that any given a provider may be experiencing.</p>		
Q&PSC 20/10/09	ANNUAL LeDeR REPORT		
	<p>The Specialist Clinical Portfolio Manager, BCCG presented the report for assurance and provided a comprehensive update on LeDeR. There have been issues with GPs reporting that they cannot provide records, because of resource not being available or needing payment. These issues have been resolved. The Specialist Clinical Portfolio Manager will provide more information to the Primary Care and Transformation Manager outside of the meeting.</p> <p>A review of archived cases has taken place and identified some learning. Themes from the reviews echo themes identified nationally. There are also themes emerging locally and the CCG will be feeding into local systems.</p>	JH/TH	December 2020
	Agreed actions: The Specialist Clinical Portfolio Manager to discuss with the Primary Care and Transformation Manager the issues regarding access to GP records for LeDeR work.	JH/TH	December 2020
Q&PSC 20/10/10	BCCG PATIENT EXPERIENCE FEEDBACK REPORT QTRS 1 & 2 2020/21		

	<p>No queries or comments were raised in relation to the Patient Experience Feedback reports for Qtrs 1 & 2 2020/21.</p> <p>The Chair stated that Martine Tune, Deputy Chief Nurse has returned to the CCG and will pick up Patient Experience as part of her portfolio.</p>		
Q&PSC 20/10/11	CHILDREN'S CONTINUING CARE APPEAL PROCESS		
	<p>The Specialist Clinical Portfolio Manager presented the Children's Continuing Care Appeal Process for approval.</p> <p>Frequent reviews of the Children's Continuing Care Appeal process will be undertaken in first 12 months to ensure that the process is operating smoothly.</p> <p>The committee approved The Children's Continuing Care Appeal Process.</p>		
Q&PSC 20/10/12	RISK REGISTER (STANDING ITEM)		
	<p>The Head of Governance and Assurance presented the Risk Register and stated that The Head of Medicines Optimisation has provided an update regarding the D1 risk.</p> <p>Work has been done through the management team to refresh the assurance framework and put an updated assurance framework in place. Prior to Covid there were 3 priority areas: mental health, transforming care and maternity. All three areas will continue to be looked at.</p> <p>A risk will be added around care homes to get the priority that it needs. This will go to governing body on 12 November.</p> <p>The Head of Governance and Assurance will discuss with the Risk, Governance and Assurance Facilitator regarding adjustment of the LeDeR risk rating.</p> <p>The Quality Manager highlighted a typo in the final progress update column relating to risk CCG 19/05 End of Life Care (EOLC). The Chair agreed to investigate this.</p>	<p>RW</p> <p>JS</p>	<p>December 2020</p> <p>December 2020</p>
	<p>Action agreed:</p> <p>The Head of Governance and Assurance will discuss with the Risk, Governance and Assurance Facilitator regarding adjustment of the LeDeR risk rating.</p> <p>The Chair to review typo error in the final progress update section relating to risk CCG</p>	<p>RW</p> <p>JS</p>	<p>December 2020</p> <p>December 2020</p>

	19/05 End of Life Care (EOLC).		
COMMITTEE REPORTS AND MINUTES			
Q&PSC 20/10/13	MINUTES OF THE 12 AUGUST 2020 AND 09 SEPTEMBER 2020 APEA PRESCRIBING COMMITTEE		
	<p>The Head of Medicines Optimisation presented the minutes for information.</p> <p>It was highlighted that the Area Prescribing Committee's reporting has been expanded to capture a wider range of issues, not just those relating to medicines.</p> <p>Also highlighted was that a major manufacturer of Lithium had given notice that they were going to withdraw their brand from the market. This was escalated nationally and the manufacturer has retracted the withdrawal. New Lithium brands have been introduced into the formulary in the meantime, and there will be a process of trying to move patients onto these as there is no guarantee that the manufacturer will not withdraw from the market again.</p> <p>A section 28 report has been received for adrenaline auto injectors. This related to a young person who had quite a severe allergy who was discharged from the hospital without their GP knowing. This is being followed up with Consultant Paediatrician, Dr Kerrin to get a follow up policy for this type of patient.</p>		
Q&PSC 20/10/14	MINUTES OF 26 AUGUST 2020 PRIMARY CARE QUALITY & COST EFFECTIVE PRESCRIBING GROUP MEETING		
	<p>The Head of Medicines Optimisation presented the minutes for information It was highlighted the CCG has restarted the 2021 medicine optimisation scheme for the period October 2020 to the end of March 2021.</p> <p>The Chair asked if there has been an increase in oxygen use for those Covid patients who have been discharged from the hospital, and asked where patients would go to if they needed it. The Head of Medicines Optimisation advised that there has not been a large increase in use the community, and that the CCG works with the Breathe Team and Baywater Health to identify patients who may be at risk.</p> <p>The Head of Governance and Assurance and the Secondary Care Clinician left the meeting at 14:58pm.</p> <p>The Head of Medicines Optimisation highlighted that</p>		

