NHS Barnsley Clinical Commissioning Group Primary Care Commissioning Committee will be held on Thursday 23 March 2017 at 1.00pm in the Boardroom, Hillder House 49/51 Gawber Road, Barnsley, S75 2PY

PUBLIC AGENDA

Item	Session	Committee Requested to	Enclosure Lead	Time
1.	Apologies	Note	Chris Millington	1.00 pm
2.	Quoracy			
3.	Questions from the public relevant to the agenda			1.00 pm 5 mins
4.	Declarations of Interest relevant to the agenda	Note	**PCCC 17/03/04** Chris Millington	1.05 pm 5 mins
5.	Minutes of the meeting held on 22 December 2016	Approve	**PCCC 17/03/05** Chris Millington	1.10 pm 5 mins
6.	Matters Arising Report	Approve	**PCCC 17/03/06** Chris Millington	1.15 pm 5 mins
	Strategy & Planning			
7.	Initiatives to support General Practice	Information	**PCCC 17/03/07** Jackie Holdich	1.20 pm 5 mins
	Quality and Patient Safety in Primary Medical Services			
8.	High Level CQC Report	Information	**PCCC 17/03/08** Jackie Holdich	1.25 pm 5 mins
	Contracting, investment, and procurement			
9.	No items			
	Finance, Governance and Performance			
10.	Finance Quarterly Update Report	Note	**PCCC 17/03/10** Roxanna Naylor	1.30 pm 10 mins
11.	Outcome of 2017/18 GMS Contract Negotiations	Information	**PCCC 17/03/11** Jackie Holdich	1.40 pm 5 mins
12.	Risk and Governance Exception Report	Approval & Assurance	**PCCC 17/03/12** Richard Walker	1.45 pm 5 mins
	Other			
13.	Any other business			1.50 pm 5 mins
14.	Items for escalating to the Governing Body Assurance Report			1.55 pm 5 mins

15.	**Date and time of the next meeting:** Thursday 29 June 2017 at 3.00pm in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley, S75 2PY.			2.00 pm Close

Exclusion of the Public:

The CCG Primary Care Commissioning Committee 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

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PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

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	Richard Walker	Head of Governance & Assurance
Author	Fran Wickham	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. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. The table below details what interests must be declared:

Type	Description
Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

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.

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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NHS Barnsley Clinical Commissioning Group Register of Interests

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning 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

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	• Partner at St Georges Medical Practice (PMS) • Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract • Member Royal College General Practitioners • Member of the British Medical 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	• 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

Name	Current position (s) held in the CCG	Declared Interest
Madhavi Guntamukkala	GP Governing Body Member	• GP partner at The Grove Medical Practice • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Chris Millington	Lay Member	• Partner Governor Barnsley Hospital NHS Foundation Trust
Brian Roebuck	Lay Member	• Lay Member for the Governing Body of NHS Leeds South & East CCG. There is a potential risk that the interest of the organisation might conflict with the interests of Barnsley CCG.
Mike Simms	Secondary Care Clinician	No interests to declare
Lesley Smith	Governing Body Member	• Husband is Director/Owner of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients potentially including the NHS. • Board Member (Trustee), St Anne's Community Services, Leeds • Member of the Regional Leadership Council (RLC), Yorkshire and Humber Leadership Academy, Health Education England • 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

Name	Current position (s) held in the CCG	Declared Interest
Jamie Wike	Head of Planning, Delivery and Performance	NIL
Richard Walker	Head of Governance & Assurance	NIL
Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)	• Husband is a Senior Lecturer at Huddersfield University; undertakes Medical and Nursing research, teaches non - medical prescribing and is a Diabetes Specialist Nurse.

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Minutes of the Meeting of the Barnsley Clinical Commissioning Group PRIMARY CARE COMMISSIONING COMMITTEE held on Thursday 22 December 2016 at 1.00pm in the Boardroom, Hillder House, 49 – 51 Gawber Road S75 2PY.

MEMBERS PRESENT:

Mr Chris Millington (in the chair)	Lay Member
Mr Mike Simms	Secondary Care Clinician
Dr Nick Balac	CCG Chairman
Mr Richard Walker	Head of Governance and Assurance
Ms Lesley Smith	Chief Officer

IN ATTENDANCE:

Mr Garry Charlesworth	NHS England Primary Care Manager
Ms Lynne Richards	Primary Care Commissioning and Quality Development Manager
Mr Jamie Wike	Head of Planning, Delivery and Performance
Ms Jackie Holdich	Integrated Head of Delivery for Primary and Out of Hospital Care
Ms Julia Burrows	Director of Public Health

APOLOGIES:

Dr Madhavi Guntamukkala	Governing Body member
Dr Mehrban Ghani	Medical Director
Ms Carrianne Stone	Healthwatch Barnsley
Ms Margaret Dennison	Healthwatch Barnsley
Mr Brian Roebuck	Lay Member

MEMBERS OF THE PUBLIC:

None

Agenda Item	Note	Action	Deadline
PCCC 16/09/01	**QUORUM**		
	It was advised that the Committee was quorate.		
PCCC 16/09/02	**QUESTIONS FROM THE PUBLIC RELEVANT TO THE AGENDA -** none		
PCCC 16/09/03	**DECLARATIONS OF INTEREST GIFTS, HOSPITALITY AND SPONSORSHIP**		

