NHS Barnsley Clinical Commissioning Group Primary Care Commissioning Committee will be held on Thursday 29 September 2016 at 1pm in the Boardroom, Hillder House 49/51 Gawber Road, Barnsley, S75 2PY

AGENDA
(Public Session)

Item	Session	Committee Requested to	Enclosure Lead	Time
1.	Apologies	Note	Chris Millington	1.00 pm
2.	Quorum			
3.	Questions from the public relevant to the agenda		Chris Millington	1.05 pm 5 mins
4.	Declarations of Interest, Gifts, Sponsorship and Hospitality	Note	**PCCC 16/09/04** Chris Millington	1.10 pm 5 mins
5.	Minutes of the meeting held on 25 August 2016	Approve	**PCCC 16/09/05** Chris Millington	1.15 pm 5 mins
6.	Matters Arising Report	Approve	**PCCC 16/09/06** Chris Millington	1.20 pm 5 mins
	Strategy & Planning			
7.	GP 5 Year Forward View	Information	**PCCC 16/09/07** Lesley Smith	1.25 pm 10 mins
8.	Accountable Care Update	Information	**PCCC 16/09/08** Lesley Smith	1.35 pm 10 mins
	Quality and Patient Safety in Primary Medical Services			
9.	No items			
	Finance, Governance and Performance			
10.	Integrated Urgent Care (inc Out of Hours)	Decide	**PCCC 16/09/10** Richard Walker	1.45 pm 20 mins
11.	Risk and Governance Report	Approve	**PCCC 16/09/11** Richard Walker	2.05 pm 5 mins
	Committee Reports and Minutes			
12.	No items			
	Other			
13.	Questions from the public relevant to the agenda			2.10 pm
14.	**Date and Time of the Next Meeting:** The next meeting of the Primary Care Commissioning Committee will be held at 1.00pm on Thursday 29 December 2016 in the Boardroom, Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY.	Information		close

Exclusion of the Public:

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

NHS
Barnsley Clinical Commissioning Group
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PRIMARY CARE COMMISSIONING COMMITTEE

29 September 2016

Declaration of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	x	*Information*	
2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Vicky Peverelle	Chief of Corporate Affairs
	Author	Lynne Richards	Governance, Assurance and Engagement Facilitator
3.	**EXECUTIVE SUMMARY**		
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. This report is to provide the Primary Care Commissioning Committee with all members' declarations of interest. Appendix 1 to this report details all Committee members' current declared interests for members to update and to enable the Chair and members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. Members should also declare if they have received any Gifts, Hospitality or Sponsorship.		
4.	**THE COMMITTEE IS ASKED TO:**		
	• Note the contents of this report and declare if members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship.		
5.	**APPENDICES**		
	• Appendix A – *Committee Members Declaration of Interest Report*		

Agenda time allocation for report:	*5 minutes.*

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:	2.1 and 5.2.
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	
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*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
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*

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REGISTER OF INTERESTS

NHS Barnsley Clinical Commissioning Group

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Groups constitution and the Clinical Commissioning Groups 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 regularly (at no more than 3-monthly intervals)

Register: Primary Care Commissioning Committee

GOVERNING BODY		
Name	**Position**	**Details of interest**
Nick Balac	Chair of Barnsley Clinical Commissioning Group	• Partner at St Georges Medical Practice (PMS) • Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract • Member Royal College General Practitioners • Member of the British Medical

GOVERNING BODY		
Name	**Position**	**Details of interest**
		Association • Member Medical Protection Society • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Mehrban Ghani	Medical Director for Barnsley Clinical Commissioning Group	• GP Partner at White Rose Medical Practice, Cudworth, Barnsley • GP Appraiser for NHS England • Directorship at SAAG Ltd, 15 Newham Road, Rotherham • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Madhavi Guntamukkala	GP Member Barnsley Clinical Commissioning Group	• GP partner at The Grove Medical Practice

GOVERNING BODY		
Name	**Position**	**Details of interest**
		• Member of British Medical Association and member of Royal College of General Practitioners • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Chris Millington	Lay Member, Barnsley Clinical Commissioning Group	• Partner Governor Barnsley Hospital NHS Foundation Trust
Lesley Smith	Chief Officer, Barnsley Clinical Commissioning Group	• Husband is Director of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients. • Board Member (Trustee), St Anne's Community Services, Leeds • Member of the Regional Leadership Council (RLC), Yorkshire and Humber Leadership Academy, Health Education England

GOVERNING BODY		
Name	**Position**	**Details of interest**

		• Chair, South Yorkshire Cancer Strategy Group
		• Chief Officer lead, Working Together
		  ○ Living With and Beyond Cancer Programme (in conjunction with McMillan Cancer Support)
		  ○ CVD Stroke
		• Chair, Working Together, Programme Executive Group

Brian Roebuck	Lay Member, Barnsley Clinical Commissioning Group	• No Declaration of Interest Form received as at 16 September 2016
Mike Simms	Secondary Care Clinician, Barnsley Clinical Commissioning Group	• No interests to declare
Richard Walker	Head of Assurance	• No interests to declare •

Minutes of the Meeting of the BARNSLEY CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE held on Thursday 25 August 2016 at 3pm in the Boardroom, Hillder House, 49 – 51 Gawber Road S75 2PY.

MEMBERS PRESENT:

Mr Chris Millington (in the chair)	Lay Member
Mrs Lesley Smith	Chief Officer
Dr M Guntamukkala	Governing Body member
Mrs Vicky Peverelle	Chief of Corporate Affairs
Dr Nick Balac	CCG Chairman
Dr Mehrban Ghani	Medical Director

IN ATTENDANCE:

Mr Garry Charlesworth	NHS England Primary Care Manager
Ms Lynne Richards	Governance Assurance and Engagement Facilitator
Ms Doriann Bailey	Interim Head of Quality for Primary Care
Mr George Dipe	Finance Manager

APOLOGIES:

Ms Carrianne Stones	Healthwatch Barnsley Manager
Ms Julia Burrows	Director of Public Health
Mr Brian Roebuck	Lay Member
Mr Nick Balac	CCG Chairman

MEMBERS OF THE PUBLIC:

Mr James Logan	Barnsley Healthcare Federation
Mr James Barker	Barnsley Healthcare Federation
Mrs Margaret Sheard	Member of the public
Mr Philip Watson	Member of the public

Agenda Item	Note	Action	Deadline
PCCC 16/08/01	**QUORUM**		
	It was advised that the Committee would be quorate on the arrival of the Chief Officer.		
PCCC 16/08/02	**QUESTIONS FROM THE PUBLIC RELEVANT TO THE AGENDA**		
	There were not any questions received from members of the public at this point in the meeting.		

Agenda Item	Note	Action	Deadline
PCCC 16/08/03	**DECLARATIONS OF INTEREST GIFTS, HOSPITALITY AND SPONSORSHIP**		
	The Committee noted the Declarations of Interest Report. The Medical Director highlighted that he was now a GP Appraiser for NHS England and it was agreed to add this to the Register of Interests. The Chair reminded members that should they feel that they have a conflict of interest at any point in the meeting they should raise it at that time. The Chief Officer joined the meeting at this point.	**LR**	
PCCC 16/08/04	**MINUTES OF THE MEETING HELD ON 29 JUNE 2016**		
	The minutes of the previous meeting were approved as a true record of the proceedings.		
PCCC 16/08/05	**MATTERS ARISING REPORT**		
	The Committee noted that all items on the Matters Arising Report were marked as complete.		
QUALITY AND PATIENT SAFETY IN PRIMARY MEDICAL SERVICES			
PCCC 16/08/06	**CARE HOMES UPDATE**		
	The Committee were informed that further to the Primary Care Event held in June 2016, the CCG was currently looking at different models to ensure Care Home patients were receiving the best primary care service and to ensure equitable distribution of Care Home patients across Barnsley GP Practices. It was advised that a questionnaire had been sent out to practices and Care Homes which would be feed into the review.		
	A member of the public queried if all Care Homes patients would be included in this work and if the CCG were looking to share patients fairly between GP Practices. The Interim Head of Quality for Primary Care advised that it was 46 Care Homes for the elderly which were being reviewed and that the CCG were looking at the numbers of Care Homes patients to ensure patients		

