Governing Body

To be held on
Thursday 19th May 2016

from 12.30pm until 3.30pm

in the Boardroom, Sovereign House,
Heavens Walk, Doncaster DN4 5HZ
Governing Body  
To be held on Thursday 19 May 2016  
Commencing at 12.30pm – 3:30pm  
In the Boardroom, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ

PUBLIC AGENDA

1. Welcome and Introductions
   Presenter: Chair

2. Apologies
   Presenter: Chair

3. Declarations of Interest
   Presenter: Chair

4. Patient Stories / Questions from Members of the Public
   (Please see our website for guidance on how to submit question/story requests)
   Presenter: Chair

5. Minutes of the previous meeting held on 21st April 2016
   Presenter: Chair  Enc A

6. Matters Arising
   Presenter: Chair

Strategy

7. Intermediate Care Update and Presentation
   Presenter: Mrs Tooley/Mrs Aitchison

8. Yorkshire Ambulance Service Contract Delegation Proposals
   Presenter: Mrs Atkins Whatley/Mrs Leighton  Enc B

9. Commissioners Working Together Programme: Communications and Engagement Update
   Presenter: Mrs Sherburn/Mr Carpenter  Enc C

Assurance

10. Finance Report
    Presenter: Mrs Tingle  Enc D

11. Corporate Assurance Report – Quarter 4
    Presenter: Mrs Atkins Whatley  Enc E
Standing Items

12. Chair & Chief Officer Report
   Mrs Pederson
   Enc F

Items to Note / Receipt of Minutes

13. Items to Note
   Enc G
   • Performance Report
     Mrs Shepherd
     Mrs Leighton
   • Minutes of the Commissioners Working Together Programme Board Meeting held on 2nd February 2016
     Mrs Sherburn

14. Receipt of Minutes from Committees
   Chair
   Enc H
   • Audit Committee – Draft Minutes from the meeting held on 12th May 2016 will be received in June 2016
   • Quality & Safety Committee – Draft Minutes from the meeting held on 5th May 2016 will be received in June 2016
   • Engagement & Experience Committee – Draft Minutes from the meeting held on 5th May 2016 will be received in June 2016
   • Primary Care Commissioning Committee – Draft Minutes from the meeting held on 27th April 2016
   • Delivery & Performance Committee – The next meeting will be held on 9th June 2016

15. Any Other Business
    Chair

16. Date and Time of Next Meeting
    Chair
    Thursday 16th June 2016 at 12.30pm

17. To resolve that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard 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.
    Chair
Minutes of the previous meeting
Minutes of the Governing Body
Held on Thursday 21 April 2016 commencing at 12.30pm
In the Boardroom, Sovereign House

Members Present: Dr David Crichton – NHS Doncaster CCG Chairman (Chair)
Miss Anthea Morris – Lay Member and Vice Chair of the Governing Body
Mrs Linda Tully – Lay Member
Dr Emyr Wyn Jones – Secondary Care Doctor Member
Dr Sam Feeney – Locality Lead, Central Locality
Dr Jeremy Bradley – Locality Lead, North East Locality
Dr Andy Oakford – Locality Lead, North East Locality
Dr Marco Pieri – Locality Lead, North West Locality
Dr Niki Seddon – Locality Lead, North West Locality
Dr Pat Barbour – Locality Lead, South East Locality
Dr Khaimraj Singh – Locality Lead, South East Locality
Dr Lindsey Britten – Locality Lead, South West Locality
Dr Karen Wagstaff – Locality Lead, South West Locality
Mrs Jackie Pederson – Chief Officer
Mrs Hayley Tingle – Chief Finance Officer
Mrs Mary Shepherd – Chief Nurse

Formal attendees present: Mrs Sarah Atkins Whatley – Chief of Corporate Services
Mrs Laura Sherburn – Chief of Partnerships Commissioning and Primary Care
Mrs Ailsa Leighton – Deputy Chief of Strategy & Delivery – Urgent Care
Dr Rupert Suckling – Director of Public Health
Mrs Deborah Hilditch – Healthwatch Doncaster Representative
(attending on behalf of Mr Stephen Shore)

In attendance: Mrs Jayne Satterthwaite – PA (Taking Minutes)

ACTION

1. Welcome and Introductions

Dr Crichton welcomed everyone to the Governing Body meeting and introductions were made around the table.

There were 6 members of the public in attendance at the meeting.

2. Apologies

Apologies were received from:
3. **Declarations of Interest**

There were no declarations of interest made for any of the agenda items or any additional declarations of interest than those previously registered.

4. **Questions from Members of the Public/ Patient Stories**

**Patient Story**

Dr Crichton informed the Governing Body that there would not be a patient story this month.

**Questions from Members of the Public**

Dr Crichton informed the Governing Body that he had received a question regarding the updating of the Black and Minority Ethnic (BME) Health Needs Assessment. Dr Crichton explained that he has an arranged meeting with the gentleman on Wednesday 27th April 2016 and would discuss this further in the meeting.

5. **Minutes of the Previous Meeting held on 17th March 2016**

The minutes of the meeting held on 17th March 2016 were agreed as an accurate record.

6. **Matters Arising**

**Minutes of the Previous Meeting held on Thursday 18th February 2016**

Mrs Leighton reported that data had been received regarding patterns of behaviour and the origin of referrals however would appreciate clarity on exactly what information was required by GP colleagues. Dr Oakford and Dr Seddon agreed to liaise with Mrs Leighton on this matter.

**Delivering the CCG Commissioning Strategy**

Mrs Hilditch confirmed that she had contacted Mrs Satterthwaite by email regarding a suitable forum to outline Healthwatch Doncaster’s current position and focus. Mrs Satterthwaite and Mrs Hilditch will liaise further outside of the meeting.
Chair and Chief Officer Report – Mental Health

Dr Seddon and Mrs Satterthwaite agreed to liaise outside of the meeting regarding a presentation at a future Strategy Development Forum.

Quality and Performance Report

Mrs Leighton confirmed that the information relating to the issues within GP Out of Hours service over the Christmas and New Year period will be presented to the Quality & Safety Committee in May 2016.

7. Quality & Performance Report

Mrs Shepherd and Mrs Leighton stated that the Quality and Performance Report was for noting however wished to highlight the following:

**Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBHFT)**

- Maternity Services - Work is ongoing to gain clarity and an understanding of the increase in Significant Incidents (SIs) for Maternity in relation to stillbirth. The Trust is below the national average on stillbirth. Mr Russell commented that the Trust has identified issues and wish to work pro-actively with NHS Doncaster CCG to identify other data metrics which may be better used. Dr Barbour stated that there are a number of indicators which are low or have decreased and queried if there was a connection with the financial situation and if it was having an impact. Mrs Leighton informed the Governing Body that it was too early to gauge at the moment however DBHFT has stated that this is not the case and despite the decrease in performance, it remains the 10th best nationally for performance.

- Stroke – The outcomes are good and the Clinical Quality Review Group (CQRG) has debated if the correct metrics are being used. A ‘walk through’ of the Stroke Pathway has been completed. Mrs Sherburn informed the Governing Body that the Hyper Acute Stroke work should accelerate the Yorkshire and Humber blueprint. A Business Case is under development and will be presented to the Working Together Programme Board in May.

- Fylde Coast Medical Centre (FCMS) - GP Out of Hours performance against the telephone clinical assessment measures has improved significantly in February from early months since the new model went live in October 2015. Telephone clinical assessments within 1 hour however did not meet the standard of 95% at 92.93%. This was due to high demand on days where there were also gaps in the rotas due to sickness and last minute locum cancellations. The service are reviewing this on a daily basis and call patients as a follow up if they have waited a long time which allows them to determine any clinical impact from the wait. Dr Oakford queried the figures between 20 minute and 60 minute waits
and Mrs Leighton reported that investigations are being made into each different cohort. The national expectation for ring back is 1 hour. FCMS undertook a detailed review of service delivery during the New Year period and identified actions to be taken as a result. These actions are now being put in place and include the role of shift co-ordinators and ensuring escalation processes are followed. Performance over the Easter weekend at the end of March was good and was significantly better compared with last year.

- FCMS Emergency Care Practitioner - In February, of all ECP visits carried out, 82.37% of patients remained at home. The remaining patients who required a secondary care referral in February required either a 999 ambulance, an attendance at A&E and/or a hospital admission.
- Yorkshire Ambulance Service (YAS) - A change to the lead commissioner arrangement has been proposed ahead of developing a joint committee for October 2016. A revised collaborative commissioning agreement with strategy has been circulated to CCGs and agreement is being sought from each CCG’s Governing Body with formal sign off required by the end of May 2016. This will impact on Doncaster and the implications will be discussed in the Strategy Development Forum on 5th May 2016.

Mrs Shepherd informed the Governing Body that a presentation would be given regarding the Quality and Performance Assurance Processes following the delegation of Primary Care to NHS Doncaster CCG and the increased responsibility as a result. Mrs Shepherd highlighted the following points which includes how we hold our commissioned services to account and assure the CCG and how we hold ourselves to account for the delivery of our strategic and statutory priorities:

The Principles we work to
- Work in partnership with our providers.
- Support performance and quality improvement.
- Duty of Candour. Develop open and honest relationships.
- Identify the correct measures and smoke detectors. NHS Doncaster CCG has inherited a plethora of Key Performance Indicator’s (KPIs) and we will attempt to use contracts where appropriate.
- Use current performance and quality issues to inform Commissioning Strategy.

How we hold our Commissioned Services to account
- A great deal of time has been devoted to our main contracts which include Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT), Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and Yorkshire Ambulance Service (YAS).
- NHS Doncaster CCG commission a large amount of Individual Placements both in and out of the Borough and work is still required in this area.
- We have increased responsibility for Primary Care following the delegation of authority from NHS England to NHS Doncaster CCG.
Intelligence we use
- KPIs exist in all our contracts and we are able to seek external assurances through the Care Quality Commission (CQC) and peer reviews.
- Care Home monitoring and Case Management has been established in respect of Individual Placements. Gaps have been identified in the joint-funded placements.
- A Primary Care Dashboard is in development. KPIs and quality metrics are available.

Contract Governance Arrangements
- Our main contracts are discussed through the DBHFT and RDaSH Strategic Contracting meetings. The Clinical Quality Review Groups (CQRG) discuss quality issues across our providers. The Finance and Performance Information Group (FPIG) and smaller provider meetings are held on a monthly basis.
- The Care Home Forum is in its infancy and will discuss quality, safety and strategy. Not all contracts are in place as there are gaps within specialist placements.
- NHS England has devised a Responsible, Accountable, Supported, Consulted, Informed (RASCI) model which is being tested between NHS England and CCGs. NHS England remains responsible for practice contracts.