Agenda Item	Note	Action	Deadline
	The Committee noted the Declarations of Interest Report.		
PCCC 16/09/04	**MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2016**		
	The minutes of the previous meeting were approved as a true record of the proceedings.		
PCCC 16/09/05	**MATTERS ARISING REPORT**		
	The Committee noted that all items on the Matters Arising Report were completed.		
STRATEGY AND PLANNING			
PCCC 16/09/06	**GP 5 YEAR FORWARD VIEW (GPFV)**		
	The Head of Delivery for Integrated Primary and Out of Hospital Care advised the Committee that the CCG would be submitting the final GP Forward View Transformation on 23 December 2016. It was noted that an action plan had been developed by the Primary Care Development Workstream to map plans to the 10 High Impact Actions within the GPFV and this would be appended to the transformation plan when submitted.		
	Members noted the update on the GP 5 Year Forward View Implementation plan for Barnsley.		
PCCC 16/09/07	**ETTF Update**		
	The Head of Planning, Delivery and Performance gave an update on the current position of the 5 successful bids for the ETTF. It was advised that PIDS had been submitted for two schemes included in Cohort 1 (Brierley Medical Centre and Brampton Medical Centre Feasibility studies) but no further information had been provided with regard to final sign off and approval to proceed. Members noted that as soon as the CCG received final confirmation back from NHS England the feasibility studies would be progressed by the providers. It was highlighted that the funding for the feasibility studies would be based on a 66/34 financial split between NHS England and the current providers.		

Agenda Item	Note	Action	Deadline
	It was also updated that PID templates had been shared with the providers for the three bids within Cohort 2 (Third I HEART Hub, Monk Bretton Health Centre Feasibility Study and CCG technology bid) to enable them to begin completing these in anticipation of a request for these from NHS England.		
	The Committee noted the ETTF Update.		
FINANCE, GOVERNANCE AND PERFORMANCE			
PCCC 16/09/08	**QUARTERLY FINANCE UPDATE**		
	The Committee received the Finance Monitoring statement for the period ending 30 November 2016. The statement highlighted that the month 8 year to date position showed an underspend of £788k. It was stated that some on the underspend would balance within the final quarter.		
	The Committee noted the Finance update and it was highlighted that the any changes in the forecast position would be reflected within the Integrated Performance Report to the Governing Body.		
PCCC 16/09/09	**RISK REGISTER AND ASSURANCE FRAMEWORK**		
	The Head of Governance and Assurance presented the Risk Register extract which detailed the risks that the Primary Care Commissioning Committee was responsible for. The Committee had a discussion on the 0 – 19 service risk and it was agreed to not change the risk scoring until the new service model began to emerge and work successfully. The Committee also received the updated Terms of Reference which had been amended following the CCG's decision to appoint a third Lay Member. It was highlighted that Page 10 'Schedule 3' paragraph required updating.	RW	
OTHER			
PCCC 16/09/10	**QUESTIONS FROM THE PUBLIC RELEVANT TO THE AGENDA –** none		

Agenda Item	Note	Action	Deadline
PCCC 16/09/11	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Primary Care Commissioning Committee will be held on 23 March 2017 at 1.00pm in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY.		

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MATTERS ARISING REPORT TO THE PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

PUBLIC

1. MATTERS ARISING

The table below provides an update on actions arising from the meeting of the Primary Care Commissioning Committee held on 22 December 2016.

Minute ref	Issue	Action	Outcome/Action
PCCC 16/09/09	**RISK REGISTER AND ASSURANCE FRAMEWORK** The updated Terms of Reference, which had been amended following the CCG's decision to appoint a third Lay Member, needs amending on Page 10 'Schedule 3'.	RW	**Complete**

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PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

Initiatives to support General Practice

PART 1A – SUMMARY REPORT

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

2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)
	Author	Lynne Richards	Primary Care Commissioning and Quality Development Manager

3. EXECUTIVE SUMMARY

This paper is to update the Committee on key areas of how the CCG is working to support the future sustainability of General Practice within Barnsley.

The GP Forward View Transformation Plan aims to improve patient care and access, and invest in new ways of providing primary care. The CCG has developed a local GPFV plan and work is being taken forward by the CCG's Primary Care Development Workstream to progress the plan. The CCG has developed a YouTube film which details the full range of initiatives being introduced to support Primary Care and some of the key highlights are covered within more detail within this report.

https://www.youtube.com/watch?v=RNyLU3nWTOo

Investment

In order to stabilise recurrent investment streams into primary care the concept of a Practice Delivery Agreement and local quality framework was co-produced by the CCG and member practices 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 through the Health Inequalities Targeted Schemes (HITS)
- Build a mutually accountable relationship that is centred on improving health outcomes in Barnsley

The recurrent investment of the PDA and HITS schemes sees over £4 million per year invested into Primary Care.