Agenda Item	Note	Action	Deadline
	were equally distributed through-out Barnsley practices as to not destabilise practices. A member of the public queried how many Care Homes had been visited as part of the review. The Interim Head of Quality for Primary Care advised that she had not visited the Care Homes but was working with Kate Anderson-Bratt from the Local Authority. It was further advised that GP's who regularly visited these Care Homes were on the Primary Care Working Group which was progressing the Care Homes Review.		
	Ms Margaret Sheard advised that she was still trying to obtain findings from a pilot involving matrons in Care Homes. It was advised that the CCG were unable to obtain the final report from this pilot however, the findings around the Medicines Management aspect in Care Homes was currently being taken forward by the CCG'S Medicines Optimisation Team.		
	The Committee thanked the Interim Head of Quality for Primary Care for the update and it was agreed that for future meetings, where possible, the Committee would provide papers in advance of the meeting and not verbal reports.		
FINANCE, GOVERNANCE AND PERFORMANCE			
PCCC 16/08/07	**FINANCE UPDATE**		
	The Committee noted that at month 4 the forecast position was in line with budgets at £34.6m. However, the year to date actual variance was currently reporting a £235.4k underspend (2%). The underspend related to rent, rates, locum costs and prescribing and are currently being reviewed to determine if this position will continue.		
PCCC 16/08/08	**RISK REGISTER AND ASSURANCE FRAMEWORK**		
	The Chief of Corporate Affairs presented the Risk Register extract which detailed the risks that the Primary Care Commissioning Committee was responsible for.		
	Agreed Actions: • **The Chief of Corporate Affairs advised that a full update on the risk relating to the 0 – 19**	**VP**	

Agenda Item	Note	Action	Deadline
	Pathway re-procurement would be obtained from Public Health in advance of the next meeting. • **It was also agreed to remove Risk Reference CCG 14/14 relating the telephony issues at Goldthorpe Medical Centre as no issues had been reported since October 2016.**	**VP**	
OTHER			
PCCC 16/08/09	**QUESTIONS FROM THE PUBLIC RELEVANT TO THE AGENDA**		
	There were not any questions received from members of the public at this point in the meeting.		
PCCC 16/08/10	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Primary Care Commissioning Committee will be held on 29 September 2016 at 3pm in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY.		

MATTERS ARISING REPORT TO THE PRIMARY CARE COMMISSIONING COMMITTEE

29 September 2016

1. MATTERS ARISING

The table below provides an update on actions arising from the meeting of the Primary Care Commissioning Committee held on 25 August 2016.

Minute ref	Issue	Action	Outcome/Action
PCCC 16/06/03	**DECLARATIONS OF INTEREST GIFTS, HOSPITALITY AND SPONSORSHIP** The Medical Director highlighted that he was now a GP Appraiser for NHS England and it was agreed to add this to the Register of Interests.	**LR**	COMPLETE
PCCC 16/08/08	**RISK REGISTER AND ASSURANCE FRAMEWORK** The Chief of Corporate Affairs advised that a full update on the risk relating to the 0 – 19 Pathway re-procurement would be obtained from Public Health in advance of the next meeting. It was also agreed to remove Risk Reference CCG 14/14 relating the telephony issues at Goldthorpe Medical Centre as no issues had been reported since October 2016.	**VP** **VP**	Emailed Julia Burrows on 16 September 2016 for an update. Risk Register updated via Q&PSC. Roxanna Naylor is working with the Council to pick up the transfer of funding from SWYPFT to BMBC to pay for the LIFT accommodation used by the 0-19 service. COMPLETE

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PRIMARY CARE COMMISSIONING COMMITTEE

29 September 2016

GP Forward View Transformation Plan

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Lesley Smith	Chief Officer
Author	Jamie Wike	Head of Planning, Delivery and Performance

3.	**EXECUTIVE SUMMARY**
	The General Practice Forward View was published in April 2016 setting out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice. As part of the development of Sustainability and Transformation Plan and Local Place Based Plans, local areas have been requested to develop local plans in response to the GP Forward View. A copy of the draft plan is attached at appendix 1 for information and comment.
4.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• Note the contents of the Draft GP Forward View Transformation Plan and provide any comments or feedback to inform finalisation of the Plan.
5.	**APPENDICES**
	Appendix 1 – Draft GP Forward View Transformation Plan

Agenda time allocation for report:	*10 Minutes*

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:	1.1, 1.3, 1.4, 2.1, 2.2
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
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?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*NA*
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*

Barnsley CCG - Delivering the GPFV – Transformation Plan

Area of plan	Description
Vision A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View	**Background and Vision** NHS Barnsley Clinical Commissioning Group in conjunction with its member practices has been pursuing an ambitious 5 year strategy for the further development of Primary Care in Barnsley. This commenced in 2015 with a vision that over the next five years our goal would be to realise a wider model of out of hospital primary care in which patients and the public in Barnsley receive: • support to manage long term conditions; • fast, responsive access to services; • proactive and coordinated care; • holistic and person centred care; • consistently high quality care; resulting in, • Improved health outcomes. Our vision is a future in which the current model of primary care is allowed to deliver its full potential. It is for an integrated wider primary and community care offer, which is comprehensive and serving the full range of need found in the community, while doing more to reduce inequalities faced by Barnsley people and ensure parity of esteem for mental health care and support. It goes beyond medicine, reaching into communities and supporting people to live well long before they need healthcare. The pillars of the 2015-2020 BCCG Primary Care Strategy were:- • Estates • Workforce • Information Technology • Delivering Primary Care at Scale This strategy obviously predated the GP Forward View (GPFV) published in April 2016 but does directly correlate with the focus within this strategy document where the key focus areas are; investment, workforce, workload infrastructure and care redesign. Considerable progress has been made under the four pillars described and further initiatives are planned, this document will detail our progress to date whilst also outlining the future refreshed initiatives to both strengthen primary care and offer a more comprehensive out of hospital offer that fully aligns with the national strategy outlined in the GPFV. **Workforce** In Barnsley in order to stabilise recurrent investment streams into primary care practices and encourage all practices to commit to local commissioned services that move services out of the acute hospital setting, the concept of a

Practice Delivery Agreement was co-produced by the clinical commissioning group and its member practices in order to:-

- Invest in the primary care infrastructure to deliver high quality equitable services for the registered population of Barnsley as close to home as possible
- Support primary care sustainability through a longer-term investment profile
- Deliver a targeted approach to the demographic health challenges on a Barnsley footprint and on a local practice basis
- Build a mutually accountable relationship that is centred on improving health outcomes in Barnsley

This recurrent investment enabled practices to employ additional staff and pilot new roles – examples included care navigation, therapy staff and alternative care home models.

Other workforce initiatives have included

- The industrialisation of Health Care Assistants through a locally commissioned Apprenticeship Programme – that will particularly focus on; care navigation and the year of care initiative to improve support for patients with long term conditions. This initiative will also support changes in roles currently undertaken in practice to improve alignment of the existing skill base ensuring the right people are delivering the right care interventions.

- A locally commissioned clinical pharmacist programme that will deliver on a number of fronts including; delivery of new care models reducing GP workload delivering medication reviews, minor ailments and other locally agreed patient consultations. Separately this skilled resource will be used to deliver the Right Care Atlas (RCA) prescribing efficiency opportunities; the plan in Barnsley is ambitious with a full year effect of circa £8 million.

Plans for the future include:-

The introduction of GP Fellowships, Nurse Fellowships, HCA's, extended training for reception staff to take on Care Navigation roles, whilst separately increasing the number of vocational training posts and the number of practices supporting these posts. Barnsley's ambition is to move to 100% of practices involved in GP training through partnership and locality working.

Separately a work force summit has been scheduled during October 2016 involving stakeholders from HEE, the Deanery, NHSE the CCG, BHF, the LMC and wider practice teams. This event will focus on exploring further workforce developments and new roles that will further enhance our current plans.

Workload Plans

Barnsley CCG has a thriving Federation, Barnsley Health Care Federation (BHF) – the CCG is currently working in partnership with both BHF and the Local Medical Committee (LMC) in order to develop a local scheme to support struggling practices. The CCG and partners are coproducing "The Practice Doctor" - this initiative will provide a combination of local expertise and private

providers to wrap a support package around practices who are finding it difficult. A business case will be submitted to access the funding available through the General Practice Resilience Programme whilst separately BHF are exploring a back office function offer to its member practices.

The CCG has also submitted a case to the Estates and Technology Transformation Fund (ETTF) to provide a full programme of Productive Primary Care across all practices; this initiative will increase both the efficiency and effectiveness of practices and will be delivered in partnership with practices improving demand management.

In order to improve the impact of workload associated with Care Home residents the CCG is currently working up proposals to deliver increased collaboration and alignment between practices and Care Homes.

Workload associated with deprivation is being addressed in a number of ways; Barnsley has a local incentive scheme Health Inequalities Targeted Scheme (HITS) that targets differential investment to address areas of the borough with greatest health needs. The Clinical Pharmacists and GP Fellowship schemes have been designed to allocate resources on the basis of the multiple indices of deprivation.

Infrastructure

As part of the overarching STP development in South Yorkshire and Bassetlaw, integration will be essential to deliver the out of hospital ambition. In Barnsley we are working collectively with healthcare providers, the local authority and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development. This includes working with other commissioners, healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties through the use of all available commissioning levers.

Primary Care premises needed to be assessed for their fitness for purpose, both in terms of delivery of core primary care, and potential to deliver more out-of-hospital services. Finite resources available for capital developments in future mean that we will have to maximise use of existing buildings, with new builds being approved only when all existing resources have been exhausted. A whole system review of current premises stock, including space utilisation and fitness for purpose for the short, medium and longer term was required.