	<p>the community pharmacy emergency hormonal contraception service ceased from 31 August 2020. BMBC has advised that people can access the medicine via Gateway Plaza. The service is being recommissioned but there has been a gap in delivery. The Chair requested a further meeting with the Head of Medicines Optimisation to discuss the Community Pharmacy Emergency Hormonal Contraception Service.</p> <p>A Medicine Rebate Policy was previously brought to Q&PSC, but it did not have an EQIA. The committee agreed that the EQIA could be processed outside of the meeting.</p> <p>Lay Member for Public and Patient Engagement and Chair of Primary Care Commissioning raised a question relating to Brexit. The Head of Medicines Optimisation informed members that national advice is not to stock pile medicines or do anything differently as this could create medicine shortages. It was noted that the government has stores of medicine in place. Work is being completed nationally looking into supplies within wholesalers</p>	JS/CL	December 2020
	<p>Agreed actions: The Chair requested a further meeting with the Head of Medicines Optimisation to discuss the Community Pharmacy Emergency Hormonal Contraception Service.</p>	JS/CL	December 2020
Q&PSC 20/08/15	<p>CLINICAL QUALITY BOARDS</p> <ul style="list-style-type: none"> • BHNFT – MINUTES 06 AUGUST 2020 • SWYPFT – MINUTES 27 AUGUST 2020 		
	The Chair stated that these are adopted sets of minutes and was presented for information and assurance. No queries were raised.		
Q&PSC 20/10/16	HEALTH PROTECTION BOARD ACTION NOTES 8 JULY 2020		
	The Chair stated that the notes were for information only. No queries were raised.		
GENERAL			
Q&PSC 20/10/17	ANY OTHER BUSINESS		
	No items were raised.		
Q&PSC 20/10/18	AREAS FOR ESCALATION TO THE GOVERNING BODY AND ITEMS TO BE COVERED IN HIGHLIGHT REPORT		
	<p>Items for escalation are</p> <ul style="list-style-type: none"> • Green - Children's Continuing Care Appeals 		

	<p>and Dispute Resolution process</p> <ul style="list-style-type: none"> • Green - BHNFT initiative for patient engagement • Amber - Maternity Incidents • Red - SWYPFT management of waiting lists. <p>The Head of Medicines Optimisation left the meeting at 15:11pm</p>		
Q&PSC 20/10/19	<p>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED:</p> <ul style="list-style-type: none"> • CONDUCT OF MEETING • ANY AREAS FOR ADDITIONAL ASSURANCE • ANY TRAINING NEEDS IDENTIFIED 		
	The Chair stated that level of reporting needs to be reviewed.	JS/HF	December 2020
	<p>Agreed actions: The Chair and the Quality Manager to review the level of reporting to Q&PSC.</p>	JS/HF	December 2020
Q&PSC 20/08/21	<p>DATE AND TIME OF NEXT MEETING 17 December 2020, 1pm via MS Teams</p>		

GOVERNING BODY

14 January 2021

EQUALITY & ENGAGEMENT COMMITTEE SUMMARY REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR		
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>
	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>
	<i>Information</i>	<input type="checkbox"/>	
2.	PURPOSE		
	This report is to highlight the work of the Equality & Engagement Committee and provide assurance to the Governing Body that this committee is discharging its statutory duty.		
3.	REPORT OF		
		Name	Designation
	Executive / Clinical Lead	Chris Millington	Lay Member
	Author	Carol Williams	Project Coordinator
4.	SUMMARY OF PREVIOUS GOVERNANCE		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	Group / Committee	Date	Outcome
	NA		
5.	EXECUTIVE SUMMARY		
	Committee members agreed to highlight the following from the 3 December 2020 meeting: <ul style="list-style-type: none"> • NHS Oversight Framework Patient and Community Engagement Indicator Green Star rating. • Actions for the NHS People Plan being taken forward. 		
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:		
	<ul style="list-style-type: none"> • Note the contents of this report for information and assurance. 		
7.	APPENDICES / LINKS TO FURTHER INFORMATION		

	<ul style="list-style-type: none">• Appendix A – Adopted Equality & Engagement Minutes 13 August 2020 (seen by the committee September 2020)• Appendix B – Unadopted Equality & Engagement Minutes 3 December 2020
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Agenda time allocation for report:	5 minutes
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PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (<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
2.	Links to statutory duties		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:		
	Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)
	Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)
	Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)
3.	Governance Considerations Checklist (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)		
3.1	Clinical Leadership		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		Y
	As members of this committee		
3.2	Management of Conflicts of Interest (s14O)		
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?		Y
	None declared		
3.3	Discharging functions effectively, efficiently, & economically (s14Q)		
	Have any financial implications been considered & discussed with the Finance Team?		NA
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		NA