NHS Doncaster CCG Governance Arrangements
- The Quality and Safety Committee and the Primary Care Commissioning Committee both feed into the Governing Body and decide what is escalated to the attention of the Governing body. Various sub-groups feed into the committees. There are currently no mechanisms in place for significant events and this is a work in progress. Providers do inform us of the events. Dr Feeney queried if a connection could be made from the Primary Care Management Delivery Group to the CQRG meetings and it was agreed this would be possible.

How we hold ourselves to account
- Transformation and Delivery Plans signed off by the Governing Body.
- Plans set out specific, measureable improvements in outcomes we expect to see, alongside actions needed to achieve this.
- Reports are produced monthly detailing delivery against plans and changes in outcomes measured.
- Reported to the Strategy Development Forum.

Approach
- Identify outcomes, specific success indicators and actions.
- Use data analysis across wide range of measures.
- Use soft intelligence with providers. Mrs Shepherd reported that she and Mrs Pederson are visiting A&E on Friday 22 June 2016.

Dr Suckling commented that the presentation was very helpful
however observed that there was no reference to the voice of patients. Mrs Hilditch reported that Healthwatch receive information and complaints and would automatically approach the provider and not the CCG as it was unsure of where to take this to.

Mrs Shepherd informed the Governing Body that contracts have patient experience information embedded into them especially relating to safety effectiveness. Members of the Quality & Safety team also attend the Engagement & Experience Committee. Mrs Tully reported that she and Mrs Atkins Whatley are in the process of developing an ambitious plan in relation to Health Ambassadors and would welcome input from Healthwatch. Mrs Tully and Mrs Shepherd will liaise with Mrs Hilditch outside of the meeting. Mrs Atkins Whatley reported that we have an Information Sharing Agreement with Healthwatch Doncaster which can be built upon.

Mrs Pederson stated that there is a definite enthusiasm regarding our ambitions as a CCG and that she and Dr Crichton have some initial ideas of how, as a CCG, we might approach things differently in the future. Mrs Atkins Whatley informed the Governing Body that she and Dr Suckling had met to discuss Health Inequalities including wider areas.

The Governing Body noted the report.

8. **Assurance Framework Report – Quarter 4**

Mrs Atkins Whatley presented the Assurance Framework Quarter 4 report and explained that it had been refreshed during the last Quarter and the position was presented as at quarter-end. The report will be presented at the Audit Committee meeting on 12th May. The closing position has been included in the Annual Governance Statement which will be submitted on 21st April 2016. There have been no new risks added to the Framework. Two risks have been removed from the Framework as forecast in the last report; one has been de-escalated to the Risk Register and one has closed completely following risk mitigation. The total number of risks on the Framework at quarter-end therefore stands at 20.

The key points from this report to which the Governing Body’s attention were particularly drawn are:

**Health inequalities (Risk 1.3): RISK BEING TREATED**

This risk remains at a score of 8 (below the risk toleration threshold) but is being treated to strengthen controls and assurances with an action to “further consider the CCG’s role in reducing health inequalities and develop any actions required as a result”. Work has been ongoing in the last Quarter in partnership with the Public Health Team in the Local Authority to develop a workshop session for Governing Body members on health inequalities. This workshop is planned to be run in Quarter 1 of 2016/17 and should result in the
development of a health inequalities plan.

Efficiency programme (Risk 1.4): RISK BEING TREATED
A change to the national business rules for CCG allocations has resulted in an extremely challenging financial position for CCGs in 2016/17 which in Doncaster could affect our local achievement of financial targets and our system transformation plans. The descriptor for Risk 1.4 which focuses on achievement of efficiency savings has therefore been refreshed to capture the current position. The financial position requires a significant efficiency programme as reported to Governing Body in March 2016. The risk identified is the impact which this significant efficiency programme could potentially have upon our local achievement of financial targets and our system transformation plans.

New controls have been added to the risk comprising Right Care analysis, prescribing analysis and our financial monitoring regime.

The likelihood of the risk has increased from a score of 2 “unlikely” where we do not expect it to happen/recur but it is possible it may do so to a score of 3 “possible” where the risk might happen or recur occasionally or a percentage likelihood of 21-50%. The likelihood risk score will be under regular review throughout the year in line with the reported financial position.

The risk treatment has been changed from “tolerate” to “treat” and an action plan has been developed to “develop and implement an efficiency programme aligned to the Right Care analysis, impact assess this against our transformation plan, and monitor progress throughout the year”. This action was opened on 17 March 2016 after the financial position was reported to the March Governing Body meeting. Since this point, the Right Care analysis received from NHS England has been reviewed by CCG team members and an efficiency programme will be developed aligned to this analysis. Prescribing has been identified as a key priority and initial meetings have taken place to begin planning.

Continuing Healthcare (Risk 1.5): RISK DE-ESCALATED TO RISK REGISTER
An informal review has been undertaken through the joint Delivery Board across all CCGs participating in the hosted service to evaluate the transition from Commissioning Support to CCG, with a positive outcome. The likelihood of the risk “failure to effectively commission, quality assure and performance manage a Continuing Healthcare (CHC) system that is safe and effective for patients and represents value for money” has therefore reduced from a score of 3 “possible” where the risk might happen or recur occasionally to a score of 2 “unlikely” where we do not expect it to happen/recur but it is possible it may do so. This results in an overall score of 8 (below the risk toleration threshold) and the risk is no longer impacting on our strategic objectives. Therefore, as proposed in the Quarter 3 update of the Assurance Framework, the risk has been de-escalated from the
Assurance Framework and will be added to the Risk Register for ongoing monitoring. Any exceptions will continue to be reported through the Quality & Performance Report received by Governing Body.

Consideration will need to be given to the risk relating to the hosted Continuing Healthcare function and the delivery of it. This is a much wider risk and will involve other CCGs. The financial risk has been incorporated into the Risk Register.

**Performance management (Risk 2.4): RISK BEING TREATED**
This risk remains at a score of 12 (above the risk toleration threshold) and it is being treated with an action to continue to take all contractual and partnership measures available to the CCG to ensure provider performance is brought back on track for key performance targets. The Governing Body receives monthly Quality & Performance reports which identify performance areas which are off trajectory. Year-end performance reports have focussed on positive performance in A&E, Referral to Treatment times, Diagnostic waiting times, Improving Access to Psychological Therapies and the Care Programme Approach (CPA). Performance issues at year-end have been particularly identified in Cancer Waiting Times and Ambulance Response Times. Remedial action on these areas has been reported to Governing Body. Given the likely pressures on the NHS system during the period of Junior Doctor industrial action and ongoing performance issues nationally in urgent care systems and Ambulance Services, the risk will be retained at its existing level and progress on performance will continue to be reported to Governing Body through the Quality & Performance Report.

**Commissioning Support Services (Risk 2.5): RISK CLOSED**
The transfer of Yorkshire & Humber Commissioning Support staff to CCGs completed on 1 March 2016 with NHS Sheffield CCG hosting shared services for Human Resources transactional support and Individual Funding Requests. That concluded the successful transfer of all services to their new host CCG. NHS Doncaster CCG had already in-housed all the services we are hosting across local CCGs (a Continuing Healthcare service and a Health, Safety & Security Service). Memorandums of Understanding are in place between participating CCGs for shared services. In the last Quarter’s reporting of the Assurance Framework, we noted that an internal review would be undertaken in March 2016 to determine the success of the transition from Commissioning Support to CCG and at this stage the risk may be closed. Due to the successful transfer of staff, the risk likelihood during the quarter decreased from a score of 5 “almost certain” where the risk will undoubtedly happen to a score of 1 “rare” where we do not expect it ever happen – as the Commissioning Support service has now terminated and staff have completed transition. This results in an overall score of 3 (below the risk toleration threshold) and the risk is no longer impacting on our strategic objectives. Therefore, as proposed in the Quarter 3 update of the Assurance Framework, the risk was closed on 31 March 2016.
Dr Jones suggested that a risk be considered regarding our hosting of services across a number of CCGs. Mrs Atkins Whatley and Mrs Shepherd will consider this risk and any outcome will be captured in the next iteration of the report.

The Governing Body noted the report.

9. **Sustainability and Transformation Plan Update**

Mrs Pederson gave the following update on the Sustainability and Transformation Plan to the Governing Body.

In December 2015, the NHS Shared Planning Guidance asked every local health and care system to come together to create their own ambitious local blueprint for implementing the priorities as laid out in the 5 Year Forward View. These are place-based, multi-year plans built on the needs of local populations and are named Sustainability and Transformation Plans (STPs).

The South Yorkshire and Bassetlaw STP has been established with membership including Accountable Officers from the five Clinical Commissioning Groups (CCGs) and colleagues from Provider organisations and Local Authorities and Sir Andrew Cash, Chief Executive of Sheffield Teaching Hospitals is the named lead.

The local plans include key local priorities and include Out of Hospital Care, End of Life Care, Children’s and Healthy Lives and Living Well and Prevention. To compliment these and based on knowledge of local need and challenges, five transformation work streams have been established as follows:

- Urgent Care
- Elective Care and Diagnostics
- Cancer
- Mental Health and Learning Disabilities
- Maternity and Children’s services

Underpinning this will also be five cross-cutting work streams as follows:

- Workforce
- Digital/IT (technology and research)
- Carter, Procurement and Shared Services
- Finance
- Economic development and Public Sector reform.

Mrs Pederson informed the Governing Body that our local plan was submitted on Friday 15th April 2016. An STP event will be held on Monday 25th April 2016. It is anticipated that attendees will be circa 260 and will provide an opportunity for people to present their initial thoughts and to discuss how to actively involve others. Dr Crichton
has been nominated as the Clinical Cancer Lead with Mr Richard Metcalfe as the Manager Lead and this will tie in with Dr Pieri’s ongoing work on Cancer. There is also an opportunity to influence on Mental Health and Learning Disabilities.

Dr Jones noted that the STP Plan is high level and queried if we are able to detect signs of hope for the people of Doncaster. Mrs Pederson stated that all organisations will be responsible for their own area however our vision is that this will be a collaborative approach.

Miss Morris supported the aims of the plan and questioned the corporate placing of the CCGs within one of the slides. Mrs Sherburn stated that this had been raised at the STP Working Group meeting where it was established that CCGs are the host and holders of the plan.

The Governing Body noted the update.

10. **Well North Update**

Mrs Sherburn gave the following update on Well North which is now one year into the programme.

Well North is a collaborative, three year programme between nine pathfinder sites, Public Health England and the University of Manchester and Well Doncaster is part of the programme and a pilot site. The objectives are to reduce health inequalities, decrease worklessness and increase resilience.