In Barnsley we commissioned a comprehensive review of the premises used for the delivery of primary care by general practices. The service specification required the undertaking of a six facet survey as well as assessing the Care Quality Commission Outcome 10 in all GP surgery premises.

This review informed estates investment priorities. The CCG invested in the minor work programmes required to meet statutory requirements locally with an investment commitment of £500,000. The information gleaned also supported the development of a local place based Estates Strategy and plans for capital investments via the ETTF to support the improvement of the Primary Care Estate in Barnsley.

Barnsley CCG has submitted 7 Schemes for ETTF funding, three of which

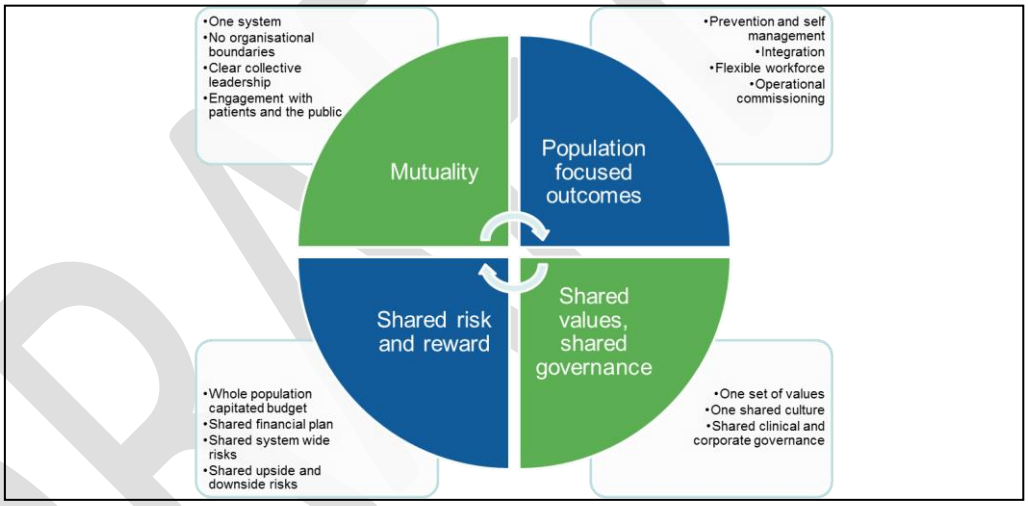
	were premises schemes linked to future housing developments across the borough, in addition a new build practice is currently being delivered in the town centre from previous NHSE capital funding. The other schemes submitted link to both workload and care redesign. These initiatives were; a mobile working information technology bid, the development of a third hub for extended GP access, project support for the development of Barnsley's Accountable Care Organisation and full costs to deliver Productive Primary Care across all GP practices. **Care Redesign** Barnsley CCG as described herein has already commenced an ambitious plan to deliver integrated ways of working to deliver both efficiencies as well as reducing the care quality gap. The plan is supported by a number of key building blocks that are already in place these include:- • A well-developed Community Interest Company -GP Federation with 80% of the practices as members • A well-developed plan to deliver an Accountable Care Organisation • A successful extended GP access programme running from 2 hubs, with plans to develop a third and further increase appointments on evenings and at weekends The CCG is currently working with all system partners on an alliance arrangement to deliver integrated urgent care.
Investment in primary care The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally. Including: 1. High level modelling that provides evidence of: - the shift of activity from hospital to out of hospital care - total spend trajectories for the shift to primary care 2. Clarity on the resource shift so the STP can be clear on the new	Barnsley CCG opted for first wave fully delegated Primary Care Co – Commissioning in view of the following financial context: the CCG's 2015/16 programme allocation was above target (9%); whilst, in stark contrast, Barnsley was the only area in South Yorkshire to be below target in terms of primary care expenditure (5%). Co-commissioning offered the CCG a unique and timely opportunity to redress this position through access to an element of its £9.6 million brought-forward surplus to pump-prime investment in primary, community and intermediate care, to deliver the CCG's strategy whilst also reducing secondary care expenditure to sustainable levels within a combined future financial allocation. The CCG has invested circa £4million per year on the Practice Delivery agreement (PDA) and the associated locally commissioned services from the programme allocation to start to redress this funding imbalance. Separately the CCG has invested in services to wrap around primary care, this includes, RightCare Barnsley – our brokerage service, enhancing the intermediate care provision and is currently procuring a full social prescribing service. The £4 Million local investment in primary care was enhanced by the successful Prime Ministers Challenge Fund bid/pilot that brought a further £2.6 million to Barnsley to increase access to primary care on evenings and at weekends. The investment plan to strengthen and expand primary and community care to support the overarching out of hospital strategy will be financed through the delivery of a number of commissioning for value schemes – identified as a

out of hospital /primary care expenditure plan – per capita shift to primary care and total spend reflecting the direction of travel for increased investment in primary care. 3. The CCG's proposed on-going investment plans and timescales for making this investment in-line with delivery of the service offer above (including where CCGs require access to supporting additional non-recurrent transformation resources)?	consequence of the Right Care analysis opportunities. Details of the per capita shift to primary care are provided below. Insert financial template JW/RN Insert 2 year timescales in line with planning guidance
Support and grow the primary care workforce A baseline assessment of workload, demand and supply side numbers. A plan to: - develop initiatives to attract and retain GPs and other practice staff, and - develop expanded multi-disciplinary primary care teams?	As at September 2015 the HSCIC Workforce Census showed Barnsley CCGs position to be as follows Showing GPs per 100,000 population as 54 compared to an England average of 65+ Current plans to grow workforce per annum are as follows;- • HCA Apprenticeship Programme (Plan 40wte) • Clinical Pharmacists (Plan 15wte) • GP Fellowship (Plan 6) • Nurse Fellowship increase student placements (Plan xx)

Staff Group	WTE in Post
General Practitioners	137
All Nurses	67
All Direct Patient Care	48
All Admin Non Clinical	281

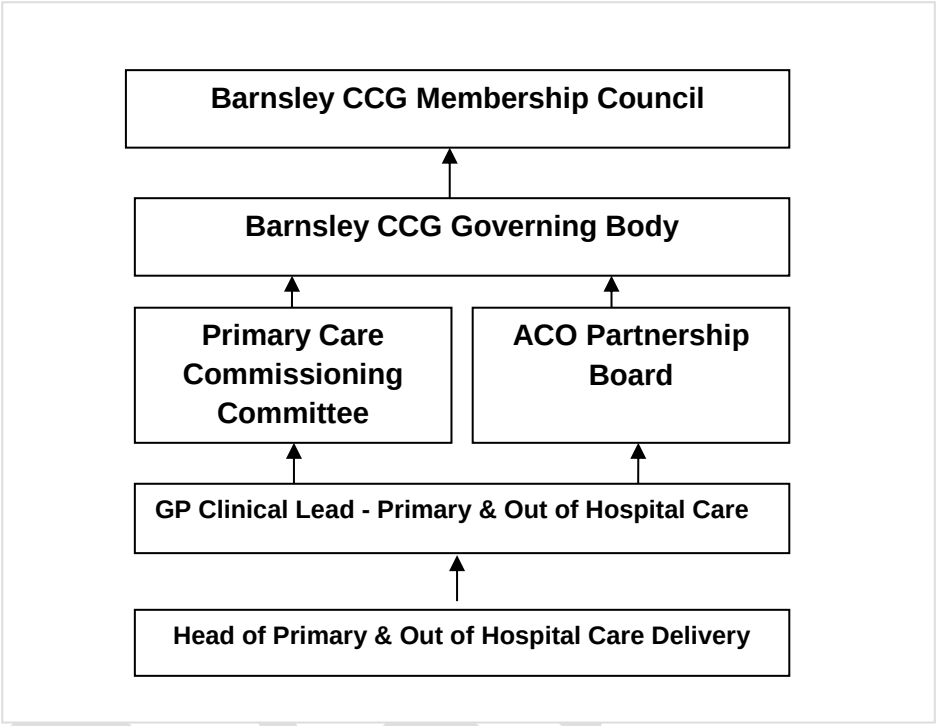
Improve access to general practice in and out of hours	
A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices	Base line assessment 35 practices providing 10.5 Core GP hours per day = 1,837.5 per week Extended hours = 129.5 per week
A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020	We currently have an GP extended access pilot which is run by BHF under an APMS contract (Iheart)– we intend to continue this scheme in the current 2 hubs and have plans to develop a third hub. Extended access will deliver 30 mins additional appointments per 1000 population per week (125 hours) The IHeart service will provide face to face appointments from 6pm-10pm Monday to Friday with day time administration, appointment allocation and Advanced Nurse Practitioner Triage and signposting. Cover at weekends will increase to deliver 6 hrs each day (10am-4pm) Plan included – BHF to Provide
A description of how wider primary care (dental, optometry, community pharmacy) will contribute to this plan	Building on learnings from PMCF and Vanguards the CCG plans to align the provision of dental, pharmacy, and eye care services with 7 day medical services and re-profiling urgent care pathways and out of hour's contracts.
A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111.	The CCG is currently in the process of working with our local system providers, IHeart, CareUK, RightCare Barnsley, SWYPFT, BHFT and 111 to fully integrate the place based urgent and emergency care offer to align with national standards.
Transform the way technology is deployed and infrastructure utilised	Core and mandated GP IT services are provided by eMBED through a national contract. Barnsley CCG also purchase some locally targeted enhanced Primary Care IT focusing on extended support desk opening hours to support our practices. Transformational Primary Care IT is delivered through a combination of means including through Estates and Technology Transformation Funding bids for example mobile working; the local Digital Roadmap and locally commissioned investments into primary care IT transformation for example the Medical
A map of current estates and	