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

ADOPTED Minutes of the Meeting of the EQUALITY AND ENGAGEMENT COMMITTEE held on Thursday 13 August 2020 at 1pm via Microsoft Teams

PRESENT:

Chris Millington (Chair)	Lay Member for Patient & Public Engagement, CCG
Kirsty Waknell	Head of Communications & Engagement, CCG
Julie Frampton	Senior Primary Care Commissioning Manager, CCG
Richard Walker	Head of Governance & Assurance, CCG

IN ATTENDANCE:

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

APOLOGIES

Dr Adebawale Adekunle	Elected Governing Body Member, CCG
Jayne Sivakumar	Chief Nurse, CCG
Colin Brotherston-Barnett	Equality, Diversity & Inclusion Lead, CCG
Susan Womack	Manager, Healthwatch Barnsley
Dr Indra Saxena	Membership Council Representative, CCG

Agenda Item	Note	Action	Deadline
EEC 20/08/01	HOUSEKEEPING		
	The Chairman informed everyone present of the etiquette for Microsoft Teams meetings.		
EEC 20/08/02	APOLOGIES		
	Apologies were received as above. The chair, on behalf of the committee, thanked the membership council representative for their input into this committee over the past few years and wished the membership council representative a happy retirement. The chair also acknowledged the valuable input from the equality, diversity & inclusion lead and all members sent		

Agenda Item	Note	Action	Deadline
	their best wishes for a speedy recovery.		
EEC 20/08/03	QUORACY		
	The chair of the committee declared that the meeting was not quorate due to the number of apologies received. The head of governance and assurance stated that the minutes of the meeting held on 20 February 2020, the HR policies and the workforce race equality standard report would be managed virtually so that members not present had the opportunity to comment and agree these documents.		
EEC 20/08/04	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	The committee considered the declarations of interest report, no new declarations of interest were declared. Jacqueline Howarth and Adrian Hobson to have their names removed from the report as this was an administrative error. Mike Simms to be removed as he is no longer a member of this committee.		
	Agreed Action: <ul style="list-style-type: none"> • The committee secretary to ask for the above changes to be made. 	CW	Completed
EEC 20/08/05	MINUTES OF THE PREVIOUS MEETING HELD ON 20 FEBRUARY 2020		
	The minutes of the meeting held on 20 February 2020 had one amendment on page 9 of the minutes: <i>“On being asked by the chair, the manager of Healthwatch Barnsley reflected that some meetings were of more interest to their organisation than others depending upon who was invited to attend the meeting. This was noted by other members of the committee. The head of communications and engagement invited members to think about and suggest any topics or speakers for future meetings.”</i> This should read: <i>“On being asked by the chair, the manager of Healthwatch Barnsley reflected that some meetings were of more interest to their organisation than others depending upon the agenda items. This was noted by other members of the committee. The head of communications and engagement invited members to think about and suggest any topics or speakers for future meetings.”</i>		

Agenda Item	Note	Action	Deadline
	With the above amendment made the minutes were adopted and verified as a correct record of the proceedings by members present.		
	<p>Agreed Action:</p> <ul style="list-style-type: none"> • The committee secretary to circulate the minutes to members highlighting the above change to obtain virtual sign off of the minutes which will then be submitted as ratified minutes to the September 2020 governing body committee meeting. 	CW	Completed
EEC 20/08/06	MATTERS ARISING REPORT		
	<p>The committee noted the actions from the 20 February 2020 meeting, two actions remained open:</p> <p>EEC 19/11/07 Barnsley Service Users Forum The head of communications and engagement to discuss the role of an independent chair of the forums with BMBC colleagues. Update: The last meeting was held as we went into lockdown and this committee was paused during this time. In Progress.</p> <p>EEC 19/11/08 An Alternative World The equality, diversity & inclusion lead to run a session with governing body members. Update: The session planned for 30.04.2020 did not go ahead as our focus was on the response to Covid-19. This will be picked up at another time. Closed.</p> <p>EEC 20/02/08 South Yorkshire & Bassetlaw Integrated Care System (SYB ICS) – Engagement and Equality Overview & Developments The SYB ICS associate director of communications and engagement discussed the EEC Citizens Panel – a data base of people to work with for engagement activities. Update: The soft launch was w/c 10 August 2020 and the ICS have promoted this on social media. Comms in Barnsley will be picked up on the Barnsley plan. The aim is for the panel to be reflective of the demographic make-up of SYB and members will be recruited and emailed to ask to join a variety of panels. The aim is to have 3000 members across the 5 SYB areas. Barnsley will contribute our part of the membership and we can register all 3000 people on our data base that will</p>		