Over the Summer of 2015, the process for determining the initial area was agreed in partnership with NHS Doncaster CCG, which looked at areas which met the criteria including unplanned healthcare, crime and employment rates and Denaby Main was selected as a starting point. Recently named through a community competition, The Denaby Community Library and Hub has been opened as a meeting place and centre for information and advice. It is co-located with the local GP surgery and Pharmacy.

**Next Steps**

The next steps for the programme include the creation of a £20k community grant which will support local projects that improve quality of life, promote a sense of ownership of local opportunities and resources, and the commencement more neighbourhood groups and the revitalisation of existing groups. Health and Wellbeing training for both residents and professionals will be given, an Aspiration Week will take place in June 2016 and the focus will be to raise aspirations and engage with young people and provide information on employment opportunities and an Identifying ‘Invisible’ People project will be initiated to identify patients needing social and medical support.
Dr Crichton queried if there were plans to roll out the programme wider. Dr Suckling reported that it is hoped that it will when positive evidence of the impact of the programme is seen.

Dr Feeney observed that, although alcohol and substance misuse is acknowledged as a major issue, it is not mentioned or reflected in the report. Mrs Sherburn and Dr Suckling stated they would be happy to liaise with Dr Feeney outside of the meeting.

Dr Britten questioned when the Governing Body would be made aware of how successful the programme has been. It is anticipated that it may be around July 2016 and the Team Doncaster meeting would be an appropriate forum in which to present the findings as it is attended by NHS Doncaster CCG and Local Authority representatives.

The Governing Body noted the update.

11. Chair and Chief Officer Report

Mrs Pederson presented the joint report for noting and addressed the following points in particular:

**Governance Structure changes – proposed Constitutional amendments:** There have been various discussions over the past few months, on the refresh and realignment of our internal governance meeting structure. The discussions have been driven by the following:

- Our successful application to NHS England for delegated responsibility for primary care medical commissioning from April 2016 and the associated requirement for a Primary Care Commissioning Committee.
- Our Governing Body Time Out session in November 2015 at which agreement was reached of the ‘design rules’ of the future governance structure.
- Feedback from Member Practices on clinical engagement in the 360 degree survey, in the annual Membership Meeting and through Localities.
- A recent Audit review and benchmarking of the Audit Committee and the Quality & Safety Committee.

The proposal is a 2 phase approach as follows:

**Phase 1 effective from 1 June 2016**
- Establish a Clinical Reference Group as a non-decision making clinical advisory group comprising of all Governing Body GPs and clinical representation from our main clinical providers and clinical partners. An effective Clinical Reference Group would remove the need for the current Strategy Development Forum and Membership Engagement Forum which will merge to form the Clinical Reference Group.
- Refresh the Terms of Reference of the current Delivery &
Performance Committee to evolve into an operational executive Committee. The Committee will direct operational aspects of the organisation and report to the Governing Body the activity of the Strategic Contracting meetings and the System Resilience Group to ensure sight of these groups by the Governing Body.

Phase 2
- Further discussion on the most effective use of clinical time including clinical added value on our Governing Body.
- Further discussion on the Locality model.

The Governing Body held a discussion and the following suggestions were made:

- With the pending abolition of the Strategy Development Forum, it would be beneficial to identify a time for Organisational Development or Time Out sessions. Mrs Pederson advised that this would be discussed at the Strategy Development Forum on 5th May 2016.
- Phase 2 – It may be beneficial to hold discussions before the next Governing Body meeting and discuss in Locality meetings to prepare the Membership that a review of the Locality structure is on the horizon. An introduction of a time frame would also help.
- Localities in the same area with the similar needs could work together and gauge interest in other Localities. An approach with clear definition could be designed.
- Ask the Membership how they would like the CCG to engage with them as providers and as commissioners.

**Annual Checkpoint Review Meeting with NHS England** – The Annual Checkpoint Review Meeting with NHS England was held on 19th April 2016. The initial feedback was positive. It was noted that good progress had been made regarding the Transformation Plan and an appreciation of NHS Doncaster CCG’s hard work was given.

NHS England continues to focus attention on the financial position and asked that we continue to manage our finances effectively and continue with our Local Transformation Plan linking into the Sustainability and Transformation Plan.

**360 Stakeholder Survey** – We have received confirmation of the final response for the national Ipsos Mori 360 Stakeholder Survey and Doncaster’s overall response rate was 47%. A low response rate was noted from our Localities and Mrs Atkins Whatley reported that, as the survey is facilitated on our behalf by IPSOS Mori, we have no control over the survey requests. It would be beneficial to review how we communicate more effectively with our Member practices and engage with them on the best model to be used.

The resulting reports are expected to be available from IPSOS Mori at the end of April and will be reported to the Governing Body in due course.
The Governing Body noted the report.

12. **Items to Note**

**Finance Report**

Mrs Tingle stated that the Finance Report was for noting by the Governing Body.

Mrs Tingle informed the Governing Body that she was in the process of finalising the Annual Report in readiness for submission that afternoon in advance of the 22\textsuperscript{nd} April 2016 deadline. The required surplus target and all the financial duties have been achieved. The final position is still to be audited within the next few weeks and will be presented to the Governing Body at a future meeting.

Mrs Pederson commented that the hard work of the Finance Team should be acknowledged and Mrs Tingle stated that it is testament to the good processes in place and the calm and diligent attitude of the Finance Team.

The Governing Body noted the report.

13. **Receipt of Minutes from Sub Committees**

The following draft minutes were received and noted by the Governing Body:

- Audit Committee – Draft Minutes of the meeting held on 10\textsuperscript{th} March 2016.
- Quality & Safety Committee – The next meeting will be held on 5\textsuperscript{th} May 2016.

The refreshed Terms of Reference for the Quality & Safety Committee were presented to the Governing Body for approval as a result of the amendments made by Internal Audit. The Governing Body approved the refreshed Terms of Reference.

- Engagement & Experience Committee – The next meeting will be held on 5\textsuperscript{th} May 2016.

The refreshed Terms of Reference were presented to the Governing Body for approval. They recommended that the meetings, currently held on a Quarterly basis, be held monthly for a period of 6 months in order to address the Governing Body challenge regarding Health Inequalities and that the Engagement & Experience Management Group be suspended also for 6 months. The Patient Participation Groups and the Health Ambassador scheme will be formalised as groups feeding into the Committee.
The Governing Body approved the refreshed Terms of Reference with one amendment – to include 2 Locality Lead representatives on the membership.

- Delivery & Performance Committee – The next meeting will be held on 12th May 2016.

14. Any Other Business

Mrs Sherburn informed the Governing Body that the General Practice Forward View document has been received and would be presented to the Governing Body when the full details and impact were available.

Dr Feeney raised the Children’s Obesity Services and queried if there were any further plans for re-investment. Dr Suckling reported that there are plans to hold three workshops, the first being held on Wednesday 27th April, to discuss this further. It is envisaged that a move away from the bio medical treatment role will be made to a local model in liaison with Doncaster Rovers.

15. Date and Time of Next Meeting

12:30pm on Thursday 19th May 2016.

16. It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard 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.
Yorkshire Ambulance Service

Contract Delegation Proposals
Overview:
NHS Wakefield CCG is the lead commissioner for the 999 service from Yorkshire Ambulance Service (YAS), and NHS Greater Huddersfield CCG is the lead commissioner for the 111 service from YAS. NHS Doncaster CCG is one of the CCGs which is party to both these contracts.

The participating CCGs have, in principle, agreed the need to further strengthen the collaborative commissioning arrangements that support these contracts. The proposal is to do this through the establishment of a joint committee structure (Joint Strategic Commissioning Board) whereby each CCG delegates authority to the joint committee to make decisions on its behalf. At present authority is delegated to an individual that represents the CCG. It is also proposed to move to the joint committee from 1 October 2016.

The Yorkshire & Humber CCGs have been supported in the development of these arrangements by the Good Governance Institute and by legal advisors.

Next steps:
- Each CCG who is party to the 999/111 collaborative commissioning arrangements has been asked to take the refreshed collaborative commissioning proposal, including establishment of the Joint Strategic Commissioning Board (JSCB) to their Governing Body public meetings in May 2016.
- Subject to agreement by all parties, the joint committee (JSCB) will be established as a formally delegated committee from 1 October 2016.
- During the interim period it is proposed that delegated authority remains with a nominated individual, but that the individuals are the nominated Urgent and Emergency Care Network representatives that will sit on the JSCB.

Documents attached:
- Main document outlining impact of proposed changes
- Appendix A: Covering paper from Lead Commissioner: Updated Collaborative Commissioning Arrangements for 111 and 999 Services
- Appendix B: Memorandum of Understanding for 111 Services
- Appendix C: Memorandum of Understanding for 999 Services
**Recommendation(s)**

The Governing Body is asked to:

- Approve the establishing of a joint committee (called the Joint Strategic Commissioning Board) for the collaborative commissioning of 999/111 services from 1 October 2016 in line with the arrangements laid out in the draft Memorandums of Understanding.
- Note that NHS Doncaster CCG Constitution has been reviewed, and this delegation to a joint Committee is reserved to the Governing Body.
- Approve the interim arrangements for delegation to our nominated Urgent & Emergency Care Network representatives rather than to the Committee up to 30 September 2016, prior to the formation of the joint committee.
- Note that the Chief Officer’s Scheme of Delegation will need to be reviewed to ensure appropriate delegation to the Urgent & Emergency Care Network Lead Officers for our region (South Yorkshire).

---

### Impact analysis

<table>
<thead>
<tr>
<th>Assurance Framework</th>
<th>2.3, 2.4, 4.2, 4.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk analysis</td>
<td>The Memorandum of Understanding clearly defines the level of decisions which are reserved and delegated within the collaborative commissioning arrangements</td>
</tr>
<tr>
<td>Equality impact</td>
<td>Positive impact expected from collaborative working across the Yorkshire &amp; Humber area to commission effectively at scale and according to the needs of the population</td>
</tr>
<tr>
<td>Sustainability impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Financial implications</td>
<td>Nil</td>
</tr>
<tr>
<td>Legal implications</td>
<td>Collaborative commissioning agreement</td>
</tr>
<tr>
<td>Consultation / Engagement</td>
<td>Involvement of CCG lead officers in the work-up of the proposal</td>
</tr>
</tbody>
</table>
1 Introduction

NHS Wakefield CCG is the lead commissioner for the 999 service from Yorkshire Ambulance Service (YAS), and NHS Greater Huddersfield CCG is the lead commissioner for the 111 service from YAS. NHS Doncaster CCG is one of the CCGs which is party to both these contracts.