technology initiatives A plan to deliver the requirements set out in the GP IT Operating Model 2016/18 A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care. Confirmation that primary care requirements have been included in Local Digital Roadmaps	Interoperability Gateway. The LDR is a system wide plan and reflects the interoperability needs to deliver an accessible digital record through system integration with a number of step changes along the roadmap. General connectivity and system infrastructure is reflected within the LDR, as is the need to develop mobile working, as shared with us by both the GP Federation and our GP IT Clinical Leads. Due to the timing of the release of the Primary Care Maturity Assessment information and submission of the LDR, the needs for digital maturity development has not yet been reflected in detail within the LDR. In addition, the CCG is working across the STP footprint to develop a digital work stream which encompasses the delivery of LDRs over the STP footprint and increased roll out of assistive and wearable technologies to ensure that we can work towards STP level interoperability to help improve the delivery of patient care across our broader footprint.
Better manage workload and redesign how care is provided A plan to improve the capacity in general practice through redesign (eg LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)	A detailed has been developed setting out the CCG response to the 'Releasing Time for Care' – 10 high Impact Actions Plan re BHF – Back office function Productive Primary Care Implementation – reduce DNAs Increasing Health literacy through universal access to information and advice empowering and supporting patients to better understand and self-manage their health conditions, leading to a step change in patient activation. Video consultations and email appointments have been piloted and will be rolled out to IHeart and other practices PC Workforce Strategy Right Care Barnsley – Brokerage Service Social Prescribing Service to commence April 2017
Organisational Form A description of the current organisational form of general practice within the CCG The ambition for primary care at scale underpinned by a delivery plan	A description of the current organisational form of General Practice within the CCG Barnsley CCG has 35 practices – 28 Practices are members of a federation – Barnsley Healthcare Federation. The ambition for Primary Care at scale is underpinned by a delivery plan for an MCP model and ACO development. Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one 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 regardless of where patients are seen; be that in hospital, in the community or

A description of how the "future state" is linked to the wider strategy for integrated out of hospital care	at home. They won't experience gaps in care; they are not isolated but supported and empowered by what feels like "one team", each delivering their part without duplication. As a result over the last six months the commissioning and provider partners in Barnsley have come together as an accountable care partnership to consider how we can develop a local model of care which achieves the objectives outlined above. Discussions have focused on how emerging "new models of care"; those that are being piloted nationally would support us in Barnsley. Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of the Borough where inequalities are greatest. Accountable Care in Barnsley could bring together commissioning and provision of local Barnsley health and care services, The partners have held a workshop to determine what would work differently and the diagram below outlines the principles on which the ACO must be built.  The partnership has also agreed a direction of travel for the establishment of an out of hospital focused Multispecialty Community Provider (MCP), centred around primary care. The scope and underpinning model of care is yet to be agreed, but current thinking is that the scope should include much of community health care, enhanced primary care services and also possibly elements of social care if this is agreed with BMBC. Key elements of the model of care are likely to include: • The centrality of primary care and clinical leadership • The establishment of Multi-Disciplinary Teams to deliver integrated care for the people of Barnsley – working to ACO principles (as above) • Self-care and prevention • Risk stratification • RightCare principles • Integrated care records • Innovation and new technologies • Neighbourhood/locality hubs **Locality Alignment** - The CCG will be working with member practices to develop a locality alignment model developing the concept of

	"Neighbourhoods" – this model will facilitate resources to be wrapped around groups of practices and create a focus for outreaching services and delivering primary care at scale in "Neighbour Hubs". The initial development of this new model will be focussed on the Community Nursing Review and revised resourcing, the alignment of the 0-19 resources and improved working with care home patients.
Engagement A description of the CCG is engaging local primary care professionals (GPs, dentists, pharmacists, optometrists) and the local population and patients in the development and delivery of the Transformation Plan.	The CCG will be working with local primary care stakeholders via its core engagement channels: CCG clinical leadership, Governing Body Development Sessions, Membership Council, Practice Manager's Forum, LPC, and LMC as well as with the local GP federation. In addition specific co-production sessions and activities will take place to look at individual workstreams. Combined with the above, patient and public involvement plans are in place as part of the engagement work to support the Sustainability and Transformation Plan, the local Barnsley Plan. These engagement activities are supported by a partnership across the local and regional health and care system. This partnership means that there is cohesiveness and consistency of messages and avoids involvement fatigue. Public and patient activities and networks in place include: Barnsley Patient Council, the Service User and Carer Board, Practice Patient Reference Groups, public events/workshops, Patient Procurement Panels, community engagement via Love Where You Live teams, local Ward Alliances/Area Council, Barnsley Community Voluntary Network, Barnsley Equality Forum and Barnsley Reach. Involving people early and at a formative stage is key and this will drive our engagement approach.
Risks and Mitigation A description of the key risks and mitigation -	**Risk** **GP Recruitment & Primary Care Work Force** If the Barnsley area continues to experience a lack of GPs in comparison with the national average, due to GP retirements, inability to recruit etc. there is a risk that: (a) Some practices may not be viable, (b) Take up of LES / DES or other initiatives could be inconsistent (c) The people of Barnsley will receive poorer quality healthcare services (d) Patient's services could be further away from their home.
	Mitigation The CCG's Primary Care Development Programme has a workforce workstream. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students The CCG continues to invest in primary care capacity. • The PDA enables practices to invest in the sustainability of their workforce. The innovation Fund saw £0.25m invested in developing new, more efficient and flexible ways of working. • The successful PMCF has enabled additional capacity to be made available outside normal hours via the I heart Barnsley Hubs • The CCG is also creating 6 GP fellowships in partnership. • The CCG has recruited and has plans for further recruitment to support the employment of 40 Health Care Assistants. • The CCG has recruited 15 clinical pharmacists to help take some of the

	pressure of primary care.
Practice Engagement If the CCG fails to secure Practice Manager engagement there is a risk that the Primary Care development project will fail to deliver transformation. (e.g. that investment in new diagnostic equipment will not deliver the intended benefits).	CCG Involvement with Practice Manager meetings to facilitate engagement and deliver transformation Work continues with Practice Managers: the Chair of the Practice Manager Group has been included in the membership of the Primary Care Development Workstream.
Provider ownership of Accountable Care Organisation (ACO) development If the CCG fails to secure system wide ownership of the development of the ACO there is a risk that this programme will fail to deliver transformation.	An Accountable Care Partnership Board has been developed and the organisational development of the ACO is being co-produced with all provider partners.
ETTF Funding for Productive Primary Care If the CCG's bids for ETTF funding are not successful there is a risk that planned investments primary care estates and technology to support transformation in primary care capacity and efficiency will not be affordable.	Robust bids have been co-developed by the CCG and GP Practices and submitted in accordance with NHSE deadlines and processes. Should the bids not be successful the CCG will need to reprioritise and / or seek alternative sources of funding to ensure the planned improvements to primary care estates and technology are progressed.

Governance A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.	The CCG has agreed this submission with its's member practices and the content included herein will form the basis of the CCGs Primary Care Commissioning intensions for 2017-2019 The Committee structures than will ensure delivery of the plan have been included in diagrammatic form below. 

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

29 September 2016

Building Accountable Care in Barnsley

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Lesley Smith	Chief Officer
Author	Richard Walker	Head of Governance & Assurance

3. EXECUTIVE SUMMARY

Background

Barnsley CCG has an ambitious strategy to integrate the delivery of health and care for the people of Barnsley. This ambition is supported by our commissioning partners in Barnsley Metropolitan Borough Council and our provider partners in BHNFT and SWYPFT and by the Barnsley Healthcare Federation.

Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one 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 regardless of where patients are seen; be that in hospital, in the community or at home. They won't experience gaps in care; they are not isolated but 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, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of the Borough where inequalities are greatest.

Progress to date

As a result over the last six months the commissioning and provider partners in Barnsley have come together as an *accountable care partnership* to consider how we can develop a local model of care which achieves the objectives outlined above. Discussions have focused on how emerging "new models of care"; those that are being piloted nationally would support us in Barnsley.