Agenda Item	Note	Action	Deadline
	replace the Open data base. The full launch is planned for w/c 17 August 2020. Updates will be brought back to future meetings in the Engagement Report. Completed.		
PATIENT AND PUBLIC ENGAGEMENT			
EEC 20/08/07	ENGAGEMENT REPORT		
	<p>The engagement report was presented to committee members for assurance.</p> <p>As part of the command and control structure implemented across Barnsley in response to the Covid-19 pandemic the engagement and experience leads from across the borough now meet fortnightly to pool collective capacity, resources and share information via the intelligence cell as part of a wider borough structure (silver tactical health & social care group) and the group contributes to the weekly surveillance report – the section ‘what people are telling us’ highlights feedback locally, regionally and nationally.</p> <p>This report also covers engagement linked to the phase 3 letter priorities over the next 3 months for the NHS and partners. The letter has a link to National Voices 5 key principles. A summary of this will be provided in the surveillance report and will be circulated to members for information. The 5 principles are ones we had already highlighted as part of our way of working and provide a framework for the approach to engagement work that will be taken forward. There is an expectation that across the NHS that all organisations will be asked to act and in accordance to the 5 principles linking in with people most affected by changes we make and ensuring there are no inequalities in our services in relation to Covid-19 and getting our services back up and running.</p> <p>The chair asked how we would respond if challenged about how we know what the people of Barnsley are telling us. The engagement manager stated that this is directly from feedback from our engagement activity across the borough, either directly or through partners therefore we are able to state that this is what Barnsley people are telling us. Some of this is a snap shot or as a collective Barnsley population and we can highlight pieces of work that had input from people that have fed back or had been directly linked to pieces of work.</p>		

Agenda Item	Note	Action	Deadline
	<p>The head of communications and engagement stated that this is a positive piece of work mobilised during Covid-19 and is something we had wanted to do for some time. We may want to think about other places where we can increase our profile e.g. provide an update on the National Voices 5 principles with the governing body and at the next primary care commissioning committee as governing body members who attend that meeting would not usually receive this type of escalation. Members agreed to the above positive escalations.</p> <p>The engagement manager will also include this in the monthly update for the SYB lay members meeting.</p>		
	<p>Agreed Action:</p> <ul style="list-style-type: none"> • The engagement manager to provide the summary of the National Voices 5 key principles document to the committee secretary to circulate to members. • The head of communication and engagement to share the National Voices 5 principles with the governing body as part of the engagement report and also to primary care commissioning committee. 	<p>EB/CW</p> <p>KW</p>	<p>31 Aug 2020</p> <p>27 Aug 2020</p>
<p>EEC 20/08/08</p>	<p>INTEGRATED ASSESSMENT FRAMEWORK 2020/21 AND BEYOND</p>		
	<p>The head of communications and engagement gave a verbal update on the CCG assessment on the community and engagement indicator. This is part of the wider CCG assessment and we are expecting an update on this by the end of August 2020 which is a slight delay. We are unsure if we will get the community engagement indicator, this will be shared with members when this is received.</p> <p>The previous year we were rated as green star scoring 14 out of 15 points. For the assessment this year lots of work was undertaken to gain the additional 1 point and the team are confident we will remain green star.</p>		
<p>EEC 20/08/09</p>	<p>HEALTHWATCH BARNSELY ANNUAL REPORT 2019/2020</p>		
	<p>The Healthwatch Barnsley annual report 2019/2020 was shared with committee members for information.</p> <p>The report has been published for some time and if members want to discuss any of the content they can</p>		

Agenda Item	Note	Action	Deadline
	<p>contact the Healthwatch manager directly or via the engagement manager as they both meet on a regular basis.</p> <p>Towards the end of the report the strategic board give an indication on what they will be looking at going forward and most of this will have been written pre-covid. In relation to GP appointments the senior primary care commissioning manager and the head of communications and engagement had a session booked in diaries with the strategic board to help them understand the bigger picture within primary care to better inform how to take this work forward. Unfortunately this meeting did not go ahead and the head of communications and engagement will pick this up with the Healthwatch manager before any activity begins in relation to this.</p> <p>The senior primary care commissioning manager stated that it was really helpful to have feedback which helps with some of the things we want to do with primary care and practices as can evidence the detail of responses from members of the public other than their own routes into practice. This was going to be a good opportunity to describe some of the context of the work that happens in primary care and gives the nuance as to how things work, how this relates to the contractual requirements and what patients want as they can be very different. The senior primary care commissioning manager is keen to pick up his work back up to ensure we do not miss any details and share information.</p> <p>The head of communications and engagement acknowledged that during Covid-19 appointment systems had changed and that this would relate to a wider piece of work across all settings, rather than just GP practices, in terms of being offered video or telephone appointments. This sits in with the work of 'what are people telling us' and Healthwatch can help us build a rich picture in relation to this. The senior primary care commissioning manager stated that the team are getting quite a lot of requests/mandates from national and regional sources and need to reflect this in the local picture.</p> <p>The chair acknowledged how well Healthwatch managed their budget to ensure we get good value for money. Their volunteer bank is a crucial part of their strategy and</p>		