The participating CCGs have, in principle, agreed the need to further strengthen the collaborative commissioning arrangements that support these contracts. The proposal is to do this through the establishment of a joint committee structure (Joint Strategic Commissioning Board) whereby each CCG delegates authority to the joint committee to make decisions on its behalf. At present authority is delegated to an individual that represents the CCG. It is also proposed to move to the joint committee from 1 October 2016.

The Yorkshire & Humber CCGs have been supported in the development of these arrangements by the Good Governance Institute and by legal advisors.

NHS Doncaster CCG also considered the proposed collaborative commissioning arrangements at the Strategy Development Forum meeting on 5 May 2016. The focus of this session was to understand the implications of the proposal and views from the discussion are included in the paper below.

2 Previous arrangements

Previously, as one of the CCGs which is party to the collaborative commissioning arrangements, we delegated authority to make decisions regarding the YAS contracts to a representative of our CCG (NHS Sheffield CCG team member) who attends a commissioning meeting on our behalf. This delegation is to the individual through the Chief Officer’s Scheme of Delegation.

3 Joint Committee Proposal

From October 2016, the CCGs across Yorkshire & Humber are seeking to delegate authority to a joint committee called a Joint Strategic Commissioning Board (JSCB). The JSCB will make decisions on strategic commissioning matters. CCG representation on the JSCB will be via two Lead Officers nominated by CCGs from within the local Urgent and Emergency Care Network (UECN) to which each CCG belongs. The UECNs will provide local regional forums for discussions of matters that affect the member CCGs in that region for the Lead Officers to escalate to the JSCB as required; ours is the South Yorkshire UECN.

The table below sets out the matters that are proposed for JSCB Decision.

<table>
<thead>
<tr>
<th>Transformational</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree the range of services to be commissioned from the Provider and how they are to be commissioned</td>
<td>Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)</td>
</tr>
<tr>
<td>Agree medium to long term planning for the integration of the Service</td>
<td>Agree communications activity relating to matters governed by the Commissioning Contract</td>
</tr>
<tr>
<td>Consider and recommend service redesign</td>
<td>Resolve issues in dispute between the Parties and</td>
</tr>
</tbody>
</table>
Transformational proposals to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and UECN Delivery Plans

Contractual issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party)

Approve proposals for CQUIN indicators

Agree actions if concerns are identified about actual and contracted activity levels

4 Lead Commissioner/Contractor Role

Operational / transactional matters will, broadly, be delegated to the Lead Commissioner/Contractor: NHS Wakefield CCG for 999 services and NHS Greater Huddersfield CCG for 111 services, in line with the scheme of delegation.

The table below sets out the matters that are proposed for Lead Commissioner/Contractor Decision.

<table>
<thead>
<tr>
<th>Transformational</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>proposals to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and UECN Delivery Plans</td>
<td>issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party)</td>
</tr>
</tbody>
</table>

Approve proposals for CQUIN indicators

Agree actions if concerns are identified about actual and contracted activity levels

5 CCG Role

The table below sets out the matters which are CCG Decisions and which are reserved to each Party (CCG). CCG Decisions will ordinarily be made by each CCG’s Chief Finance Officer in accordance with its constitution.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiate and recommend the Finance schedule for 16-17 contract</td>
<td>Ratify variations to the Commissioning Contract that only affect that Party</td>
</tr>
</tbody>
</table>
Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend | Resolve issues between the Party and the Provider that do not impact on any other Party

Additional in year investment from CCGs | Final approval of the terms of the following year’s Commissioning Contract

6  Interim Period

In the interim phase prior to the establishment of a formal joint committee, the Lead Officers who are members of the JSCB will make the decisions, not the JSCB itself. Our lead officers will be the UECN nominees. Two MOUs (one for each service) have been drafted to capture the updated arrangements until establishment of the joint committee. The spread of decision making and roles will apply during the interim period as described above.

7  Items for Consideration in Response to the Proposal

At the meeting on 5 May 2016 the Strategy Development Forum noted the collaborative commissioning proposals. The following points were made for inclusion with the final response to NHS Wakefield CCG/ NHS Greater Huddersfield CCG, the lead Commissioner/ Contractors, following the discussion and decision at the Governing Body meeting.

7.1  Representation for Doncaster

The governance will be via the Urgent and Emergency Care Network through to the Doncaster System Resilience Group (SRG). Good communication flow through to the Network lead officers will be essential and it was recommended that the governance mechanisms to support this are formalised.

The CCG will be looking for YAS representation on the SRG and the weekly operational group to continue, in order to ensure both good operational communication and that YAS remain a core part of the Doncaster healthcare system.

Development of a formal communication strategy to support the proposed collaborative arrangements was recommended.

7.2  Contract Reporting and Management

It is key that information relating to Doncaster specific quality outcomes and performance continues to flow from YAS, despite the proposed changes. It was recognised that whilst the contract will be managed for the full YAS patch, local delivery and flexibility in response to local needs is essential to the Doncaster urgent care system. Live intelligence will also need to continue to be shared in order that the urgent care system can be managed effectively in Doncaster.

7.3  Review of Arrangements

It was recommended that the proposed collaborative commissioning arrangements are reviewed in 12 months to ensure that the points above are being met.
Updated Collaborative Commissioning Arrangements
for 111 and 999 Services

Paper for Governing Bodies

1. PURPOSE

1.1 This note provides details of proposed updating of the existing collaborative commissioning arrangements for commissioning 111 and 999 services from Yorkshire Ambulance Service NHS Trust ("YAS") across Yorkshire and Humber.

2. BACKGROUND

2.1 The current collaborative commissioning arrangements for 111 and 999 services are structured around the Contract Management Board and a lead commissioner arrangement.

2.2 The CCGs have in principle agreed to further strengthen the arrangements by establishing a joint committee structure whereby each CCG delegates authority to the joint committee (rather than a representative) to make decisions on its behalf. The proposed timescale to move to a joint committee structure is 1 October 2016. In order to achieve this timescale, the terms of reference for the joint committee, amended scheme of delegation and updated collaborative commissioning agreement will need to be in final draft form by 31 July 2016.

2.3 This note focuses on the updating of the existing arrangements for the interim period until October 2016 to facilitate the move to a joint committee arrangement later in the year.

3. UPDATED COLLABORATIVE ARRANGEMENTS

3.1 Under the current collaborative commissioning arrangements, the CCGs delegate authority to make decisions on certain matters to a representative who attends the Contract Management Board alongside representatives of the other CCGs who all have the same delegated authority from their respective CCGs. Certain matters are delegated to the Lead Commissioner under the current arrangements.

3.2 Under the updated arrangements, the existing three Sub-Regional CBUs are effectively replaced by the three Urgent and Emergency Care Networks (UECNs) which together match the Yorkshire and Humber CCG combined footprint. In respect of the 999 and 111 services, the UECNs will be regional forums for discussions of matters that affect the member CCGs. Each CCG delegates decision-making authority to two Lead Officers who represents the CCGs in the UECN at a new Joint Strategic Commissioning Board.

3.3 The role of the Joint Strategic Commissioning Board ("JSCB") will be to consider and make decisions relating to transformational matters, in line with the updated scheme of delegation in the draft MOU. Transactional matters will, broadly, be delegated to the Lead Commissioner / Contractor in line with the revised scheme of delegation.

3.4 In this interim phase prior to the establishment of a joint committee, the Lead Officers who are members of the JSCB make the decisions, not the JSCB. This approach can be inefficient as each Lead Officer must have the appropriate authority from the CCGs it represents to make that decision – any non-alignment in delegated authority will require a representative to go back to the CCG to seek approval. Additionally there must be unanimous decision-making. Where one Lead Officer dissents, the decision cannot be made so as to bind the dissenting party.
3.5 Whilst the Contract Management Board will continue to exist under the updated arrangements, neither it, nor its members, will have delegated authority to take decisions which bind the CCGs. It will be chaired, as it is currently, by the Lead Commissioner / Contractor, and will continue to be the forum through which the Lead Commissioner / Contractor will hold YAS to account for the delivery of the Services and implement decisions made by individual CCGs, the JSCB and the Lead Commissioner / Contractor (in line with the revised scheme of delegation).

Updated documentation

3.6 Two MOUs (one for each service) have been drafted to capture the updated arrangements until establishment of the joint committee. Two separate MOUs are required as there are additional CCGs who are commissioners of the 111 service and to amalgamate the two arrangements would be likely to result in unwieldy documentation that is difficult to navigate.

3.7 The MOUs include the following updated terms:

3.7.1 the principles and objectives of collaboration;

3.7.2 clarity on what is expected from each Party in terms of discussion, participation and attendance at meetings;

3.7.3 the service variation procedure where a variation is proposed by the CCGs or YAS;

3.7.4 detailed explanation of how matters are dealt with at different levels (CCG level, JSCB level, Lead Commissioner / Contractor level);

3.7.5 how costs are dealt with for commissioning support services;

3.7.6 a dispute resolution procedure;

3.7.7 a process for new CCGs to join or leave the collaboration;

3.7.8 terms of reference for the JSCB; and

3.7.9 a detailed Scheme of Delegation setting out which decisions are made at which level.

3.8 The Scheme of Delegation is critical as it provides information to the CCGs to amend their respective schemes of delegation to ensure aligned delegation to the Lead Officers which is necessary for efficient and lawful decision-making.