At the same time we have also been playing our part in developing the Sustainability and Transformation Plan for South Yorkshire and Bassetlaw. This is leading towards new forms of governance across the wider South Yorkshire and Bassetlaw patch. The acute hospitals are increasingly working together in a clinical network or vanguard and commissioners have formed a "joint" commissioning committee which will enable us to commission collectively and at scale, from the provider network in the future.

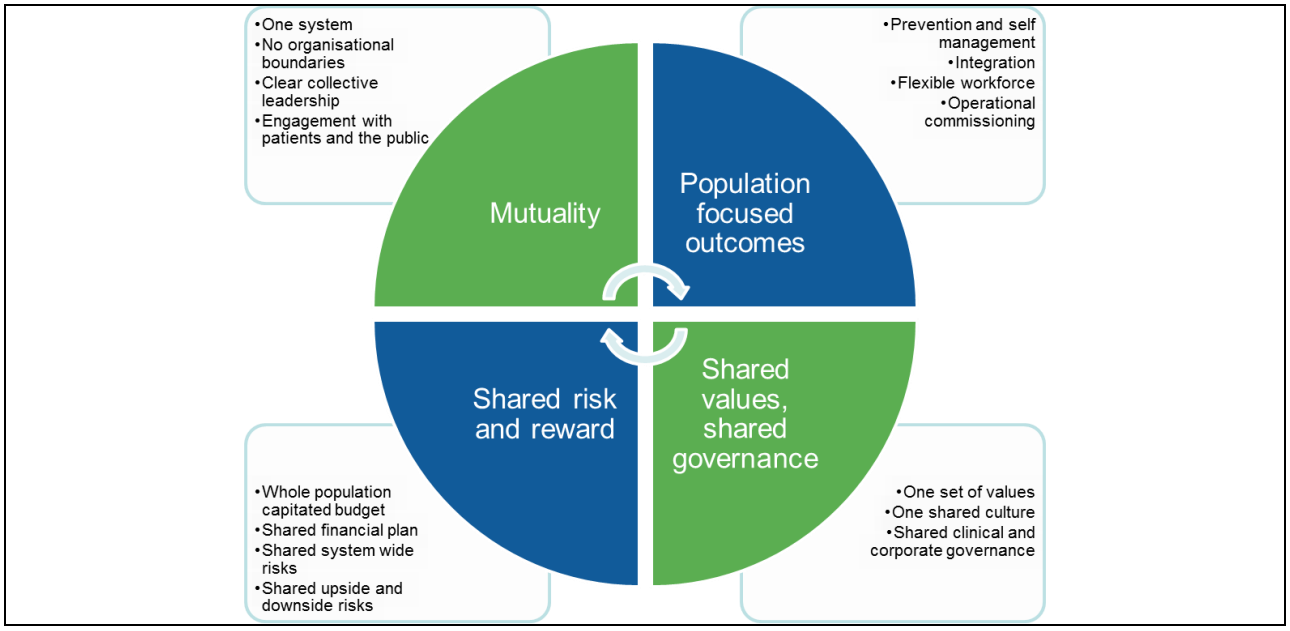
The way forward

These developments are moving at pace and this leaves us with the need to consider what is the out of hospital model of care that would work best for Barnsley in the future? What is becoming increasingly apparent is that joined up health and care for Barnsley is likely to be created by integrating some of our existing commissioning and provider functions, bringing together into one organisation (an Accountable Care Organisation) aspects of commissioning with the management of service delivery.

The Accountable Care Organisation in Barnsley could bring together commissioning and provision of local Barnsley health and care services, that take place or could potentially take place out of a hospital setting. The ACO would therefore bring together 2 elements:

- CCG tactical commissioning (Health needs assessment, service redesign, service planning, quality assurance and performance monitoring); with,
- Service delivery; bringing together primary and community health and care into an integrated provider model.

The partners have held a workshop to determine what would work differently and the diagram below outlines the principles on which the ACO must be built.



As a result the partnership has also agreed a direction of travel for the establishment of an out of hospital focused Multispecialty Community Provider (MCP), centred around primary care. The scope and underpinning model of care is yet to be agreed, but current thinking is that the scope should include much of community health care, enhanced primary care services and also possibly elements of social care if this is agreed with BMBC. Key elements of the model of care are likely to include:

- The centrality of primary care and clinical leadership
- The establishment of Multi-Disciplinary Teams to deliver integrated care for the people of Barnsley – working to ACO principles (as above)
- Self-care and prevention
- Risk stratification
- RightCare principles
- Integrated care records
- Innovation and new technologies
- Neighbourhood/locality hubs

An initial system wide model of care event was held on the 8th September at the Priory Campus, attended by a wide range of health and care front line managers and staff from across our partner organisations. The purpose of the event was to determine what benefits to patients and citizens could be unlocked by working together in an Accountable Care Organisation. This started the process for developing the case for change and was an excellent opportunity for engagement on the ACO with staff and partners from across the health and care economy. Future engagement events will be held on the direction of travel for Barnsley including the development of a new model of care.

What does this mean for the CCG and Commissioning?

Central to the development of an ACO is the development of a "CCG Light", with strategic commissioning and a small number of other functions remaining in the CCG Light and with tactical commissioning staff being separated as above and becoming part of an ACO. This is in tune with South Yorkshire and Bassetlaw wide developments, with the establishment of a joint CCG committee expected to be decided in October, bringing together the local CCGs to make STP wide commissioning decisions.

The decision to proceed with the development of CCG Light, which will include the identification of tactical commissioning functions which would form part of the ACO, lies entirely in the hands of the CCG. Initial legal and national advice indicates that creation of a CCG Light is possible, although there are clearly a number of issues that will need to be carefully worked through. Amongst these are:

- How clinical leadership will continue to function and how primary care clinical leadership can retain its role in the new ACO
- Options on how governance arrangements can be developed and protected ensuring that the clinical leadership provided currently by the CCG will continue to be central
- Which CCG statutory duties can be delegated and which cannot (and on which there is clear emerging national guidance)
- Engagement with staff to ensure that recruitment and retention is not de-stabilised
- Whether the CCG Light should work in a more integrated way with BMBC on joint strategic commissioning.

Pursuing the development of CCG Light has two main advantages:

- The development remains in the hands of the CCG in terms of form and function
- It would act as a genuine catalyst for change with our partners, signalling strongly that the CCG is serious about change and the development of an ACO.

4.	**THE COMMITTEE IS ASKED TO:**
	• Note the direction of travel set out in this report
5.	**APPENDICES**
	• None

Agenda time allocation for report:	*10 minutes.*

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:	1.1, 2.1, 2.2, 3.1, 4.2
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
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?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*Yes*
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*

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

29 September 2016

Integrated Urgent Care

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Richard Walker	Head of Governance and Assurance
Author	Jamie Wike Patrick Otway	Head of Planning, Delivery and Performance Head of Commissioning (Mental Health, Children's and Specialised)

3.	**EXECUTIVE SUMMARY**
	It was agreed at the Governing Body meeting on 8 September 2016 to delegate the procurement route decision for Integrated Urgent Care Services, including Primary Medical Out of Hours Services to the Primary Care Commissioning Committee in order to manage any potential conflicts of interest. The purpose of this paper is therefore to provide the context in relation to Integrated Urgent Care, describe the current services and the proposed approach to developing an integrated service and to seek approval from the committee for the proposed procurement route.
4.	**THE COMMITTEE IS ASKED TO:**
	• Note the details of the report and approve the proposed procurement route to develop Integrated Urgent Care Access, Treatment and Clinical Advice Services including Out of Hours Service GP services
5.	**APPENDICES**
	• None