Agenda Item	Note	Action	Deadline
	<p>is now hosted by Barnsley CVS and this link has helped them to grown their volunteers by 27 people in the last year and this is how they undertake a lot of their work.</p> <p>Healthwatch had GP access on their list of work they wanted to do rather than the CCG asking Healthwatch to do this for us. We want to work collaboratively to inform Healthwatch of the bigger picture in primary care and to look at how this work could be delivered. As a Barnsley wide group they have an independent voice and collaborative working will ensure that we can make the most of this piece of work.</p> <p>It was noted that because of the restrictions of being in a pandemic Healthwatch will have had approximately 6 months where they would not have been able to consult with members of the public in the usual way and the head of communications and engagement is keen to know how they have been dealing with this – be that waiting to go back out to meet with people or by mobilising something else.</p> <p>The head of communications & engagement will meet with the Healthwatch Manager, colleagues are welcome to join in this and an update will be provided at the next meeting.</p>		
	<p>Agreed Action:</p> <ul style="list-style-type: none"> • The head of communications and engagement to contact the Healthwatch manager to agree how they can inform the strategic board of wider work in relation to GP appointments before the board progresses with this piece of work. 	KW	Completed
EEC 20/08/10	<p>VERBAL UPDATE OF THE PATIENT COUNCIL MEETING HELD ON 29 JULY 2020</p>		
	<p>The committee chair gave a verbal update of the patient council meeting held on 29 July 2020 and highlighted the following:</p> <p>As the meeting was held during Covid-19 the main focus of the meeting was to trial new technology by utilising Zoom. 13 people attended and were keen to embrace the technology and everyone had something to contribute which was excellent. The meeting also allowed members to share some of their concerns about Barnsley residents which was useful during this unusual time.</p>		

Agenda Item	Note	Action	Deadline
QUALITY GOVERNANCE			
EEC 20/08/11	CCG RISK REGISTER AND ASSURANCE FRAMEWORK		
	<p>The head of governance & 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>Governing Body Assurance Framework (GBAF) There is no GBAF update for the committee at this stage as the GBAF is currently in abeyance. Updating the GBAF was suspended at the peak of Covid-19 and it is now proposed that a new GBAF is developed once 2020/21 planning guidance is received and priorities & key deliverables are clearer.</p> <p>Risk Register 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"> • 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. • 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. <p>Both risks had been updated at the height of the Covid-19 response as that was our focus, now our focus is returning to business as usual and a fuller update will be available at the next meeting.</p> <p>The head of communications & engagement asked that it was noted that engagement work did not stop during Covid-19, it was different during this time and it was important that this noted to ensure the updates on the risk register were not taken out of context. For the next meeting this can be updated. In addition equality work did not stop, only the formal meetings.</p> <p>The committee agreed that the risks are being appropriately managed and scored as at 13 August</p>		

Agenda Item	Note	Action	Deadline
	2020.		
EEC 20/08/12	HR POLICIES		
	<p>On the 19th of June a number of policies were approved virtually by this committee and are being brought today for formal ratification and recording of this approval. These policies were:</p> <ul style="list-style-type: none"> • Policy on Trade Union Recognition & Facilities & Time Off for Trade Union representatives • Maternity, Paternity, Adoption, Carers and Parental Leave • Disciplinary Policy • Acceptable Standards of Behaviour Policy <p>Policies being shared with the committee for the first time today are:</p> <ul style="list-style-type: none"> • Grievance Policy • Retirement Policy • Equality, Diversity and Inclusion Policy • Study Leave Policy <p>Summarised below are minor amendments being proposed:</p> <p>Grievance Policy</p> <ul style="list-style-type: none"> • Amendments to section 1.1 and 2.1 to reflect the involvement of the HR Team within the informal and formal process. • Section 2.2 amended to clarify manager's responsibilities. <p>Retirement Policy</p> <ul style="list-style-type: none"> • Section 7.6, 8.5, 8.6, 8.9 and 8.10 deleted and consolidated into section 8.4 to clarify all requests are to be submitted in writing. • Section 8.10 expanded to clarify the rules set by NHS Pensions around minimum break in service and maximum working hours allowed when flexibly retiring. <p>Equality, Diversity and Inclusion Policy</p> <ul style="list-style-type: none"> • Amendment to title of policy (and throughout policy document) to include 'inclusion'. • Section 5.3 added to clarify definition of 'inclusion'. <p>Study Leave Policy</p> <ul style="list-style-type: none"> • Section 2.5 added by counter-fraud specialist to 		