3.9 Each CCG is advised to review its constitution and schemes of delegation to identify what amendments may be required to give effect to the scheme of delegation in the MOUs.
Dated

MEMORANDUM OF UNDERSTANDING
FOR THE
COLLABORATIVE COMMISSIONING OF 111 SERVICES
BETWEEN
CLINICAL COMMISSIONING GROUPS
ACROSS
YORKSHIRE, HUMBER AND LINCOLNSHIRE

[DRAFT VERSION 3 – 29 MARCH 2016]
# CONTENTS

1. DEFINITIONS AND INTERPRETATION ................................................................. 4  
2. DURATION OF THE AGREEMENT ................................................................. 7  
3. PRINCIPLES OF THE COLLABORATIVE .................................................. 7  
4. OBJECTIVES OF THE COLLABORATIVE .................................................. 7  
5. ROLES AND RESPONSIBILITIES ................................................................. 8  
6. DECISION-MAKING ARRANGEMENTS ....................................................... 8  
7. INSPECTION .................................................................................................. 10  
8. COLLABORATIVE COSTS AND RESOURCES ............................................ 10  
9. INDEMNITY ................................................................................................... 11  
10. VARIATION .................................................................................................... 11  
11. NOTICES ....................................................................................................... 12  
12. DISPUTE RESOLUTION ................................................................................ 12  
13. JOINING THE COLLABORATIVE ............................................................... 13  
14. TERMINATION ............................................................................................. 13  
15. CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING .... 14  
16. SURVIVAL .................................................................................................... 14  
17. CONFIDENTIALITY ....................................................................................... 14  
18. DATA PROTECTION ...................................................................................... 14  
19. FREEDOM OF INFORMATION ................................................................. 15  
20. STATUS .......................................................................................................... 16  
21. ASSIGNMENT AND SUB-CONTRACTING ................................................ 16  
22. THIRD PARTY RIGHTS ................................................................................ 16  
23. COMPLAINTS .............................................................................................. 16  
24. ENTIRE AGREEMENT .................................................................................. 16  
25. SEVERABILITY ............................................................................................. 17  
26. WAIVER ......................................................................................................... 17  
27. COSTS AND EXPENSES ............................................................................ 17  
28. GOVERNING LAW AND JURISDICTION .................................................. 17  
29. FAIR DEALINGS ............................................................................................. 17  
30. COUNTERPARTS .......................................................................................... 17  

SCHEDULE 1 ..................................................................................................... 21  
PRINCIPLES OF THE COLLABORATION .................................................. 21  
SCHEDULE 2 ..................................................................................................... 22  
OBJECTIVES .................................................................................................... 22  
SCHEDULE 3 ..................................................................................................... 25  
UECNS AND LEAD OFFICERS .................................................................... 25  
SCHEDULE 4 ..................................................................................................... 28  
JSCB – ROLE AND TERMS OF REFERENCE ............................................ 28  
SCHEDULE 5 ..................................................................................................... 32  
LEAD COMMISSIONER / CONTRACTOR ROLE ............................................ 32
Appendix B

SCHEDULE 6 .........................................................................................................................................33
SCHEME OF DELEGATION ..................................................................................................................33
SCHEDULE 7 .........................................................................................................................................37
VARIATIONS TO THIS AGREEMENT ...................................................................................................37
SCHEDULE 8 .........................................................................................................................................38
SERVICE VARIATION PROCESS ........................................................................................................38
SCHEDULE 9 .........................................................................................................................................42
MEMORANDUM OF ADHERENCE ....................................................................................................42
SCHEDULE 10 ......................................................................................................................................47
EXISTING PARTIES ..........................................................................................................................47
THIS AGREEMENT is dated the    day of                     2016

BETWEEN

The clinical commissioning groups listed in Schedule 10, each a “Party” and together the “Parties”.

BACKGROUND

(A) NHS Greater Huddersfield CCG, on behalf of all Parties, is a signatory to a single contract with Yorkshire Ambulance Service NHS Trust for the provision of 111 services in each Party’s area.

(B) This Agreement sets out a framework for collaborative decision-making by the Parties in relation to matters concerning the commissioning of those services.

(C) The Parties intend to establish a joint committee of the Parties to enable collaborative decision-making in respect of the Services. The provisional timescale for setting up such joint committee has been agreed as October 2016.

IT IS AGREED:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

"999 Commissioning Contract" the contract between some of the Parties and the Provider for the provision of 999 services dated 1 April 2015;

"Agreement" this agreement between the Parties comprising these terms and conditions, together with all Schedules;

"CCG" a clinical commissioning group Party listed in Schedule 10;

"CCG Decisions" has the meaning set out in Clause 6.1.1;

"Collaborative" the collaborative commissioning arrangements set out in this Agreement;

"Commencement Date" 1 April 2016;

"Commissioning Contract" the contract between NHS Greater Huddersfield CCG (as Lead Commissioner / Contractor on behalf of all the Parties as commissioner) and the Provider for the provision of the Services dated 1 April 2013;

"Commissioning Contract Variation Report" has the meaning set out in Clause 10.12

"Defaulting Party" a Party that commits a persistent or material breach of this Agreement;

"Dispute Resolution" the process set out in Clause 12;

"DPA" the Data Protection Act 1998 as amended from time to time;

"Exiting Party" has the meaning in Clause 15.1;

"FOIA" the Freedom of Information Act 2000 as amended from time to time;
"Functions" the statutory functions of each of the Parties in relation to the provision of, or making arrangements for the provision of, the Services;

"Guidance" any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Parties and/or the Provider have a duty to have regard (and whether specifically mentioned in the Commissioning Contract or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Parties and/or any relevant Regulatory or Supervisory Body;

"JSCB" the Joint Strategic Commissioning Board, the role and terms of reference for which are set out in Schedule 4;

"JSCB Decisions" has the meaning set out in Clause 6.1.2;

"Law" (i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;

(ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972;

(iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;

(iv) Guidance;

(v) National Standards; and

(vi) any applicable code, in each case in force in England and Wales;

"Lead Officer" has the meaning set out in Clause 6.7.4;

"Lead Commissioner / Contractor" NHS Greater Huddersfield CCG;

"Lead Commissioner / Contractor Decisions" has the meaning set out in Clause 6.1.3;

"National Standards" those standards applicable to the Provider under the Law and/or Guidance as amended from time to time;

"Objectives" the objectives set out in Clause 4.1 and Schedule 2;

"Personal Data" has the meaning given to it in the DPA;

"Provider" Yorkshire Ambulance Service NHS Trust;

"Regulatory or Supervisory Body" any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party must comply or to which it must or should have regard, including:

(i) Care Quality Commission;

(ii) Monitor;
(iii) NHS Trust Development Authority;
(iv) NHS England;
(v) the Department of Health;
(vi) NICE; and
(vii) HealthWatch England;

"Service Variation" a variation to the Commissioning Contract which refers to the Service and reflects:

(i) the assessment by the Parties of pathway needs, the availability of alternative providers and demand for the Service; and/or

(ii) the joint assessment of the Provider and Parties of the quality and clinical viability of the Service and the Services Environment; and/or

(iii) the likely impact of any transformational need and/or reconfiguration of a care pathway that might affect the Service; and/or

(iv) a change to the Service that could potentially have a material impact on any or all of quality and safety, performance and activity and finance, such material impact not to be confined to the proposing Party and “material” is to be interpreted taking into account the potential impact on other Parties, the UECNs and the Commissioning Contract as a whole;

"Services" the 111 call handling, the urgent primary medical care services and the minor injury unit services provided by the Provider under the terms of the Commissioning Contract;

"Services Environment" has the meaning set out in the Commissioning Contract;

"Service Users" any individual for whose benefit the Services are provided;

"Term" one (1) year from the Commencement Date;

"Terminating Party" a Party exercising its rights to terminate this Agreement in accordance with Clauses 14.6 and 14.8;

"UECNs" the Urgent and Emergency Care Networks listed in Schedule 3, and “UECN” shall be construed accordingly;

"Variation" an addition, deletion or amendment to the Clauses of or the Schedules to this Agreement, agreed by the Parties in accordance with Clause 10 (Variation);

"Variation Report" has the meaning in Clause 10.4; and

"Working Day" any day other than Saturday, Sunday, a public or bank holiday in England and Wales.

1.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
1.3 The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are clauses in this Agreement.

1.4 References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

1.5 References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

1.6 Words importing the singular number only shall include the plural.

1.7 Where anything in this Agreement requires the mutual agreement of the Parties, then unless the context otherwise provides, such agreement must be in writing.

1.8 If there is any conflict between the terms of this Agreement and the terms of the Commissioning Contract, the terms of the Commissioning Contract will prevail.

1.9 If there is any conflict between the Clauses of this Agreement and the provisions of any Schedule to this Agreement, the Clauses of this Agreement will prevail.

2. DURATION OF THE AGREEMENT

2.1 This Agreement comes into effect on the Commencement Date and shall remain in force until the end of the Term, subject to earlier termination in accordance with Clause 14 (Termination) and any extension agreed in accordance with Clause 2.2 below.

2.2 The Parties may agree in writing to extend the Term any number of times but each time by a period of up to twelve (12) months. The Agreement shall expire automatically without notice at the end of the Term (subject to earlier termination in accordance with Clause 14 (Termination)).

3. PRINCIPLES OF THE COLLABORATIVE

3.1 In performing their respective obligations under this Agreement, the Parties must act in accordance with the principles set out in Schedule 1.

4. OBJECTIVES OF THE COLLABORATIVE

4.1 The Parties agree that, with effect from the Commencement Date, the main objective of the Collaborative is to improve the provision of the Services through the arrangements set out in this Agreement.

4.2 The Parties agree that further objectives of the Collaborative in relation to the Services are as set out in Schedule 2 and the Parties agree to act in the furtherance of these Objectives.

4.3 The Parties agree to seek to achieve the Objectives of the Collaborative through:

4.3.1 planning for the provision and transformation of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Parties’ respective commissioning intentions and ambitions;

4.3.2 agreeing the extent of the Services and negotiating the Commissioning Contract;

4.3.3 managing and maintaining the Commissioning Contract, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services; and
4.3.4 managing variations to the Commissioning Contract in accordance with national policy, the needs of Service Users and clinical developments.

5. ROLES AND RESPONSIBILITIES

5.1 The Parties acknowledge that the Services comprise three types of service - all Parties jointly commission the 111 call handling services but only certain of the Parties jointly commission the urgent care primary services and the minor injury units services.

5.2 The Parties agree that:

5.2.1 only those Parties (or their representatives) set out at paragraph 2 of Schedule 5 may make decisions in relation to urgent primary medical care services; and

5.2.2 only those Parties (or their representatives) set out at paragraph 3 of Schedule 5 may make decisions in relation to minor injury units services.

5.3 Each Party must:

5.3.1 participate in discussions at meetings of the UECN at which they are a member;

5.3.2 agree with other members of the relevant UECN two representatives (“Lead Officers”) to represent that UECN at meetings of the JSCB;

5.3.3 ensure the relevant Lead Officers have considered all documentation and are fully prepared to discuss matters at meetings of the JSCB;

5.3.4 make all reasonable efforts to require their Lead Officers to inform the other Lead Officers in advance if a relevant Lead Officer is unable to attend meetings of the JSCB;

5.3.5 ensure its relevant Lead Officers engage with all other Lead Officers and attendees, if relevant, in matters related to this Agreement;

5.3.6 communicate openly and in a timely manner about concerns, issues or opportunities relating to this Agreement; and

5.3.7 respond promptly to all requests for, and promptly offer, information or proposals relevant to the operation of the Collaboration.

6. DECISION-MAKING ARRANGEMENTS

6.1 The Parties agree that, for matters relating to the Commissioning Contract and the achievement of the Objectives of the Collaborative, there are three different levels of decision-making (as set out in Schedule 6):

6.1.1 those decisions reserved to each Party (“CCG Decisions”);

6.1.2 those decisions which are delegated by each Party to a Lead Officer acting in collaboration with the other Lead Officers (“JSCB Decisions”); and

6.1.3 those decisions which are delegated to the Lead Commissioner / Contractor by each Party (“Lead Commissioner / Contractor Decisions”).