Workforce

The Practice Delivery Agreement and Barnsley Quality Framework has enabled practices to employ additional staff and pilot new roles. In addition to this the CCG has rolled out the Clinical Pharmacist Programme and Health Care Assistant Apprenticeship Programme which has seen 15 Clinical Pharmacists and 12 HCA Apprentices commence in Primary Care over 2016/17.

The CCG will shortly commence the roll out of the First Port of Call Plus which is a programme aimed to develop local Practice Administration staff through Care Navigation training. Practice Staff will be able to signpost and give information to help primary care patients move through the health and social care system as smoothly as possible to ensure that unmet needs are met.

This project is centred on improved patient outcomes and releasing GP time. Evidence in West Wakefield demonstrated that effective care navigation could release nearly 14% of GP time.

The CCG is also working closely with Health Education England to develop a plan to expand student Nurse placements.

Workload

In addition to recognising the workforce challenges, it is equally important to address the workload challenges in Primary Care. The CCG has already implemented a number of schemes aimed at maximising the use of resources across primary care and taking some of the workload away from GP's to release capacity. Examples include:
- 'Pharmacy First', a minor ailment scheme
- Primary Care Eye Assessment and Referral Scheme (PEARS)

The CCG will shortly start the roll out of a capacity and demand tool capable of effectively monitoring and predicting demand and capacity which will take the strain and pressure away from practices and provide a framework for change that can provide a solution.

Barnsley CCG has an at scale Federation in place, Barnsley Health Care Federation and in line with the aspiration set out in the GPFV the CCG will continue to support BHF to play a central part in developing new models of care, through the development of a Multispecialty Provider model which will integrate the provision of primary and community services. To support the development of primary care at scale Barnsley Healthcare Federation have developed a centralised back office function and offered this all practices within Barnsley.

Workload associated with deprivation is being addressed in a number of ways; Barnsley has PDA sister scheme the Health Inequalities Targeted Scheme (HITS) that targets differential investment to address areas of the borough with greatest health needs.

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 the CCG is working collectively with healthcare providers, the Local Authority and other community partners to ensure that local strategies for out-of-hospital care include appropriate plans for premises development.

Barnsley CCG submitted seven Schemes for ETTF funding. Three of these were feasibility studies for potential new build premises linked to future housing developments across the borough. Two of these, for potential premises at Brierley and Brampton are being taken forward as part of cohort 1 and will see investment of £456,000 during 2016/17. The third which relates to the feasibility of new health centre at Monk Bretton will be taken forward as part of cohort 2 with investment of £540,000 between 2017 and 2019. In addition a new build practice is currently being delivered in the town centre from previous NHSE capital funding.

The other schemes submitted for ETTF funding related to both workload and care redesign. Two of these have been included in cohort 2 for potential investment between 2017 and 2019. These schemes will see the development and roll out of mobile working across all GP Practices (£896,920) and the development of a third hub for extended GP access services through iHEART Barnsley (£526,000).

The CCG has implemented the Medical Interoperability Gateway (MIG) in Barnsley which is allowing access to GP records in other healthcare settings. All 35 GP practices are now signed up to using the MIG.

Care Redesign

Barnsley CCG has commenced working with partners across health and care on an ambitious plan to deliver new models of care and integrated ways of working to deliver both efficiencies as well as reducing the care quality gap. The overall plan is supported by a number of key building blocks that are already in place these include:-

- A well-developed Community Interest Company – Barnsley Healthcare 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.

4.	**THE COMMITTEE IS ASKED TO:**

	• Note the work being taken forward in Primary Care as part of the GPFV.

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: .	*1.4 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	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	
	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*
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*
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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Barnsley Clinical Commissioning Group

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PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

CQC Update Report

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

	Name	*Designation*
Executive Lead	Jackie Holdich	Head of Delivery (Integrated Primary and Out of Hospital Care)
Author	Lynne Richards	Primary Care Commissioning and Quality Development Manager

3.	**EXECUTIVE SUMMARY**
	To provide the Primary Care Commissioning Committee with the latest CQC update for Primary Care. Appendix 1 details the current CQC ratings for the 35 GP Practices within Barnsley. The overall picture is extremely positive with 34 practices rated as Good and 1 practice requiring improvement. The CCG and CQC have offered support to the practice rated requiring improvement and the CCG is confident that this practice will achieve a good rating at its re-inspection. Four Barnsley Healthcare Federation practices are currently awaiting inspection dates. The Primary Care Team have bi-monthly meetings scheduled with the CQC Inspector for Barnsley to share intelligence and build relationships.
4.	**THE COMMITTEE IS ASKED TO:**
	• Note the content of the report and make comments.