Agenda Item	Note	Action	Deadline
	<p>clarify the definition within this policy of fraud and bribery.</p> <ul style="list-style-type: none"> Section 3.5 added by TU representatives to ensure consistency within CCGs across the local patch. <p>The head of communications & engagement had looked at the policies to consider if any changes needed to be made in relation to flexible working that may influence policies in the future however if there is anything that needs to be changed then these policies can be reviewed at any time if required.</p> <p>Noted these policies are following principles that are applied in all SYB CCG's to provide a consistent approach across the area.</p> <p>Committee members present approved these policies which will be circulated to members not present for their approval.</p>		
	<p>Action Agreed</p> <ul style="list-style-type: none"> The HR manager to email members of the committee not present to give them an opportunity to approve changes and agree these policies, noting that these had been approved in our meeting. A deadline of 1 week was set to enable policies to be fully signed off and published. 	ES	31 Aug 2020
EQUALITY			
EEC 20/08/13	EQUALITY OBJECTIVES AND ACTION PLAN 2019-2021		
	<p>The equality, diversity & inclusion working group has not met since 9 January 2020 as the meeting planned for 31 March 2020 was cancelled to allow staff to focus on the response to Covid-19. This group has been reinstated and will meet again on 25 September 2020. The notes from this and future meetings will be an agenda item for information only and we will only detail any points of escalation.</p>		
	<p>The head of communications & engagement gave a verbal update in relation to the equality objectives and action plan for 2019-2021. We are on track to publish our draft objectives Workforce Race Equality Standards and Public Sector Equality Duties. There will be a huge number of actions that will come out of the Covid-19</p>		

Agenda Item	Note	Action	Deadline
	<p>work in terms of equality, inequality, for the way we commission and for our staff. There is a lot of information in national guidance and the new NHS People Plan therefore we will need to review our action plan to ensure all the above will be covered and the action plan will be considered in more detail at future a meeting.</p>		
<p>EEC 20/08/14</p>	<p>WORKFORCE RACE EQUALITY STANDARDS</p>		
	<p>The HR manager presented the workforce race equality standards (WRES) report to committee members for assurance and highlighted the following:</p> <p>The equality, diversity and inclusion lead had input to the WRES and there are still minor amendments to ensure that equality, diversity and inclusion is referenced throughout the document.</p> <p>There are two strands to the WRES</p> <ul style="list-style-type: none"> • Data - this was taken from electronic staff records and staff survey and this was uploaded to a national spreadsheet for NHS England to have an overview of each geographical area. • Action Plan - which can be amended as we go forward e.g. linking to the People Plan. <p>Members were asked for comments to contribute to the final version:</p> <p>Workforce race equality indicators – BAME VSM 100% needs clarity - If this was 1 clinical individual on the very senior manager on the clinical pay scale from a black, asian, minority, and ethnic background this would be 100%. Data was presented last year to compare to this year and this year we have more BAME staff.</p> <p>The relative likelihood of white staff being appointed from shortlisting compared to BAME staff has changed from 1.35 to 1.42 times greater. It has been firmly stated in the action plan how to address this. One of the HR training modules planned this year is recruitment and selection and as many staff as possible will be encouraged to undertake this. We may state in the future that at least one person on an interview panel has to have attended this training. Committee members would support this.</p>		

Agenda Item	Note	Action	Deadline
	<p>The HR manger gave assurance to the committee that the equality, diversity and inclusion lead is happy with action plan and that this can be addressed as situations change.</p> <p>The head of communications & engagement wants to ensure this information goes outside of this committee for discussion across the entire organisation. We have a group of staff that has formed since the black lives matter movement who want to be proactive and start having conversations within the CCG about this agenda – part of this was their own personal wish to do this taking a collaborative/coproduction approach with training that may be offered to staff. The group has a list of things for discussions; we are unsure if this may have been based their own personal experience or not so it was agreed to look at all the data available and move forward with an informed position of where the CCG is and then bring in people’s own experiences to this. The group of staff are keen to set up a network group and this is a good example of what we could take to them.</p> <p>The head of communications & engagement queried the language as the report references BME and the CCG uses BAME which sits slightly more comfortably with individuals, it was asked that this was referenced.</p> <p>Once complete it is advisable that the WRES is shared with staff and published on our website. It is likely that we will want to run a session at staff briefing before publication.</p> <p>KSF 26 the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. 13.2% of white employees stated that they had experienced harassment, bullying or abuse in last 12 months from managers compared to 10% of BAME staff. 11.8% of white employees stated that they had experienced harassment, bullying or abuse in last 12 months from other colleagues compared to 10% of BAME staff.</p> <p>This shows that there is not much of an obvious difference between BAME to non BAME staff but raw numbers appear to be higher than the previous year which is a matter of concern for us. Over the last few months we have adopted a zero tolerance policy; during</p>		