Agenda time allocation for report:	*10 minutes.*

PART 1B – SUPPORTING INFORMATION

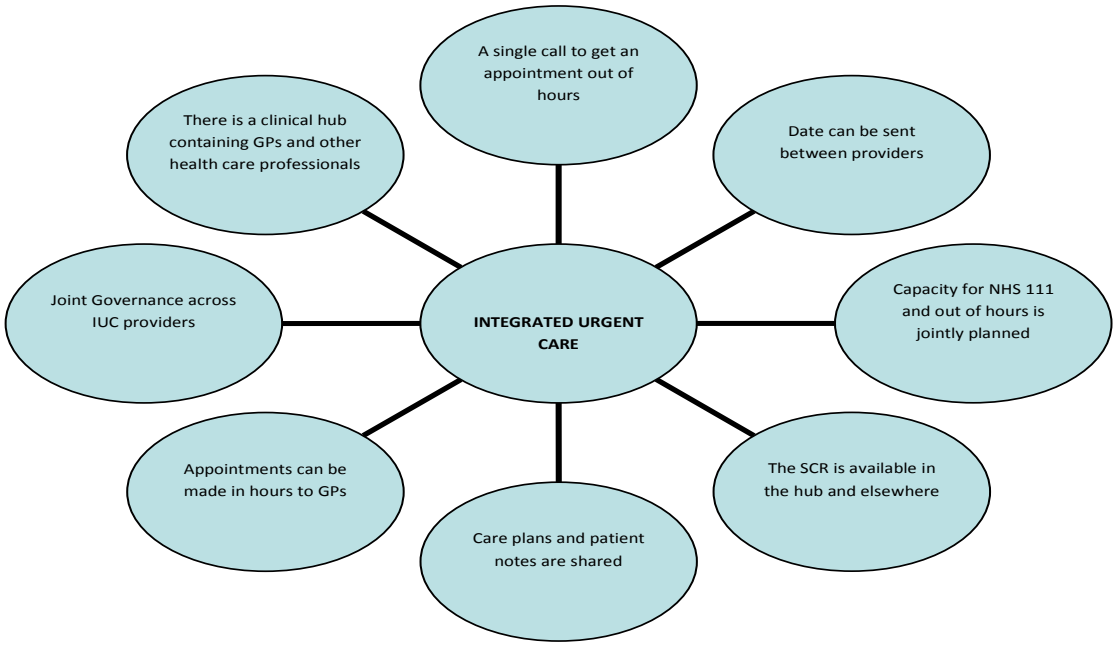
1.	**Links to the Governing Body Assurance Framework**	**Risk ref(s)**
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	1.1, 1.2, 1.3, 2.1, 2.2, 4.1, 5.1
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
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?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*N/A*
	Is actual or proposed engagement activity set out in the report?	*Yes*
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
1.1	In July 2015 NHS England wrote to all CCG's setting out the emerging requirements from the National Urgent and Emergency Care Review in relation to commissioning a 'Functionally Integrated Urgent Care Access, Treatment and Clinical Advice Service and fundamentally redesigning the NHS urgent care 'front door' including A&E, GP's, 999, NHS111, Primary Medical Care Out of Hours, community services and social services.
1.2	The letter also requested that any procurement of NHS 111 and OOH services should be suspended (whatever stage of procurement had been reached) until the publication of revised commissioning standards in September 2015.
1.3	At this time the CCG had recently commenced an engagement process and were planning to undertake a procurement exercise for the Primary Medical Care Out of Hours Service. The contact was due to end in June 2016. This process was therefore put on hold and the current contract extended for a further year. The contract now runs to July 2017.
1.4	In September 2015, the Commissioning Standards for Integrated Urgent Care were published by NHS England setting out a vision for a more closely integrated urgent care service which builds upon the success of NHS 111 in simplifying access for patients and increasing the confidence that patient, local commissioners and the public have in the services.
1.5	The Commissioning Standards recognise that to deliver the vision and bring together the wide range of service and service providers, there will need to be more collaborative approaches to commissioning which involve all providers working together. It is suggested that commissioners should consider using the process to encourage current provider organisations to collaborate or work together to deliver the standards for an Integrated Urgent Care Service.
1.6	The current service configurations, standards and requirements have been discussed with Governing Body members along with potential options for procurement and it was agreed to delegate the procurement route decision for the Out of Hours Service to the Primary Care Commissioning Committee in order to manage any potential conflicts of interest.
1.7	The purpose of this paper is therefore to provide the context in relation to Integrated Urgent Care, describe the current services and the proposed approach to developing an integrated service and to seek approval from the committee for the proposed procurement route.
2.	**DISCUSSION/ISSUES**
2.1	The current health services in Barnsley and or available for Barnsley patients which are integral to developing an effective integrated urgent care access, treatment and advice service are: • Primary Medical Care in Hours and Out of Hours • GP Extended Hours (IHEART)

- NHS 111
- Ambulance Service
- Emergency Departments (and other Hospital Departments)
- Community Services

2.2 In order to deliver real change and move towards a more integrated approach to service delivery, the CCG will need to work with local providers to meet the key requirements of the commissioning standards. These are shown in the diagram below.



2.3 The services involved are all currently subject to different contract arrangements, with different contract periods, different commissioning arrangements and different types of contract. The Primary Medical Care Out of Hours Service contract expires in July 2017 and therefore it is important to agree the proposed procurement route now in order to ensure a robust process is followed. The GP Access Fund, extended hours service currently has funding in place until March 2017, subject to meeting national requirements, and therefore consideration also needs to be given to commissioning of extended hours services post March to ensure they integrate with and work in collaboration with other providers to meet the national standards. Hospital and Community Services contracts and annually reviewed and utilise the NHS standard contract. Ambulance and NHS 111 contracts are managed through a lead commissioner arrangement and contracts cover a wider geographical footprint than Barnsley.

2.4 The CCG have 2 broad options for procurement, these being:

- A full procurement of all services to drive integration, or
- A managed change process (transparent co-production) with existing providers working together and engaging patients and the public to drive the transformation and the integration required.

2.5	The proposed approach is to undertake a managed change process to work with current providers to develop integrated urgent care services and take a joint, collaborative approach to move towards delivering joined up services where practical on a local basis and to implement locally the changes and requirements arising from regional and national developments including those arising from the National Urgent and Emergency Care Review and the South Yorkshire and Bassetlaw Urgent and Emergency Care Network.
2.6	It is felt that this approach will ensure that local services are not destabilised whilst the change and transformation to more integrated services takes part and that better outcomes for patients can be delivered from working together in a collaborative way to build on what are already good services which meet the standards required for example the National Quality Requirements for Out of Hours Services.
2.5	In relation to the procurement of public sector services there are two key documents that the CCG must consider when deciding the most appropriate route. These are the NHS Monitor (now NHS Improvement) document, 'Procurement, Patient Choice and Competition Regulations (2014) and The European Union Procurement Directives implemented into UK law by The Public Contracts Regulations 2015.
2.6	There is no default process that commissioners should use to secure services, and so commissioners need to make a balanced judgment depending on local circumstances. What is relevant will depend on those circumstances, but may include, for example, existing provider performance or ensuring service sustainability by delivering care in a more integrated way. The CCG therefore needs to balance the short-term and long-term impact of their commissioning decisions (including the potential impact of any procurement decision on the sustainability of services).
2.7	The NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 (PPCCR) [IRG35/13 of 2013], explicitly states that:- *"Some models for integrated care may involve the creation of an "integrated pathway" for all or a number of services that a patient requires. This might be structured in a number of different ways. For example, a commissioner may procure an integrated pathway from a single provider responsible for delivering all aspects of the patient's care, or it might appoint a "lead" or "prime" provider that is responsible for delivering some of the services itself and arranging for other providers to provide the remaining services, or it might commission services from an "alliance" of providers that will work together to provide different elements of the patient's care. The extent to which these models are likely to deliver better integrated care and their impact on competition and choice will need to be considered by the commissioner on a case-by-case basis".*
2.8	Clinical services fall under the 'light touch' element of the EU Directive which gives the CCG a much greater flexibility in how services are developed, the fundamental test being to ensure that whatever route is chosen (i.e. competitive tender or developing an alliance model etc) is in the best interest of the Barnsley population. To develop an integrated, local, urgent care service/network via a managed change process therefore adheres to the

	principles outlined in key public procurement documents.
3.	**IMPLICATIONS**
3.1	**Financial implications** There are no direct financial implications as a result of decisions relating to this paper and the proposed procurement route. There may be financial implications arising for the service redesign and transformation work but if that is the case these will be subject to further papers to the Governing Body.
3.2	**Consultation & Engagement** Consultation and engagement will be an integral part of the commissioning and procurement process regardless of the procurement decision and a full consultation and engagement plan will be developed. An initial stakeholder event for current providers of urgent and emergency care and patient representatives was held on 23 September 2016 to begin to explore the opportunities for developing locally integrated services. The proposed approach is to undertake an open and transparent managed change process, co-producing the service specifications and requirements with providers, patients, members of the public and other key stakeholders.
3.3	**Equality & Diversity** An Equality Impact Assessment will be undertaken
3.4	**Information Governance** Information governance, particularly in relation to data sharing and sharing of patient records, will be considered as part of the overall process.
3.5	**Procurement Issues** Procurement advice has been sought on the options available. Information regarding procurement advice and legislation is included in sections 2.5 to 2.8
4.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
4.1	There are no specific risks to the CCG as a result of this paper, however it will be important to recognise the procurement advice and seek further advice and guidance throughout the process if the proposed option is agreed to ensure the CCG decision making remains in line with procurement legislation.
5.	**APPENDICES TO THE REPORT**
	None
6.	**CONCLUSION**
	The proposed procurement route for delivering Integrated Urgent Care Services in Barnsley has been described in the paper and therefore the Committee is asked to: • Note the details of the report and approve the proposed procurement

	route to develop Integrated Urgent Care Access, Treatment and Clinical Advice Services including Out of Hours Service GP services.

Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

29 SEPTEMBER 2016

RISK AND GOVERNANCE REPORT

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Richard Walker	Head of Governance & Assurance
Author	Richard Walker	Head of Governance & Assurance

3. EXECUTIVE SUMMARY

Risk Register and Assurance Framework

In common with all committees of the CCG, the Primary Care Commissioning Committee receives and reviews at every meeting extracts of the Governing Body Assurance Framework (GBAF) and Corporate Risk Register providing details of the risks allocated to the Committee for monitoring and updating. There are currently no risks on the GBAF allocated to the PCCC.