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: .	*1.4 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	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	
	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*
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*
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*

CQC ratings update - December 2016

CQC Inspections													
Practice	**Date of Visit**	**Practice overall CQC Rating**	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-led**	**Older people**	**People with long term conditions**	**Families, Children and Young People**	**Working age people (including those recently retired and students)**	**People whose circumstances may make them vulnerable**	**People experiencing poor mental health (including people with dementia**
St Georges Medical Centre PMS Practice	02/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Victoria Medical Centre PMS Practice	02/12/2014	**Good**	Good	Good	Good	Good	Outstanding	Good	Good	Outstanding	Good	Good	Good
Penistone Group PMS Practice	02/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
The Dove Valley Practice	03/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Royston Group Practice	03/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Outstanding	Good	Good
Huddersfield Road	09/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Hill Brow Surgery	09/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
The Rose Tree PMS Practice	10/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Hoyland First PMS Practice	16/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Ashville Medical Practice	16/12/2014	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
The Kakoty Practice	20/10/2015	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Wombwell Medical Centre	10/11/2015	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Rotherham Road	14/12/2015	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Lundwood Medical Centre	17/12/2015	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
High Street Royston	11/01/2016	**Good**	Requires improvement	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Woodland Drive Medical Centre	18/01/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Hollygreen Practice	25/01/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Lakeside Surgery	26/01/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Grimethorpe Surgery	12/02/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Outstanding	Good	Good
Wombwell PMS Practice	15/02/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Hoyland Medical Practice	22/02/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Outstanding	Good	Good	Good
Dr Mellor and Partners	07/03/2016	**Good**	Good	Good	Good	Outstanding	Good	Good	Good	Good	Good	outstanding	Good
Dearne Valley Group Practice	14/03/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Apollo Court	21/03/2016	**Good**	Good	Good	Good	Good	Good	Good	Requires improvement	Good	Good	Good	Good
Monk Bretton	04/04/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Eko G - Darton Health Centre	11/04/2016	**Good**	Requires improvement	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Park Grove Surgery	09/05/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
The Grove Medical Practice	23/05/2016	**Good**	Good	Good	Good	Outstanding	Good	Good	Good	Good	Good	Good	Good
Caxton House	12/07/2016	**Good**	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Kingswell Surgery	03/10/2016	**Requires improvement**	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Goldthorpe Medical Centre PMS Practice	Not yet inspected under new provider (awaiting inspection date)												
BHF Highgate Surgery	Not yet inspected under new provider (awaiting inspection date)												
BHF Lundwood	Not yet inspected under new provider (awaiting inspection date)												
BHF Brierley Medical Centre	Not yet inspected under new provider (awaiting inspection date)												

Blue: Outstanding
Green: Good
Amber: Requires Improvement
Inadequate: Red
Awaiting report

Barnsley Clinical Commissioning Group
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PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

FINANCE MONITORING STATEMENT - PRIMARY CARE COMMISSIONING (DELEGATED BUDGETS)

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Jackie Holdich	Head of Primary & Out of Hospital Care Delivery
Author	Roxanna Naylor	Head of Financial Management and Contracting/DCFO

3.	**EXECUTIVE SUMMARY**
	This report provides an update on the financial position for delegated Primary Care Commissioning budgets as at January 2017 (Month 10). The Forecast position as at Month 10 is £814k underspend, Appendix A sets out the movements from budget with a detailed narrative. The financial position is updated and reported on a monthly basis through the Integrated Performance Report which is a standing agenda item at the Finance and Performance Committee and Governing Body.
4.	**THE COMMITTEE IS ASKED TO:**
	• Note the contents of the report
5.	**APPENDICES**
	• Appendix A – Finance Monitoring Statement

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:	*N/A*
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	✓
	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?	*N/A*
	Are any financial implications detailed in the report?	*N/A*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*N/A*
	Is actual or proposed engagement activity set out in the report?	*N/A*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*N/A*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*N/A*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*N/A*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*N/A*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*N/A*

APPENDIX A

NHS
Barnsley Clinical Commissioning Group

NHS BARNSLEY CLINICAL COMMISSIONING GROUP
Finance Monitoring Statement - Primary Care Commissioning (Delegated budgets) - Month 10
FOR THE PERIOD ENDING 31st January 2017

PRIMARY MEDICAL SERVICES	TOTAL ANNUAL BUDGET (£)			FORECAST OUTTURN (£)			
(CO-COMMISSIONING - DELEGATED BUDGETS)	RECURRENT	NON RECURRENT	TOTAL BUDGET (£'000)	FORECAST OUTTURN	VARIANCE OVER / (UNDER)	VARIANCE AS % OF TOTAL BUDGET	Forecast Outturn Variance Explanation
ENHANCED SERVICES	1,452,598	-	1,452,598	1,303,774	(148,824)	-10.25%	Enhanced Services received a benefit of £148k which relates to 15/16
GENERAL PRACTICE - APMS	1,244,379	-	1,244,379	1,121,242	(123,137)	-9.90%	Primary Care Co-Commissioning forecast on GMS, APMS and PMS contracts are based on up to date list sizes (January 2017). We have seen an overall increase in list sizes over the four quarters by 1351. However the allocated funding for these three contracts is sufficient to meet the increase growth in list sizes.
GENERAL PRACTICE - GMS	9,278,979	-	9,278,979	9,229,399	(49,580)	-0.53%	
GENERAL PRACTICE - PMS	12,030,329	-	12,030,329	12,096,485	66,156	0.55%	
OTHER GP SERVICES	1,258,219	-	1,258,219	1,258,219	0	0.00%	
OTHER GP SERVICES CONTINGENCY	182,872	-	182,872	-	(182,872)	-100.00%	GP Services (Contingency) are the remaining funds available that are not committed.
OTHER PREMISES	355,391	-	355,391	222,304	(133,087)	-37.45%	Other premises costs are based on actual rent charges.
PREMISES COST REIMBURSEMENT	5,000,983	-	5,000,983	4,962,425	(38,558)	-0.77%	Premises cost reimbursements are underspending due to project savings as a result of GL Hearn rates review.
QOF	3,450,250	-	3,450,250	3,245,686	(204,564)	-5.93%	QOF forecast is based on 15/16 achievement and is in line with current achievement in 16/17.
TOTAL PRIMARY MEDICAL SERVICES	**34,254,000**	**-**	**34,254,000**	**33,439,532**	**(814,468)**	**-2.38%**	