Agenda Item	Note	Action	Deadline
	<p>Covid-19 line managers have had 1:1's with staff and have discussed in detail staff wellbeing in relation to working from home. There have been isolated incidences of inappropriate behaviour that have been raised and fully investigated, so we are doing what we can but the message has to be continually reinforced to staff in the CCG the kind of behaviours we expect and that staff will be supported if they come forward to raise any issues. The chair echoed the above comments and stated that the capturing of this information and how we are going to address this is very important and we need to drill down to a granular level to deal with this.</p> <p>Local and national CCGs have an average of 14% which is usually a lot lower and we are just below the average. The HR manager will reflect in the report the average/comparator to the national indicator – whilst this will not change the result it will give some context as this does not resonate with HR cases so it is hard to know what is behind this. HR training for bullying, harassment and prevention addresses the need to check individual levels of understanding of thresholds of behaviour as this will be differ and we need a common understanding of what this is.</p> <p>It was raised that during this unprecedented time, where staff members are working in isolation, there has been a small number of minor incidences of unacceptable standards of behaviour; therefore this report may not reflect a true picture of what is happening in the organisation now. Members are assured that the work planned by HR will address any ongoing issues.</p>		
	<p>Action Agreed</p> <ul style="list-style-type: none"> • The HR manager to email members of the committee not present to give them an opportunity to comment and approve the WRES report, noting this had been approved in our meeting. A deadline of 1 week was set to enable the WRES to be fully sign off. 	ES	31 Aug 2020
GENERAL			
EEC 20/08/15	EQUALITY & ENGAGEMENT COMMITTEE WORKPLAN 2020-2021		
	Changes had been made to the work plan on the advice of the audit committee to ensure that all relevant items from the committee terms of reference were reflected on		

Agenda Item	Note	Action	Deadline
	the workplan and the reference numbers in the terms of reference has been added to specific sections of the workplan.		
	Action Agreed: <ul style="list-style-type: none"> • The committee secretary to share the workplan and committee terms of reference for members comments on how we may evidence some of the requirements of the terms of reference within future papers and reflect this in the workplan. 	CW	31 Aug 2020
EEC 20/08/16	ANY OTHER BUSINESS		
	No items were raised.		
EEC 20/08/17	ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT		
	Committee members agreed to highlight the following areas: <ul style="list-style-type: none"> • National Voices 5 Principles will be included in the engagement report and the chair will focus on this when reviewing the equality and engagement minutes. • WRES data has been given thorough consideration. 		
EEC 20/08/18	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED		
	The Chair thanked members for their input, good quality and content of papers and a good meeting. Committee members feel assured by the ongoing activities in relation to equality and engagement and no training needs were identified.		
EEC 20/08/19	DATE AND TIME OF THE NEXT MEETING		
	The next meeting of the equality and engagement committee will be held on Thursday 3 December 2020 in meeting room 1 Hillder House or via Microsoft Teams.		

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
EEC 20/12/01	HOUSEKEEPING / APOLOGIES		
	The Chairman informed everyone present of the etiquette for Microsoft Teams meetings. Apologies were received as above.		
EEC 20/12/02	QUORACY		
	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	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	<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"> The daughter of the head of governance and assurance employed by Health Education England. 		
	<p>Agreed Action:</p> <ul style="list-style-type: none"> The head of governance and assurance to ensure that Dr Saxena is removed from the DOI report. 	RW	31.12.2020
EEC 20/12/04	MINUTES OF THE PREVIOUS MEETING HELD ON 13 AUGUST 2020		
	<p>The minutes of the meeting held on 13 August 2020 were adopted and verified as a correct record of the proceedings by members present.</p>		
EEC 20/12/05	MATTERS ARISING REPORT		
	<p>The committee noted the actions from the 13 August 2020 meeting, one action remained open:</p> <p>EEC 19/11/07 Barnsley Service Users Forum The head of communications and engagement to discuss the role of an independent chair of the forums with BMBC colleagues.</p> <p>Update 13.08.2020: The last meeting was held as we went into lockdown and this committee was paused during this time.</p> <p>Update 03.12.2020: Groups have started to meet again ad hoc.</p>		
	<p>Agreed Action:</p> <ul style="list-style-type: none"> The head of communications and engagement will check to see if this item can be closed. 	KW	31.12.2020
PATIENT AND PUBLIC ENGAGEMENT			
EEC 20/12/06	ENGAGEMENT REPORT		
	<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>Agreed Actions:</p> <ul style="list-style-type: none"> 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. 	EB	31.01.2021
EEC 20/12/07	SURVEILLANCE REPORTING		
	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>NHS OVERSIGHT FRAMEWORK PATIENT & COMMUNITY ENDGAGEMENT INDICATOR</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 & 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>MINUTES OF THE PATIENT COUNCIL MEETINGS HELD ON 30 SEPTEMBER 2020 & 28 OCTOBER 2020</p>		
	<p>Patient Council minutes shared for information highlighting the following:</p> <p>30 September 2020 - Care homes and primary care realignment. 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>28 October 2020 - Intermediate Care 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 & 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>		
QUALITY GOVERNANCE			
EEC 20/12/10	CCG RISK REGISTER AND ASSURANCE FRAMEWORK		
	<p>The head of governance & 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>Governing Body Assurance Framework (GBAF). 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 & 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>Risk Register 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"> • 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. • 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. 		