The Risk Register is an important governance document that facilitates the effective management of the CCG's strategic and operational risks. The Risk Register is a repository of current risks to the organisation, including risk ratings and the controls in place to mitigate the risk. There are currently seven risks on the Corporate Risk Register allocated to the PCCC which the Committee are responsible for managing (Appendix 1). Members are asked to review that all of the risks detailed on Appendix 1 are being appropriately managed and scored.

Members are asked to note that, as decided at the last meeting of this Committee and subsequently approved by the Governing Body, Risk Reference CCG 14/14 - *If the problems with telephony in the Goldthorpe LIFT building are not resolved there is a risk that Barnsley patients may be unable to access services and / or that the safety of patients will be compromised* has been removed from the Risk Register.

	Primary Care Commissioning Committee Terms of Reference At its meeting in September 2016 the Governing Body approved a number of changes to this Committees Terms of Reference, so that those changes took effect in advance of this meeting taking place. The amended Terms of Reference are Appended to this report. The Committee is asked to note the changes which were: • Replace the Chief of Corporate Affairs with the Head of Governance & Assurance in light of the Chief of Corporate Affairs' recent departure • Elected representatives on the Committee to become non-voting clinical advisors rather than full voting members in accordance with recent *Statutory Guidance on the Management of Conflicts of Interest* • Inclusion of the Governing Body Secondary Care Clinician in the Committee's membership • Inclusion of the Head of Delivery Integrated Primary and Out of Hospital Care among the regular attendees • Amendments to the sections on voting and quorum to reflect these changes. Subsequent to the above, in order to ensure and demonstrate full compliance with the *Statutory Guidance on the Management of Conflicts of Interest,* the CCG is considering appointing a third Lay Member who would become a Member (and Vice Chair) of the Primary Care Commissioning Committee. The Head of Governance & Assurance will draft appropriate further revisions to the revised Terms of Reference as required.
4.	**THE COMMITTEE IS ASKED TO:**
	Review the Risk Register attached and: • Consider whether the risks identified are appropriately described and scored • Consider whether there are other risks which need to be included. Note the amended Terms of Reference, and note that further changes may be required to reflect the possible appointment of a third Lay Member to the Committee's membership.
5.	**APPENDICES**
	• Appendix 1 – Risk Register • Appendix 2 – Amended Terms of Reference

Agenda time allocation for report:	10 mins

PCCC 16/09/11

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:	All
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
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?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*NA*
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*

PCC RISK REGISTER –September 2016

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)	6	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	26	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	12	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	2	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

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

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
15/14(b)	4	In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that there will be a negative impact on primary care workforce and capacity.	4	4	**16**	As for risk 15/14(a) Monitoring at practice level delivery of 0-19 KPIs in relation to practice contracts, utilizing identified escalation routes when core service KPIs are not delivered in real time.	MG (Primary Care Commissioning Committee)	Governing Body	4	4	**16**	08/16	**August 2016** BMBC and SWYPFT are working through the transitional arrangements to move this service to BMBC **March 2016** BMBC, SWYPFT and the CCG are continuing to discuss the optimum solutions to deliver high quality services for this patient group. **February 2016**	09/16

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													The CCG is still in discussions with the Council through our Chair, Chief Officer and Chief Nurse to establish how we can ensure that the service we have will be the best for people of Barnsley.	
CCG 15/02		If there is not an adequate response to the CQC reports in respect of those practices deemed to be inadequate, there is a risk that when they are re-inspected the practices will not meet the requirements potentially leading to poor quality or unsafe services; reputational damage to the CCG; and the practices involved not maintaining their registration.	**3**	**3**	**9**	The CCG has provided resources and support to the affected practices to ensure robust action plans were provided to CQC in accordance with their required timescales. The Head of Quality for Primary Care Commissioning will continue to work with the practices as they work to deliver the necessary improvements. Practice visits have been undertaken to all GP practices who have not yet had a CQC inspection. This has provided an opportunity	JH (Primary Care Commissioning Committee)	CQC reviews	**3**	**3**	**9**	08/16	**August 2016** All practices have now been inspected the CCG has supported the 5 practices where issues were highlighted **June 2016** The two practices that were in special measures following the inspection visit in Nov/Dec 2014 are now out of special measures. One	11/16

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
						to share best practice and to help practices put systems and processes in place to meet the regulations. An information matrix on what contributes “good” and” outstanding” practice has been developed and shared with all practices. CQC is a main agenda item at the practice manager forum.								scoring good in all domains the other sill requires improvement in three of the domains. A further practice has been put into special measures and support has been given by the CCG. The majority of practices have now been inspected by the CQC. The CQC will be inspecting the practices that have merged by the end of the year. Two practice have scored requires improvement in there safety domain **January 2016** The CQC re inspected the two practices in Special Measures	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													during November 2015 - one practice is now out of special measures and graded good in all 5 domains. The report is awaited from CQC regarding the second practice. The CQC met with the CCG in December 2015 and information has been shared re data packs which are collated prior to the practice being inspected . This information will be discussed at the next Membership Council in January 2016. The CQC now meets with the CCG on a quarterly basis.	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 15/03		If the CCG does not effectively discharge its delegated responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.	**3**	**4**	**12**	The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement. The CCG will seek to integrate Area team resources to ensure that the role is carried out consistently with the CCG's culture & approach. The CCG is also undertaking a review of management capacity which will incorporate proposed delegated responsibilities. The CCG has an open channel of communication with the Membership Council regarding commissioning and contracting arrangements (eg equalisation).	JH (Primary Care Commissioning Committee)	Risk Assessment	2	4	**8**	09/16	**September 2016** All controls and working arrangements are being followed to manage this residual risk. **March 2016** All controls and working arrangements are being followed to manage this residual risk. **January 2016** All controls and working arrangements are being followed to manage this residual risk.	12/16
CCG 15/04		If the CCG is unable to secure sufficient operational & strategic capacity to fulfil the delegated functions this may impact on the ability of the CCG to deliver its existing	**3**	**5**	**15**	CCG considered its strategic capacity & capability as part of the successful application process. The CCG has access to existing primary care commissioning resource	RW (Primary Care Commissioning Committee)	Risk Assessment	**2**	**3**	**6**	08/16	**August 2016** The CCGs delegated functions are being managing through CCG capacity in	02/17

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
		delegated statutory duties, for instance in relation to quality, financial resources and public participation.				within the Area Team under the RASCI agreement. In addition the CCG is recruiting a Head of Quality for Commissioning Primary Medical Services. The CCG is undertaking a review of management capacity including delegated responsibilities.							conjunction with support from NHSE **January 2016** BCCG is managing its delegated functions through internal resource and links to central NHSE expertise.	
CCG 15/05	1, 3, 8	If the CCG does not comply in a fully transparent way with the statutory Conflicts of Interest guidance issued in December 2014 there is a risk of reputational damage to the CCG and of legal challenge to the procurement decisions taken.	**3**	**3**	**9**	Conflicts of Interest Policy updated. Register of Interests extended to incorporate GP practice staff. Declarations of interest to be tabled at start of every meeting to enable updating. PCCC has Lay Chair and Lay & Exec majority. Register of Procurement decisions to be established to record how any conflicts have been managed.	RW (Primary Care Commissioning Committee)	Risk Assessment	**2**	**3**	**6**	08/16	**August 2016** New COI guidance received the CCG are currently working through the implications of this guidance and ensure full compliance is achieved. **June 2016** 360 Assurance reviewed arrangements and provided assurance that the CCG were	02/17

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
						Guidance to be provided to minute takers on recording decisions re managing conflicts of interest.							complying with conflicts of interest guidance in practice. **March 2016** Q4 Self - Assessment declaration and PCCC Annual Assurance Report to be approved and submitted as at 31.03.16. **January 2016** Quarterly Declarations completed and audited by the CCGs internal audit function.	
CCG 16/02		If GP Practices opt to cease provision under their Primary Medical Services Contract there is a risk that the CCG could not source appropriate provision of services in all localities in Barnsley.	2	4	**8**	Impact could be mitigated by local provision e.g. BHF APMS Contracts allow increased diversity of provision.	JH (Primary Care Commissioning Committee)		1	4	**4**	09/16	**September 2016** Individual contract are monitored through the Primary Care Commissioning Committee's Contractual Issues Report.	03/17

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													July 2016 Proposed new risk. Requires Scoring	
CCG 15/06		There is a risk that if the CCG does not effectively engage with the public, member practices and other stakeholders on matters relating to the delegated commissioning of primary care (including redesign of service delivery), the CCG's reputation with its key stakeholders could therefore be affected.	**2**	**3**	**6**	The CCG has a well-established and effective PPE function currently commissioned from CSU, as well as robust governance supporting the function. Arrangements going forward are being reviewed. The existing primary care commissioning resource and expertise within the Area Team can be accessed by the CCG. The CCG considered its strategic capacity & capability as part of the successful application process.	JR (Primary Care Commissioning Committee)	Risk Assessment	1	3	**3**	08/16	**August 2016** The CCG continues to hold practice engagement events with practices the last one being at the end of June **June 2016** Estates issues resolved, the CCG has a practice Engagement event scheduled for 30th June 2016	08/17

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Primary Care Commissioning Committee

Terms of Reference

~~April~~ September 2016

Terms of Reference – NHS Barnsley CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Barnsley CCG. The delegation is set out in Schedule1.