6.2 CCG Decisions

6.3 Each Party must ensure that the matters set out as CCG Decisions in Schedule 5 are reserved to the Party (or governing body or committee of the Party as appropriate).

6.4 The Parties agree that the Lead Commissioner / Contractor does not have delegated authority to make CCG Decisions. Each Party agrees that its Chief Finance Officer (or duly authorised alternative in their absence) shall be authorised to take CCG
Decisions on its behalf, in accordance with that Party’s constitution and scheme of delegation.

6.5 Each Party shall put in place mechanisms to ensure CCG Decisions are notified to the Lead Commissioner / Contractor within 14 days of such CCG Decisions being taken for appropriate action to be taken in relation to the Commissioning Contract.

6.6 JSCB Decisions

6.7 The Parties acknowledge that:

6.7.1 the Parties are able to discuss matters related to Lead Officer Decisions at UECN meetings;
6.7.2 the Parties included in each UECN are set out in Schedule 1;
6.7.3 the Parties that are included in each UECN may send representatives to meetings of the UECN to represent that Party;
6.7.4 the Lead Officers take the recommendations of the Parties at UECNs to the JSCB to inform JSCB Decisions; and
6.7.5 the Lead Officers will consider the recommendations of UECNs at meetings of the JSCB in making JSCB Decisions as appropriate.

6.8 Each Party agrees:

6.8.1 that the relevant Lead Officers indicated in Schedule 3 represent that Party at meetings of the JSCB;
6.8.2 that the relevant Lead Officers indicated in Schedule 3 make JSCB Decisions on behalf of that Party at meetings of the JSCB; and
6.8.3 the role and terms of reference of the JSCB that are set out in Schedule 4.

6.9 Each Party must

6.9.1 ensure that the matters set out as JSCB Decisions in Schedule 6 are delegated effectively and lawfully to the relevant Lead Officers indicated in Schedule 3 such that the Lead Officers have the appropriate power to bind that Party in relation to JSCB Decisions made at meetings of the JSCB;
6.9.2 ensure that the Lead Officers are sufficiently appraised of the scope of the delegation by the relevant Party to the Lead Officers in relation to JSCB Decisions; and
6.9.3 ensure the Lead Officers are able to give and receive notices and other communications that relate to the Collaborative.

6.10 The Parties agree that:

6.10.1 the JSCB is not a joint committee of the Parties and does not have delegated authority to make decisions that bind the Parties; and
6.10.2 it is the relevant Lead Officers that makes JSCB Decisions which bind the Party represented by those Lead Officers; and
6.10.3 the Lead Commissioner / Contractor does not have delegated authority to make JSCB Decisions.

6.11 The Parties acknowledge that there needs to be unanimity across all Lead Officers in order for JSCB Decisions to be made in collaboration.

6.12 Where unanimity is not reached between the Lead Officers, the Parties agree that the matter may be referred to dispute resolution in accordance with Clause 12 (Dispute Resolution).
6.13 The Lead Officers shall agree mechanisms to ensure JSCB Decisions that are unanimously determined by the Lead Officers are notified to the Lead Commissioner / Contractor for appropriate action to be taken in relation to the Commissioning Contract.

6.14 **Lead Commissioner / Contractor Decisions**

6.15 Each Party must ensure that the matters set out as Lead Commissioner / Contractor Decisions in Schedule 6 are delegated effectively and lawfully to the Lead Commissioner / Contractor.

6.16 Subject to Clause 6.15, the Parties acknowledge that the Lead Commissioner / Contractor is able to:

6.16.1 make Lead Commissioner / Contractor Decisions and such decisions will bind all of the Parties;

6.16.2 take appropriate action under the Commissioning Contract in relation to Lead Commissioner / Contractor Decisions without reference to the Parties or the Lead Officers.

6.17 The Lead Commissioner / Contractor shall chair meetings of the Contract Management Board, through which the Provider shall be held to account (the terms of reference for which are set out in Schedule 5). The Contract Management Board shall not have any authority in and of itself to make decisions which bind the Parties; it is a forum in which:

6.17.1 Lead Commissioner / Contractor Decisions may be made and/or implemented by the Lead Commissioner / Contractor; and

6.17.2 JSCB Decisions and/or CCG Decisions may be implemented by the Lead Commissioner / Contractor.

7. **INSPECTION**

7.1 The Parties shall co-operate with any investigation undertaken by any Regulatory or Supervisory Body in respect of the Services.

8. **COLLABORATIVE COSTS AND RESOURCES**

8.1 The Parties agree that payments due under the Commissioning Contract shall be made in accordance with the provisions of the Commissioning Contract.

8.2 Each Party agrees to set aside £20,000 per year to reimburse costs incurred by the Lead Commissioner / Contractor associated with the purposes set out in Clause 8.3 and the costs associated with the purposes set out in the 999 Commissioning Contract.

8.3 The Lead Commissioner / Contractor shall be authorised by all Parties to agree and pay the following costs in respect of the Collaborative:

8.3.1 audit fees;

8.3.2 fees for consultancy fees including expenses;

8.3.3 booking of facilities for meetings of the JSCB; and

8.3.4 fees relating to initiatives and contributions to support the National Ambulance Commissioners Network.

8.4 The Lead Commissioner / Contractor shall pay such costs incurred as set out in Clause 8.3 and recharge each Party its share of the costs proportionately according to the relevant Party’s CCG population as a proportion of the total population of all of the CCGs combined.
8.5 Staff costs associated with the management of the Commissioning Contract will be managed separately to the costs set out in Clause 8.3 and each Party agrees to pay their share of the costs proportionately according to the relevant Party’s CCG population as a proportion of the total population of all of the CCGs.

8.6 The Parties shall ensure prompt payment of their share of such costs set out in this Clause 8 to the Lead Commissioner / Contractor and in any event shall pay such shares within 30 days of receipt of a claim for payment from the Lead Commissioner / Contractor.

9. **INDEMNITY**

9.1 Nothing in this Agreement shall affect the liabilities of the Parties to the Service Users in respect of their Functions.

9.2 Each Party undertakes to indemnify each other Party against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses, whether arising in tort (including negligence) or as a result of default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of the indemnifying Party (or its employees, agents or sub-contractors), except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the indemnified Party or (or its employees, agents or sub-contractors).

9.3 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer’s liability, liability to third parties and all other potential liability under this Agreement.

10. **VARIATION**

10.1 If at any time during the term of this Agreement any Party requests in writing any Variation to this Agreement (which may include changes required as a result of a change in law), Clauses 10.4 to 10.8 shall apply.

10.2 If at any time during the term of this Agreement any Party requests in writing any variation to the Commissioning Contract, Clauses 10.10 to 10.14 shall apply.

10.3 **Variations to this Agreement**

10.4 The Party proposing the Variation shall provide a report in writing to the other Parties (the **"Variation Report"**) setting out:

   10.4.1 the Variation proposed;
   10.4.2 the date upon which the Variation is to take effect;
   10.4.3 a statement of the impact the Variation will have on, and any change required to, the Schedules;
   10.4.4 a statement on the individual responsibilities of the Parties for any implementation of the Variation; and
   10.4.5 details of any proposed staff and employment implications.

10.5 Following receipt by the receiving Parties of the Variation Report and allowing twenty (20) Working Days in which to consider the Variation Report, the Parties shall meet to discuss the proposed Variation and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

10.6 Where the Parties are unable to agree on the terms of the Variation then any Party may refer the matter to dispute resolution under Clause 12 (Dispute Resolution).

10.7 All Variations made to this Agreement shall be agreed between the Parties. Such Variations to this Agreement are only to be effective if made in writing and signed by all the Parties.
10.8 Variations to this Agreement shall be appended to this Agreement at Schedule 6.

10.9 **Variations to the Commissioning Contract**

10.10 Where a variation to the Commissioning Contract is a Service Variation, the process set out in Schedule 7 shall be followed.

10.11 Where a variation to the Commissioning Contract is not a Service Variation, the process set out in Clauses 10.12 to 10.14 shall be followed.

10.12 The Party proposing any variation to the Commissioning Contract shall provide a report in writing to the Lead Officers (the "**Commissioning Contract Variation Report**") setting out:

10.12.1 the variation proposed;

10.12.2 the date upon which the variation is to take effect; and

10.12.3 a statement on the individual responsibilities of the Parties for any implementation of the variation;

10.13 Following receipt by the receiving Lead Commissioner / Contractor of the Commissioning Contract Variation Report, the JSCB shall meet to hear the Lead Commissioner / Contractor’s recommendations on the proposed variation and acting reasonably and in good faith shall use reasonable endeavours to agree the variation.

10.14 Where the variation is agreed by the JSCB, the Lead Commissioner / Contractor shall make the necessary arrangements to implement the variation in accordance with the relevant provisions of the Commissioning Contract.

11. **NOTICES**

11.1 Any notices to be given under this Agreement must be in writing and served on the Lead Officers either by hand, post, or e-mail to the address for that Lead Officer as set out in Schedule 3.

11.2 Notices:

11.2.1 by post will be effective upon the earlier of actual receipt, or five (5) Working Days after mailing;

11.2.2 by hand will be effective upon delivery;

11.2.3 by e-mail will be effective when sent in legible form subject to no automated response being received.

11.3 The Lead Officers shall circulate such notices as soon as reasonably practicable to the Parties they represent.

11.4 Any notices to be given under the Commissioning Contract shall be served in accordance with the provisions of the Commissioning Contract.

12. **DISPUTE RESOLUTION**

12.1 Where any dispute arises between the Parties (including the Lead Commissioner / Contractor) or where a decision of the JSCB is not unanimous, the Parties, through the relevant Lead Officers, must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the JSCB.

12.2 Where any matter referred to dispute resolution is not resolved under Clause 12.1, any Lead Officer may request an emergency meeting of the JSCB and use their best endeavours to resolve that dispute on an informal basis.

12.3 If any dispute is not resolved under Clauses 12.1 and 12.2, any Party in dispute may refer the dispute to the Chief Officers of the relevant Parties, who will co-operate in
good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

12.4 Where any dispute is not resolved under Clauses 12.1 to 12.3, any Party in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the Parties in dispute.

13. JOINING THE COLLABORATIVE

Joining

13.1 A clinical commissioning group that wishes to join the Collaboration may do so, subject to:

13.1.1 that Party agreeing to be bound by the terms of this Agreement; and

13.1.2 the agreement of all the existing Parties.

13.2 If a clinical commissioning group becomes a Party to this Agreement, that clinical commissioning group must sign a memorandum of adherence in the form set out in Schedule 9.