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>EEC 20/12/11</p>	<p>HR POLICIES</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"> • Employment Break Policy • Managing Concerns with Performance Policy • Recruitment and Selection Policy <p>Summary of Proposed Changes</p> <p>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"> • 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. • Addition to section 2.8.8 as a reminder to employees of the need to confirm resignation in writing during an employment break. • 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. <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"> • How to identifying poor or diminishing performance, as well as possible reasons for diminishing performance. • Clarification around the purpose and the running order of a formal performance review meeting • Section 8 added to policy following manager feedback in order to address how concerns can be managed when they are reported via other 		

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	<p>colleagues.</p> <ul style="list-style-type: none"> • 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. • Text explaining the purpose and suggested running order of the formal review meeting added to Section 10.1. <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"> • Section 8 condensed and moved to section 10 to reflect best practice and accurately reflect process, as described in the Organisational Change Policy. • Section 11 deleted and incorporated in section 10 of the policy. • Additional text in Section 13 clarifies the process / options for line managers should an applicant request different T&C's to those which we advertised e.g. reduced hours. • Statement with regards to 'Declarations of Interest' included in section 14. • Update to Appendix 1 following changes to the process for applicants with regards to work permits. • Update to Appendix 3 to reflect the process now followed with regards to Criminal Convictions self-declaration forms / DBS checks. <p>Next Steps Once the changes are approved by the Committee the policies will be updated, placed on the CCG's external website and the changes notified to staff via the weekly communication update.</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</p>		

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	be presented to the governing body in January 2021 for sign off.		
EQUALITY			
EEC 20/12/12	EQUALITY OBJECTIVES AND ACTION PLAN 2019-2021		
	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.		
EEC 20/12/13	WORKFORCE RACE EQUALITY STANDARDS ACTION PLAN		
	<p>The committee signed off the Workforce Race Equality Standard (WRES) report at the 13 August 2020 Equality & 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>		

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	<p>Conversations have taken place during Black History month and at staff briefings re racial inequalities and have been 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>		
	<p>Action Agreed</p> <ul style="list-style-type: none"> Action to check if the WRES action plan is fit for purpose and to ask staff for solutions to the actions. Discuss at senior management team if we should undertake a pulse survey in relation to inequalities, in particular for the BAME community. 	<p>KW/ CBB</p> <p>RW</p>	<p>31.12.2020</p> <p>31.12.2020</p>
<p>EEC 20/12/14</p>	<p>NHS PEOPLE PLAN ACTIONS</p>		
	<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 & inclusion lead to ensure</p>		

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	actions are brought together.		
	<p>Agreed Actions:</p> <ul style="list-style-type: none"> • The interim NHS People Plan to be brought back to the February 2021 committee. • 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 & wellbeing are brought together in the HR Plan. 	<p>CBB</p> <p>ES/ CBB</p>	<p>31.01.2021</p> <p>31.01.2021</p>
EEC 20/12/15	HEALTH INEQUALITIES OF COVID-19 IN BARNESLEY		
	<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>		
GENERAL			
EEC 20/12/16	REVIEW OF EQUALITY & ENGAGEMENT COMMITTEE TERMS OF REFERENCE		
	<p>The head of governance & 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>		

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	<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 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>		
EEC 20/08/17	ANY OTHER BUSINESS		
	<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>https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf</p>		
EEC 20/08/18	ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT		
	<p>Committee members agreed to highlight the following areas:</p> <ul style="list-style-type: none"> • NHS Oversight Framework Patient and Community Engagement Indicator Green Star rating. • Actions for the NHS People Plan being taken forward. 		
EEC 20/08/19	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED		
	<p>The Chair thanked members for their input, good quality and content of papers and a good meeting. Committee</p>		

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	members feel assured by the ongoing activities in relation to equality and engagement and no training needs were identified.		
EEC 20/08/20	DATE AND TIME OF THE NEXT MEETING		
	The next meeting of the equality and engagement committee will be held on Thursday 18 February 2021 at 3pm via Microsoft Teams.		

UNADOPTED