3. The CCG has established the NHS Barnsley CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
    - NHS Barnsley CCG;
    - Healthwatch Barnsley (non-voting attendee);
    - Barnsley Metropolitan Borough Council (non-voting attendee).

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

   a) Management of conflicts of interest (section 14O);

   b) Duty to promote the NHS Constitution (section 14P);

   c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

   d) Duty as to improvement in quality of services (section 14R);

   e) Duty in relation to quality of primary medical services (section 14S);

   f) Duties as to reducing inequalities (section 14T);

   g) Duty to promote the involvement of each patient (section 14U);

   h) Duty as to patient choice (section 14V);

   i) Duty as to promoting integration (section 14Z1);

   j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

   - Duty to have regard to impact on services in certain areas (section 13O);
   - Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the Governing Body of NHS Barnsley CCG in accordance with Schedule 1A of the “NHS Act”.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Barnsley, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Barnsley CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. The specific obligations of the CCG with respect to the delegated functions are set out in section 6 and schedule 2 of the Delegation Agreement and include:

a) Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contract including:
- the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach / remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Local incentive schemes as an alternative to the national Quality Outcomes Framework (QOF) (including the design of such schemes);
- 'Discretionary' payments (e.g., returner/retainer schemes);
- Commissioning urgent care for out of area registered patients.

b) Planning the primary medical services provider landscape in Barnsley, including considering and taking decisions in relation to:
- The establishment of new GP practices (including branch surgeries) in the area, and the closure of GP Practices;
- Approving practice mergers;
- Managing GP practices providing inadequate standards of patient care;
- The procurement of new Primary Medical Services Contracts;
- Dispersing the lists of GP practices;
- Agreeing variations to the boundaries of GP practices; and
- Co-ordinating and carrying out the process of list cleansing in relation to GP practices.

c) Decisions in relation to the management of poorly performing GP Practices including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

d) Decisions in relation to the Premises Costs Directions Functions.

16. The CCG will also carry out the following activities:

a) Planning the Commissioning of Primary Medical Services, including:

- carrying out needs assessments for primary medical care services in Barnsley;
- recommending and implementing changes to meet any unmet primary medical services needs; and
- undertaking regular reviews of primary medical care needs and services in Barnsley.

b) Co-ordinate a common approach to the commissioning of primary care services generally;

c) Manage the delegated allocation for commissioning of primary medical care services in Barnsley

d) Obtain and provide to the Governing Body assurance regarding the quality and safety of primary medical care services in Barnsley (this function to be exercised through the Quality and Patient Safety Committee).

17. The Primary Care Development Workstream will review operational contractual issues impacting on primary care delivery; however decision making will remain the responsibility of the Primary Care Commissioning Committee.

Geographical Coverage

18. The Committee will comprise the NHS Barnsley CCG.

Membership

19. The Committee shall consist of:

Lay / Executive Members:

- Lay Member for Patient and Public Engagement and Primary Care Commissioning (Chair)
- Governing Body Secondary Care Clinician (Vice Chair)
- Lay Member for Governance ~~(Vice Chair)~~
- Chief Officer
- ~~Chief of Corporate Affairs~~
- Head of Governance and Assurance

Elected Practice Representatives (Non-Voting Clinical Advisors):

- Chair of the Governing Body
- Medical Director
- One other elected member of the Governing Body

(The list of members is included as Schedule 3).

20. In addition to the people stated above the Head of Delivery Integrated Primary and Out of Hospital Care , a representative of Healthwatch Barnsley, a Local Authority representative of the Health and Wellbeing Board, and other attendees (as necessary) will be invited to attend meetings and participate in the decision making discussions of the Primary Care Commissioning Committee in a non-voting capacity.

21. The Chair of the Committee shall be the Lay Member for Patient and Public Engagement and Primary Care Commissioning. The holder of this post is appointed for a period of 3 years under a process overseen by the Remuneration Committee in accordance with best guidance.

22. The Vice Chair of the Committee shall be the ~~Lay Member for Governance~~ Governing Body Secondary Care Clinician. The holder of this post is appointed for a period of 3 years under a process overseen by the Remuneration Committee in accordance with best guidance.

23. There will be a standing invitation to a HealthWatch Barnsley representative and a Local Authority representative of the Health and Wellbeing Board to attend the Committee as non-voting attendees.

Meetings and Voting

24. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

25. Each voting member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of voting members present, but with the Chair or Vice Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

26. No meeting of the Committee shall be held without a minimum of ~~four~~ three members present (excluding non-voting Clinical Advisors and attendees), including either the Chair or Vice Chair~~, and provided that the Elected Practice Representatives are not in a majority~~. The Committee may call on additional lay members or CCG members when required, for example where the Committee would not be quorate because of conflicts of interest.

25. An Officer in attendance but without formal acting up status may not count towards the quorum.

Urgent decisions

26. Where urgent decisions are required to be made outside Committee meetings. including where decisions must be taken in accordance with externally-driven timescales, t~~T~~hese can be made by a minimum of two voting members of the Committee, including at least one of the Primary C~~c~~are Commissioning Committee Chair and the Chief Officer~~, Either the CCG Chair or the Medical Director will be consulted unless they are prevented from participating as a result of declared conflicts of interest~~. Decisions taken under these provisions will be reported back to the next meeting of the Committee for ratification.

Administration

27. Secretarial support for the Committee will be provided by the CCG's administration function, overseen by the ~~Chief of Corporate Affairs~~ Head of Governance and Assurance.

Frequency and conduct of meetings

28. The Committee will meet at least quarterly with more frequent meetings if required~~on a bi-monthly basis and more frequently as required~~, either by circumstances, the Governing Body or the Committee.

29. Meetings of the Committee shall:

a) be held in public, subject to the application of 29(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

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

31. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

32. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

33. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Confidentiality Code of Conduct.

34. The Committee will present its minutes to NHS England (North) area team of NHS England ~~each month~~ after each meeting for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 30 above. An ~~monthly~~ assurance report will be presented to the Governing Body of the CCG after each meeting.

35. The CCG will also comply with any reporting requirements set out in its constitution.

36. These Terms of Reference will be reviewed annually, reflecting the experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Accountability of the Committee

37. The Committee will make collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee will manage the delegated allocation for commissioning of primary care services in Barnsley.

38. The Committee will operate in such a way as to ensure appropriate consultation and engagement takes place with members of the public. For example:
    - The Committee will be Chaired by the Lay Member for Patient and Public Engagement
    - It will be attended by a representative of Healthwatch Barnsley
    - Meetings will be held in public (subject to the application of paragraph 28(b) above)
    - The minutes of every meeting will be made publicly available on the website of NHS Barnsley CCG except where those minutes record Committee business conducted in private.

Procurement of Agreed Services

39. The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement. In doing so the CCG will comply with public procurement regulations and with statutory guidance on conflicts of interest.

Decisions

40. The Committee will make decisions within the bounds of its remit.

41. The decisions of the Committee shall be binding on NHS England and NHS Barnsley CCG.

42. The Committee will produce an executive summary report which will be presented to NHS England (North) area team of NHS England and the governing body of NHS Barnsley CCG at least quarterly for information.

43. As soon as practicable after the end of each Financial Year the CCG must provide to NHS England a report on how the CCG has exercised the Delegated Functions during the previous Financial Year.

Schedule 1 – Delegation

The CCG and NHS England signed the Delegation Agreement on 26 March 2015. The Agreement became effective on 1 April 2015. The Agreement sets out the arrangements that apply in relation to the exercise of the Delegated Functions by the CCG.

Schedule 2 – Delegated functions

NHS England has delegated to NHS Barnsley CCG the following functions relating to the commissioning of primary medical services under section 83 of the NHS Act:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

Schedule 3 - List of Members Lay / executive members:

- Lay Member for Patient and Public Engagement and Primary Care Commissioning (Chair)
- Governing Body Secondary Care Clinician (Vice Chair)
- Lay Member for Governance ~~(Vice Chair)~~
- Chief Officer
- ~~Chief of Corporate Affairs~~
- Head of Governance and Assurance

Elected Governing Body members (Non-voting Clinical Advisors) :

- Chair of the Governing Body
- Medical Director
- One other elected member of the Governing Body

In addition to the people stated above, a representative of Healthwatch Barnsley, a Local Authority representative of the Health and Wellbeing Board, and other attendees (as necessary) will be invited to attend meetings and participate in the decision making discussions of the Primary Care Commissioning Committee in a non-voting capacity.