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

Outcome of 2017/18 GMS Contract Negotiations

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead	Catherine Wormstone	Senior Primary Care Commissioning and Contracting Manager
Author	Lynne Richards	Primary Care Commissioning and Quality Development Manager

3.	**EXECUTIVE SUMMARY**

Outcome of 2017/18 GMS Contract Changes

Appendix 1 details the official outcome of the 2017/18 GMS Contract negotiations between NHS Employers and the BMA's General Practitioners Committee. Key changes to the GMS contract are detailed with the attached letter and amendments will apply to GMS contractual arrangements from 1 April 2017.

NHS England and the CCG are currently working together on how these changes can support local strategic plans for strengthening the quality of General Practice services and making more effective use of NHS resources and how the changes might need reflecting in co-commissioning plans.

4.	**THE COMMITTEE IS ASKED TO:**

- Consider and note potential implications from the 2017/18 GMS Contract changes.

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: .	*1.4 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	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	
	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*
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*
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 England

Medical Directorate
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

Gateway Ref: 06446

To: Directors of Commissioning,
Regional Heads of Primary Care
Heads of Primary Care
CCG Clinical Leads and Accountable Officers

7 February 2017

Dear Colleague

OUTCOME OF 2017/18 GMS CONTRACT NEGOTIATIONS

This letter confirms the outcome of the contract negotiations between NHS Employers (on behalf of NHS England) and the BMA's General Practitioners Committee (GPC) on amendments that will apply to GMS contractual arrangements in England from 1 April 2017.

An agreement has been reached with GPC on changes to the GMS contract for 2017/18 which seeks to address concerns of the profession in relation to workload and increasing expenses and other agreed changes. The agreement also reflects commitments made as part of the General Practice Forward View (GP Forward View) and continues to make significant investment in primary care. The agreement has been approved across Government.

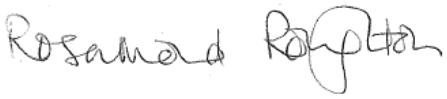
We suggest regional teams discuss with clinical commissioning groups (CCGs) how these changes can support local strategic plans for strengthening the quality of general practice services and making more effective use of NHS resources and how the changes might need to be reflected in co-commissioning plans.

As last year, we will now work with NHS Employers and GPC to develop more detailed guidance where appropriate, on all of the agreed changes which are provided in the attached annex.

The NHS Employers contract website www.nhsemployers.org/gms provides details of the agreement www.nhsemployers.org/gms201718 and we will be updating this and NHS England's dedicated GP contracts page https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/ with details of the implementation guidance, links to supporting legislation and standard contract documentation in time for these new arrangements to take effect from 1 April 2017. Given the timing of this announcement we will be implementing the changes to the Regulations from July 2017 at the earliest.

Please ensure that this letter is distributed to all relevant people within your teams.

Yours faithfully



Rosamond Roughton
Director of NHS Commissioning

Key Changes to GMS Contract for 2017/18

Contract Uplift and Expenses

We have agreed an investment of £238.7 million in the contract for 2017/18. This investment is to uplift the contract and to take into account increasing expenses, covering:

- A pay uplift on pay of 1% (based on DDRB formula) and an uplift on expenses of 1.4% (using latest OBR inflation forecast for CPI)
- Payments for indemnity costs that will be made based on registered patients at 51.6p per patient
- An increase in the value of a QOF (Quality and Outcomes Framework) point
- The payment fee for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check

Carr-Hill formula

Negotiations on changes to the Carr-Hill formula will begin shortly. Full implementation of any agreed changes will be effective from 1 April 2018 at the earliest.

QOF

We have agreed that for 2017/18 there will be no change to the number of QOF points available, the clinical or public health domains and no changes to QOF thresholds. However, the CPI will be adjusted to reflect the changes in list size and growth in the overall registered population for one year from 1 January 2016 to 1 January 2017.

We have also agreed that a working group will be set up immediately following these negotiations to discuss the future of QOF after April 2017.

Directed Enhanced services (DESs)

The payment for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check. A new learning disabilities health check template has been developed by NHS England for practices to use if they so choose. All other requirements of the enhanced service will remain unchanged.

The Extended Hours Access DES will continue unchanged until 30 September 2017 (see below – core opening hours and extended hours access DES).

The Avoiding Unplanned Admissions DES will cease at 31 March 2017. Funding of £156.7 million will be transferred into global sum, weighted and without the out-of-hours deduction applied, and used to support the new contractual requirement on Identification and Management of Patients with Frailty (see below).