13.3 The Parties agree that statutory successor bodies to any one or more of the Parties shall be deemed to be Parties to this Agreement and the agreement of the remaining Parties in accordance with Clause 13.1 is not required. For the avoidance of doubt, this includes an organisation formed as a result of a statutory merger of two or more Parties.

14. TERMINATION

14.1 Termination of this Agreement

14.2 The Parties may agree in writing at any time to terminate this Agreement from such date as may be agreed between the Parties.

14.3 Termination of a Defaulting Party

14.4 The remaining Parties acting in agreement may, at any time terminate a Defaulting Party's participation in the Agreement by notice in writing to the Defaulting Party where such default is not capable of remedy or, where capable of remedy, has not been remedied within two (2) weeks of the Defaulting Party receiving notification of such default.

14.5 Termination of a Party in relation to the Service

14.6 Where a Party terminates its participation in the Commissioning Contract, that Party's participation in this Agreement shall automatically terminate on the same date.

14.7 Termination of a Party's participation in the Agreement

14.8 Any Party may terminate its participation in this Agreement by giving the other Parties notice in writing if that Party's fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of State, regulations or legislation issued or enacted after the Commencement Date.

14.9 Upon termination in accordance with Clauses 14.4 to 14.8, this Agreement shall partially terminate as between the remaining Parties and the Defaulting Party or Terminating Party (as the case may be) only. For the avoidance of doubt, this Agreement shall continue in force as between the remaining Parties notwithstanding any partial termination in respect of any one or more Parties and the remaining Parties shall effect such amendments to this Agreement as may be necessary in accordance with Clause 10 (Variation).
15. **CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING**

15.1 In the event that this Agreement expires, is terminated (whether in full or in part) or a Party leaves the Collaborative (the "Exiting Party"), the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement and the following provisions shall (unless agreed otherwise by the Parties) have effect:

15.1.1 each Party shall ensure or procure the continued provision of the Services related to its Functions;

15.1.2 insofar as it is necessary, each Party shall use its reasonable endeavours to arrange and ensure the novation of any relevant contracts which are necessary to be novated from an Exiting Party to a remaining Party who shall accept such novation.

15.2 The Parties shall at all times act in such a manner as not to adversely affect the delivery of the Services.

16. **SURVIVAL**

16.1 The provisions of this Agreement which are expressly stated to survive its termination or expiry or which are intended by their nature to survive termination or expiry shall continue in force (including but not limited to Clauses 7, 8, 9, 12, 15, 16, 17, 18 and 28 together with those other Clauses, the survival of which is necessary for the interpretation or enforcement of this Agreement).

16.2 Termination or expiry of this Agreement does not affect any accrued rights or remedies under this Agreement or any other agreement between the Parties.

17. **CONFIDENTIALITY**

17.1 Except as required by law and specifically pursuant to Clause 19 (Freedom of Information), each Party agrees at all times during the continuance of this Agreement and after its termination or expiry to keep confidential any and all information, data and material of any nature which that Party may receive or obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of another Party, its employees, agents and/or any other person with whom it has dealings. For the avoidance of doubt this Clause shall not affect the rights of any workers under section 43 A-L of the Employment Rights Act 1996.

17.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions and concerning Service User information relating to users of the Services (including material affected by the DPA in force at the relevant time) to enable the efficient operation of the Collaborative.

18. **DATA PROTECTION**

18.1 The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

18.2 To the extent that a Party is acting as a Data Processor (as such term is defined in the DPA) on behalf of one or more of the other Parties, that Party shall, in particular, but without limitation:

18.2.1 only process such Personal Data as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the other Party or Parties under this Agreement;

18.2.2 put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in Clause 18.3.3 below, the state of technical development and the level of damages that may be
suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

18.2.3 take reasonable steps to ensure the reliability of employees who will have access to such Personal Data, and ensure that such employees are aware of and trained in the policies and procedures identified in Clauses 18.3.4, 18.3.5 and 18.3.6 below; and

18.2.4 not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the other Party or Parties (as relevant).

18.3 The Parties shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation, which shall include without limitation the obligation to:

18.3.1 perform an annual information governance self-assessment;

18.3.2 have an information guardian able to communicate with the other Parties, who will take the lead for information governance and from whom the other Parties shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches;

18.3.3 (where transferred electronically) only transfer essential data that is (i) necessary for direct care of users of the Services; and (ii) encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes);

18.3.4 have policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data;

18.3.5 have agreed protocols for sharing Personal Data with other NHS organisations and non-NHS organisations; and

18.3.6 have a system in place and a policy for the recording of any telephone calls, where appropriate, in relation to the Services, including the retention and disposal of such recordings.

19. FREEDOM OF INFORMATION

19.1 Each Party acknowledges that the other Parties are subject to the requirements of the FOIA and each Party shall assist and co-operate with the others (at their own expense) to enable the other Parties to comply with their information disclosure obligations.

19.2 Where a Party receives a "request for information" (as defined in the FOIA) in relation to information which it is holding on behalf of another Party, it shall (and shall procure that its sub-contractors shall):

19.2.1 transfer the request for information to the other Party as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information;

19.2.2 provide the other Party with a copy of all information in its possession or power in the form that the other Party requires within five (5) Working Days (or such other period as may be agreed) of the other Party requesting that information; and

19.2.3 provide all necessary assistance as reasonably requested to enable the other Party to respond to the request for information within the time for compliance set out in section 10 of the FOIA.
19.3 Where a Party receives a request for information which relates to the Agreement, it shall inform the other Parties of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information.

19.4 If any Party determines that information must be disclosed pursuant to Clause 19.3, it shall notify the other Parties of that decision at least two (2) Working Days before disclosure.

19.5 Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

19.6 Each Party acknowledges that the other Parties may be obliged under the FOIA to disclose information:

19.6.1 without consulting with the other Parties; or

19.6.2 following consultation with the other Parties and having taken their views into account.

20. STATUS

20.1 The Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this Agreement shall be treated as an NHS Contract and shall not be legally enforceable.

20.2 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render any Party directly liable to any third party for the debts, liabilities or obligations of any other Party.

20.3 Save as specifically authorised under the terms of this Agreement, a Party shall not hold itself out as the agent of any other Party.

21. ASSIGNMENT AND SUB-CONTRACTING

21.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by any Party without the prior written consent of the other Parties, except to any statutory successor to the relevant function.

22. THIRD PARTY RIGHTS

22.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

23. COMPLAINTS

23.1 Any complaints relating to a Party's Functions shall be dealt with in accordance with the statutory complaints procedure of that Party.

23.2 Insofar as any complaint may relate to the content of this Agreement such complaints shall be referred to the meetings of the JSCB. The Parties shall co-operate as to the resolution of complaints.

23.3 In the event that a complaint arises about the Commissioning Contract, that complaint should be dealt with in accordance with the procedure set out in the Commissioning Contract.

24. ENTIRE AGREEMENT

24.1 This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Agreement.
25. **SEVERABILITY**

25.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

26. **WAIVER**

No failure or delay by a Party to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

27. **COSTS AND EXPENSES**

27.1 Each Party shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

28. **GOVERNING LAW AND JURISDICTION**

28.1 This Agreement shall be governed by and construed in accordance with English Law and, subject to Clauses 12 (Dispute Resolution) and 20.1 (Status), the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

29. **FAIR DEALINGS**

The Parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any of them and that if in the course of the performance of this Agreement, unfairness to any of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

30. **COUNTERPARTS**

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Parties shall constitute a full original of this Agreement for all purposes.

This Agreement is effective on the date stated at the beginning of it.

IN WITNESS OF WHICH the Parties have signed this Agreement on the date shown below

**NHS EAST RIDING OF YORKSHIRE**

**CLINICAL COMMISSIONING GROUP**

Authorised Officer Date

**NHS HULL**

**CLINICAL COMMISSIONING GROUP**

Authorised Officer Date
NHS VALE OF YORK
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS HARROGATE AND RURAL DISTRICT
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS SCARBOROUGH AND RYEDALE
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS WAKEFIELD
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS LEEDS NORTH
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS LEEDS SOUTH AND EAST
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS LEEDS WEST
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BRADFORD CITY
NHS DONCASTER
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BASSETLAW
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS NORTH LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS NORTH EAST LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date
SCHEDULE 1

PRINCIPLES OF THE COLLABORATION

1. Principles of the Collaboration

1.1. In performing their respective obligations under this Agreement, the Parties must:

1.1.1. act in the best interests of patients and the public;

1.1.2. at all times act in good faith towards each other;

1.1.3. collaborate and co-operate to work towards ensuring that the commissioning ambitions and intentions of each of the Parties are met with the aim of achieving fairness and equity between the Parties as to the costs and quality of the Services provided;

1.1.4. act in a timely manner and recognise the time-critical nature of the Commissioning Contract and respond accordingly to requests for support;

1.1.5. be accountable by taking on, managing and accounting to the other Parties for the performance of their respective roles and responsibilities set out in this Agreement;

1.1.6. learn from best practice of other commissioning organisations and seek to develop as a collaborative to achieve the full potential of the relationship;

1.1.7. share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

1.1.8. adopt a positive outlook and behave in a positive, proactive manner;

1.1.9. act in an inclusive manner with regards to collaboration;

1.1.10. adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information;

1.1.11. manage internal and external stakeholders effectively;

1.1.12. work toward a reduction in health inequality and improvement in health and well-being;

1.1.13. focus on quality;

1.1.14. seek best value for money, productivity and effectiveness;

1.1.15. develop towards a level of commissioning that is equal to best international practice; and promote innovation.
Appendix B

**SCHEDULE 2**

**OBJECTIVES**

1. **Objectives**

1.1. The further objectives of the Collaborative in relation to the Services are to:

1.1.1. regulate the respective rights and duties of the Parties in relation to the Commissioning Contract, in particular:

   (a) the sharing of liabilities arising from a breach of, or any costs payable in terms of, the Commissioning Contract;

   (b) compensating the Lead Commissioner / Contractor for the costs or liabilities incurred by the Lead Commissioner / Contractor in relation to the Commissioning Contract;

1.1.2. manage the performance of the Commissioning Contract by the Provider generally and, in particular, ensure that the Provider’s performance is closely monitored so that the Services are provided to the specifications and service levels contained in the Commissioning Contract;

1.1.3. co-ordinate the respective requirements of the Parties for the Services;

1.1.4. act collaboratively in the planning, securing and monitoring of the Services so as to:

   (c) plan (including needs assessment), procure and performance monitor services (as defined and agreed by the Parties) to meet the health needs of the local population;

   (d) undertake reviews of the Services, manage the introduction of new services, drugs and technologies and oversee the implementation of NICE and/or other national guidance or standards relating to the Services;

   (e) agree the range of the Services;

   (f) conduct market management and service design;