Identification and management of patients with frailty

We have agreed a new contractual requirement to be introduced from 1 July 2017.

Practices will use an appropriate tool, e.g. Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions. In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this by seeking informed patient consent to activate the enriched SCR.

Practices will code clinical interventions for this group appropriately. Data will be collected on the number of patients recorded with a diagnosis of moderate frailty, the number of patients with severe frailty, the number of patients with severe frailty with an annual medication review, the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months and the number of severely frail patients who provided explicit consent to activate their enriched SCR. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management purposes or benchmarking purposes.

National diabetes audit (NDA)

Practices will be contractually required to allow collection of data relating to the NDA from July 2017 at the earliest.

NHS Digital Workforce Census

Practices will be contractually required to allow collection of data relating to the NHS Digital Workforce Census from July 2017 at the earliest. Recurrent funding of £1.5 million has been agreed to support this requirement and will be added to global sum allocations without the out of hours deduction applied.

Data collection

We will introduce a contractual requirement, from July 2017 at the earliest, for practices to allow data collections for a selection of agreed retired QOF indicators (INLIQ) and retired DESs .

Registration of prisoners

We will introduce a contractual change from July 2017 at the earliest, to allow prisoners to register with a practice before they leave prison. This agreement will include the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the practice from the prison to enable better care when a new patient first presents at the practice.

Access to healthcare

We have agreed contractual changes that help to identify patients with a non-UK issued EHIC or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015.

Practices will be required to provide all new patients with a revised GMS1 form, which includes supplementary questions to determine a patient's eligibility to healthcare. For those patients who self-declare that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. The Department of Health has agreed to provide practices with hard copy patient leaflets which will explain the rules and entitlements overseas patients accessing the NHS in England.

We have also agreed that NHS England and GPC will work with GP system suppliers to put in place an automated process, as soon as possible, to replace the manual process. This will include discussions on development of systems to support collection of GP appointment data for these patients.

Once the technical solution to automatically collect this data is in place, we have agreed that further discussions on implementing the system to support collection of the data will take place.

New recurrent investment of £5 million will be added to global sum allocation, without the out of hours deduction applied, to support this requirement.

GP retention scheme

We have agreed a new scheme to replace the existing one, with the key changes being as follows:

- Tighter criteria for those who are joining the new scheme. The scheme is aimed at those GPs who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or require greater flexibility.

- In 2016, under an interim scheme, the practice payment rose from £59.18 to £76.92 per session, an increase of approximately 30 per cent. NHS England will fund the 2017 scheme wholly from within the primary care allocation budget and the practice payment and bursary professional expenses salary supplement will remain the same as the 2016 scheme. The payment is to be used by the practice as an incentive to provide flexibility for the retained GP and should be used towards the retained GP's salary, to cover human resources administration costs and to provide funding to cover any educational support required from the practice, including course fees where relevant.

- A professional expenses salary supplement will be payable to the GP via the practice (on a sliding scale, net of any applicable deductions payable by the doctor in respect of income tax, national insurance and superannuation contributions) and is to go towards the costs of the GP's indemnity cover, professional expenses and Continuing Professional Development (CPD) needs.

- A strong element of the new scheme is around education and CPD. The retained GP will be entitled to the pro rata full time equivalent of CPD as set out within the salaried model contract. The CPD aspects will be based on the needs of the individual, as established at their appraisal and in discussion with the educational supervisor.

- GPs can be on the scheme for a period of up to five years. In exceptional circumstances an extension can be made for up to a further 24 months.

Any retainers on the 2016 Retained Doctors Scheme will continue under these arrangements until 30 June 2019 after which time they will default to the new scheme.

Retainees who have been accepted on to the Retained Doctor Scheme 2016 (where the application form has been approved by the NHS England DCO) but who are not in post before 31 March 2017, will be accepted onto the GP Retention scheme without the need to re-apply.

Payments for sickness leave cover

We have agreed changes to the arrangements for making sickness leave payments, as follows:

- To allow for cover to be provided by external locums or existing GPs already working in the practice but who do not work full time.

- An amendment to the qualifying criteria for reimbursement to begin when the absence is two or more weeks (as opposed to current arrangements which is linked to patient numbers and the period of absence).

- An increase in the maximum amount payable to £1,734.18 per week. Payments will no longer be discretionary and will be payable where the absence is two or more weeks.

- Sickness leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the Statement of Financial Entitlements (SFE).

These changes will be applicable as from 1 April 2017 and all other requirements will remain unchanged.

Parental leave payments

We have agreed that parental leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the SFE. All other requirements will remain unchanged.

Business Improvement District (BID) levies

Agreement has been reached for eligible practices to be reimbursed for costs relating to BID levies. The reimbursement is to be made via the Premises Costs Directions on submission of a paid invoice. Payment of the BID levies will not be a discretionary payment.

Care Quality Commission (CQC) Fees

CQC Fees will be reimbursed directly. Practices will present their CQC invoices to the CCG (where delegated powers exist) or the NHS England regional team and they will be reimbursed as part of the practice's next regular payment.

Vaccinations and immunisations (V&I)

We have agreed to the following V&I programme changes from April 2017:

- Childhood seasonal influenza – the removal of four year olds from enhanced service patient cohort (transferring to schools programme) and the removal of the requirement to use Child Health Information Systems (CHIS).

- MenACWY programmes – a reduction in the upper age limit from 'up to 26th birthday' to 'up to 25th birthday' (in line with the Green Book).

- Seasonal influenza – the inclusion of morbidly obese patients as an at-risk cohort in the DES and a reminder for practices that it is a contractual requirement to record all influenza vaccinations on ImmForm. Funding to cover this new cohort will be from Section 7A.

- Pertussis or pregnant women – a reduction in the eligibility of patients for vaccination from 20 weeks to 16 weeks.

- Shingles (routine) – a change in patient eligibility to the date the patient turns 70 rather than on 1 September.

- Shingles (catch-up) – a change in patient eligibility to the date the patient turns 78 rather than on 1 September.

The following programmes will roll-over unchanged:

- hepatitis B (newborn babies)
- HPV for adolescent girls

- measles mumps and rubella (aged 16 and over)
- meningococcal B
- pneumococcal polysaccharide
- rotavirus.

Core opening hours and extended hours access DES

In relation to the extended hours access DES new conditions will be introduced from October 2017 which will mean that practices who regularly close for a half day, on a weekly basis, will not ordinarily qualify for the DES. GPC have agreed that Local Medical Committees should be integral partners in working with local commissioners in ensuring practices are fulfilling their contractual requirements.

GMS digital

We have agreed to build on the work of recent years to develop high quality secure electronic systems and pro-actively encourage patients and practices to use them. The changes that we have agreed for 2017/18 will be taken forward through non-contractual working arrangements which we will jointly promote in guidance.

Recognising the importance of cyber security, practices will want to ensure that they have strong underpinning information governance which supports their and patients' use of all electronic systems.

We have further agreed non-contractual changes to joint guidance that will promote:

- practice compliance with the ten new data security standards in the National Data Guardian Security Review

- practice completion of the NHS Digital Information Governance toolkit including attainment of level 2 accreditation, and familiarisation with the July 2016 Information Governance Alliance guidance

- an increased uptake of electronic repeat prescriptions to 25 per cent with reference to co-ordination with community pharmacy

- an increased uptake of electronic referrals to 90 per cent where this is enabled by secondary care

- continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy

- uptake of patient use of one or more online service to 20 per cent including, where possible, apps to access those services and increased access to clinical correspondence online

- better sharing of data and patient records at local level, between practices and between primary and secondary care.

Indemnity Inflation

When the GP Indemnity Review was published (available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf), NHS England agreed to make payments to practices to cover indemnity inflation experienced in 2016/17 and 2017/18.

Further work

NHS England and GPC have committed to take forward discussions in the coming months on a national programme of self-care and appropriate use of GP general practice services and information sharing between practices.

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

23 March 2017

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	Kay Morgan	Governance and Assurance Manager

3. EXECUTIVE SUMMARY

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.

Risk Register
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.

The full risk register is submitted to the Committee on a six monthly basis and the red and amber rated risks are considered at each meeting of the Committee. In line with reporting timescales, Members' attention is drawn to Appendix 1 of this report which provides the Committee with an extract of all the risks associated with the Primary Care Commissioning Committee.

There are currently six risks on the Corporate Risk Register allocated to the PCCC for which the Committee is responsible for managing. Of the six risks, there is one red (extreme) rated risk, one amber risks (high), three yellow risks (moderate) and 1 green (low) risk. Members are asked to review all risks detailed on Appendix 1 to ensure that the risks are being appropriately managed and scored.

	Additions / Removals There have been no new risks identified or removed since the previous meeting of the Primary Care Commissioning Committee.
4.	**THE COMMITTEE IS ASKED TO:**
	Review the Risk Register attached and: • Consider whether all risks identified are appropriately described and scored • Consider whether there are other risks which need to be included on the Risk Register.
5.	**APPENDICES**
	• Appendix 1 – Risk Register

Agenda time allocation for report:	5 mins

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 – March 2017

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)	7	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	20	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	7	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**	02/17	**February 2017** Position remains as at January 2017 **January 2017** Work commencing on new model – GP involvement Transition Board met December 2016 New Head of Service in post from 3/11/16 and came to Membership Council on 17/11/16. GPs	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**
													actively involved in new model work. **November 2016** Service transferred on 1/10/16 to BMBC. CCG Chair on Transition Board New Head of Service in post from 3/11/16 and coming to Membership Council on 17/11/16 **October 2016** CCG Chair & Chief Nurse met with colleagues from the LA. CCG Chair is part of the transition Board, meeting fortnightly overseeing the change**.**	
CCG 15/03		If the CCG does not effectively discharge its delegated	**3**	**4**	**12**	The CCG has access to existing primary care commissioning resource	JH (Primary	Risk Assessment	2	4	**8**	01/17	**January 2017** The CCG is currently	04/17

			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**
		responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.				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).	Care Commissioning Committee)							managing it's delegated responsibility for contract performance effectively. The management of contract performance will be further enhanced when the Primary Care Senior Commissioning and Contracting Manager commences in post within the CCG's Primary Care Team in March 2017. **December 2016** All controls and working arrangements are being followed to manage this residual risk **September 2016** All controls and working	

			Initial Risk Score						Residual Risk Score					
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													arrangements are being followed to manage this residual risk. **March 2016** All controls and working arrangements are being followed to manage this residual risk.	
CCG 15/04		If the CCG is unable to secure sufficient operational & strategic capacity to fulfil the delegated functions this may impact on the ability of the CCG to deliver its existing delegated statutory duties, for instance in relation to quality, financial resources and public participation.	**3**	**5**	**15**	CCG considered its strategic capacity & capability as part of the successful application process. The CCG has access to existing primary care commissioning resource 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.	JH (Primary Care Commissioning Committee)	Risk Assessment	**2**	**3**	**6**	01/17	**January 2017** The Head of Delivery (Integrated Primary & Out of Hospital Care) is now in post, as is the Primary Care Commissioning and Quality Development Manager. The Primary Care Senior Commissioning and Contracting Manager has been recruited and will take up her post in March	06/17

			Initial Risk Score						Residual Risk Score					
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													2017. **November 2016** Position remains as at August. The CCG has recruited a Head of Primary Care who commences her role in November 2016, and is in the process of recruiting an additional 2 members of the primary care team. **August 2016** PCCC to review this risk score The CCGs delegated functions are being managing through CCG capacity in conjunction with support from NHSE	

			Initial Risk Score						Residual Risk Score					
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CCG 15/05	1, 3, 8	If the CCG does not comply in a fully transparent way with the statutory Conflicts of Interest guidance issued in June 2016 there is a risk of reputational damage to the CCG and of legal challenge to the procurement decisions taken.	**3**	**3**	**9**	Standards of Business Conduct Policy and procurement Policy updated. Registers of Interests extended to incorporate relevant GP practice staff . Declarations of interest tabled at start of every meeting to enable updating. Minutes clearly record how any declared conflicts have been managed. PCCC has Lay Chair and Lay & Exec majority, and GP members are non voting. Register of Procurement decisions established to record how any conflicts have been managed. Guidance provided to minute takers on recording decisions re managing conflicts of interest.	RW (Primary Care Commissioning Committee)	Risk Assessment	**2**	**3**	**6**	03/17	**March 2017** Third Lay now recruited and will commence on 1.4.17 . Internal Audit has found CCG fully or partially compliant across all areas. **January 2017** A third Lay Member is in the process of being recruited – once appointed they will join the PCCC as Vice Chair. Internal Audit is currently reviewing the CCG's degree of compliance with the statutory C of I Guidance. **November 2016** The CCG has continued to embed the requirements of the revised statutory conflicts	09/17

			Initial Risk Score						Residual Risk Score					
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													of interest guidance. NHSE has agreed in principle to the CCg appointing an Associate Lay Member to add additional Lay capacity – thgis person once recruited will become a member of the PCCC.	
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**	01/17	**January 2017** Individual contracts are monitored through the Primary Care Commissioning Committee's Contractual Issues Report. **September 2016** Individual contract are monitored through the Primary Care Commissioning Committee's Contractual	06/17

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													Issues Report. **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, as well as robust governance supporting the function. 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. The CCG is a member of the Consultation Institute and as such uses learning, best practice and advice service to support any consultation activity.	JR (Primary Care Commissioning Committee)	Risk Assessment	1	3	**3**	10/16	**October 2016** – general update to mitigation and treatment **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 held a practice Engagement event scheduled for 30th June 2016	10/17

NEW RISK FEBRUARY 2017

			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**
17/01 (risk added 09.02.17)	1,2, 5,6,7,8	Ophthalmology Contract – If the 'incomplete' number of patients and current waiting times for ophthalmology result in BHNFT being unable to deliver RTT standards, there is a risk to the reputation of the CCG and the quality of care provided to the people of Barnsley in respect of this service. Delivery of RTT standards also impacts upon the CCG's assessment rating as part of the CCGIAF and the level of Quality Premium.	3	3	**9**	CCG are working with both the old and new provider as part of mobilisation of the new contract from February 2017. TRHFT are undertaking a full RTT validation on all patients identify actual number of patients waiting, length of waits and any breaches against 18 and 52 week standards and reporting to the CCG on a weekly basis.	JW (Finance & Performance Committee)	Risk Assessment	3	3	**9**	03/17		

RISK REMOVED FEBRUARY 2017

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 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.	JH (Primary Care Commissioning Committee)	CQC reviews	**3**	**3**	**9**	01/17	**February 2017** Recommended to Governing Body for removal - GB agreed risk could be removed **January 2017** Propose to remove this risk as currently there are not any practices rated **inadequate.** All practices visited have been rated 'good' with 1 practice 'requiring improvement', (an action plan is in place within the practice to address the issues relating to the 'requiring improvement' rating). Overall the CCG is pleased with the current CQC ratings of Barnsley practices and therefore this risk is no longer relevant to the current situation **December 2016** No further CQC

													Inspections have taken place **August 2016** All practices have now been inspected the CCG has supported the 5 practices where issues were highlighted