   (g) provide a coordinated approach to commissioning input to clinical networks, local commissioning fora and partnerships;

   (h) engage with patients and service users and their carers and families;

   (i) monitor and review the effectiveness of the Collaborative;

   (j) set quality standards;

   (k) design demand management processes;

   (l) obtain best performance, quality and value from the Services by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
(m) ensure the Services meet patients’ rights under the NHS Constitution including Service User booking, patient choice and waiting time standards;

(n) ensure the Services are reviewed for cost effectiveness and represent best value for money;

(o) from time to time negotiate and agree variations of specifications and contract terms;

(p) co-ordinate and plan for demand, financial and investment needs of the Parties during the life of the Commissioning Contract;

(q) implement in-year financial adjustments required under the Commissioning Contract with the Provider, and consequential adjustments between the Parties;

(r) carry out annual or other reviews with the Provider, as required under the Commissioning Contract;

(s) agree referral, discharge and other protocols with the Provider under the Commissioning Contract;

(t) establish the arrangements for managing the day to day contact in the Commissioning Contract;

(u) co-ordinate the Parties’ proposals for, and plan with the Provider, the development of the Services and undertake or commission related research;

(v) monitor and control disclosure of NHS confidential information to the Providers, and use of the Provider’s confidential information by the Parties and within the NHS, as required by Law or the Commissioning Contract;

(w) co-ordinate proposals of the Parties to move provision of the Services from the Provider to others as part of service or pathway reconfiguration;

(x) participate in and monitor clinical networks;

(y) deliver the 111 strategy;

(z) enable the Parties to have a strategic view of key relevant issues impacting across respective populations to ensure a clear focus on patient and health outcomes;

(aa) enable robust working relationships between the Parties and the Provider and share early thinking on key issues;

(bb) ensure that the cumulative impacts of service reviews/development are identified and managed;

(cc) enable the benefit of working together on achieving best value for money and optimising productivity and efficiency;

(dd) establish any links and/or reporting networks with other patient care commissioning groups, as may from time to time be convenient;

(ee) participate in Quality Surveillance and Assurance Groups;
(ff) provide management information to the Parties on both the cumulative overview and each Party’s local perspective;

(gg) establish clear reporting and escalation protocols regarding quality, safety and performance issues for each Party and review these on a regular basis;

(hh) work within the Quality Surveillance principles and processes; and

(ii) work towards adopting a joint committee approach to collaborative commissioning of the Services by October 2016.
**SCHEDULE 3**

**UECNS AND LEAD OFFICERS**

1. Parties

1.1. The table below sets out:

1.1.1. the UECNs;

1.1.2. the relevant Lead Officers (and contact details of the Lead Officers) for each UECN; and

1.1.3. the Parties (and address of the principal office of the Parties) that are included in each UECN and represented by the Lead Officers:

<table>
<thead>
<tr>
<th>UECN</th>
<th>Lead Officers</th>
<th>Contact details of Lead Officers</th>
<th>Party</th>
<th>Address of principal office of Party</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[insert]</td>
<td>Email: [insert] Address: [insert]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name: [insert] Tel: [insert] Email: [insert] Address: [insert]</td>
<td></td>
<td>NHS Hull Clinical Commissioning Group (&quot;Hull CCG&quot;)</td>
<td>2nd Floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Vale of York Clinical Commissioning Group (&quot;Vale of York CCG&quot;)</td>
<td>West Offices, Station Rise, York, YO1 6GA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (&quot;Hambleton, Richmondshire and Whitby CCG&quot;)</td>
<td>Hambleton District Council, Civic Centre, Stone Cross, Northallerton, North Yorkshire, DL6 2UU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Harrogate and Rural District Clinical Commissioning Group (&quot;Harrogate and Rural District CCG&quot;)</td>
<td>1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Scarborough and Ryedale Clinical Commissioning Group (&quot;Scarborough and Ryedale CCG&quot;)</td>
<td>Scarborough Town Hall, St Nicholas Street, Scarborough, North Yorkshire, YO11 2HG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS North Lincolnshire Clinical Commissioning Group</td>
<td>The Health Place, Wrawby Road, Brigg, South Humberside,</td>
</tr>
<tr>
<td>Region</td>
<td>[insert]</td>
<td>Name: [insert]</td>
<td>Tel: [insert]</td>
<td>Email: [insert]</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------</td>
<td>---------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>South Yorkshire</td>
<td>[insert]</td>
<td>NHS Sheffield Clinical Commissioning Group (&quot;Sheffield CCG&quot;)</td>
<td>722 Prince of Wales Road, Darnall, Sheffield, South Yorkshire, S9 4EU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>NHS Barnsley Clinical Commissioning Group (&quot;Barnsley CCG&quot;)</td>
<td>Hillder House, 49-51 Gawber Road, Barnsley, South Yorkshire, S75 2PY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>NHS Rotherham Clinical Commissioning Group (&quot;Rotherham CCG&quot;)</td>
<td>Oak House, Moorhead Way, Bramley, Rotherham, South Yorkshire, S66 1YY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>NHS Doncaster Clinical Commissioning Group (&quot;Doncaster CCG&quot;)</td>
<td>Sovereign House, Heavens Walk, Doncaster, South Yorkshire, DN4 5HZ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>NHS Bassetlaw Clinical Commissioning Group (&quot;Bassetlaw CCG&quot;)</td>
<td>Retford Hospital, North Road, Retford, Nottinghamshire, DN22 7XF</td>
<td></td>
</tr>
<tr>
<td>West Yorkshire</td>
<td>[insert]</td>
<td>NHS Wakefield Clinical Commissioning Group (&quot;Wakefield CCG&quot;)</td>
<td>White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>NHS Bradford City Clinical Commissioning Group</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5</td>
<td></td>
</tr>
<tr>
<td>Bradford City CCG</td>
<td>7JR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>North Kirklees CCG</th>
<th>4th Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Greater Huddersfield CCG</th>
<th>Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Airedale, Wharfedale and Craven CCG</th>
<th>Millennium Business Park, Station Road, Steeton, West Yorkshire, BD20 6RB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Calderdale CCG</th>
<th>5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX</th>
</tr>
</thead>
</table>
1. Role of the JSCB

1.1. The primary role of the JSCB shall be to determine transformational decisions regarding the Services, including:

1.1.1. the range of services to be commissioned from the Provider;

1.1.2. how the Services are to be commissioned;

1.1.3. the medium to long term planning for the integration of the Service; and

1.1.4. service redesign to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and Urgent and Emergency Care Network Delivery plans of the Parties.

1.2. Patient transport services are excluded from the remit of the JSCB.

2. Terms of References of the JSCB

Frequency and types of meetings

2.1. Meetings shall be held as and when required by the Lead Officers; usually quarterly.

2.2. Meetings may be held by telephone or video-conference. Members may participate (and count towards quorum) in a face-to-face meeting via telephone.

2.3. The Chair shall set the agenda and arrange for the circulation of any papers to be considered at least five Working Days prior to the meeting.

Members

2.4. The Lead Officers (two people nominated by each Urgent and Emergency Care Network in accordance with Clause 5.1.2) shall be members of the JSCB.

2.5. In addition, if either of the two Chief Officers of the two Lead Commissioner / Contractors (for 999 Services and 111 Services respectively) are not appointed as Lead Officers they will be a non-voting member of the JSCB.

<table>
<thead>
<tr>
<th>Appointed By:</th>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Yorkshire and York and Humber Urgent and Emergency Care Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Yorkshire and York and Humber Urgent and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quorum

2.6. Meetings shall be quorate when all Lead Officers and the Chair are present.

2.7. In circumstances where a Lead Officer be unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the Chair of their nominating UECN may send to a meeting of the JSCB a deputy (a "Deputy") to take the place of a Lead Officer. Where a Deputy is sent to take the place of the Lead Officer, references in these terms of reference to Lead Officer shall be read as references to the Deputy.

Attendees

2.8. The following representatives from the Parties may be invited to meetings:

2.8.1. Director with responsibility for Clinical Quality, NHS Wakefield CCG (Lead Commissioner / Contractor 999) or named deputy; and

2.8.2. Director with responsibility for Clinical Quality, NHS Greater Huddersfield CCG (Lead Commissioner / Contractor 111) or named deputy.

2.9. The following representatives from the Provider may be invited to attend:

2.9.1. Chief Executive Officer;

2.9.2. Director – Business Development; and

2.9.3. Associate Medical Director (Vanguard Lead).

2.10. Other persons may be invited to attend by the Chair of the JSCB or agreed by all Lead Officers.

2.11. No such persons invited to attend meetings shall be able to vote on a matter.

Voting

2.12. Each two Lead Officers from each UECN shall have one vote between them.

2.13. If the Chief Officers of the two Lead Commissioner / Contractors are members of the JSCB (but not Lead Officers) then they will not have a vote.

2.14. The Parties acknowledge that there needs to be unanimity across all Lead Officers in order for JSCB Decisions to be determined.
2.15. Where unanimity is not reached, the Parties agree that the matter will be referred to dispute resolution.

Chair

2.16. The JSCB will appoint one of the Lead Officers to act as Chair. In addition the JSCB will appoint one of the Lead Officers to act as Deputy Chair.

2.17. The Chair shall ensure that administrative support and advice is provided to the JSCB including but not limited to:

2.17.1. taking of the minutes and keeping a record of matters arising and issues to be carried forward;

2.17.2. maintaining a register of interests for the JSCB (Lead Officers); and

2.17.3. advising the Lead Officers and attendees if relevant as appropriate on best practice, national guidance and other relevant documents.

2.17.4. Duties

2.18. The JSCB will:

2.18.1. make JSCB Decisions;

2.18.2. undertake actions as set out in this Agreement; and

2.18.3. undertake the actions set out in paragraph 2.19 below to support the making of JSCB Decisions.

2.19. In accordance with this Agreement the JSCB will undertake the following actions:

Transformation

2.19.1. Planning for the provision and transformation of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Sustainability and Transformation Plan respective commissioning intentions and ambitions;

2.19.2. Oversight of Strategic Commissioning Intentions of the CCGs in Yorkshire and the Humber in relation to work undertaken around Urgent and Emergency care Networks, including Ambulance Services;

2.19.3. Ensure that strategic intent agreed by the CCGs in Yorkshire and the Humber is captured and reflected contractually; and

2.19.4. Consider different delivery models to seek to provide equity of performance across both urban and rural area.

Commissioning Contract

2.19.5. Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party);

2.19.6. Agree communications activity relating to matters governed by the Commissioning Contract;

2.19.7. Resolve issues in dispute between the Parties and issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party);
2.19.8. Approve proposals for CQUIN indicators; and,

2.19.9. Agree actions if concerns are identified about actual and contracted activity levels.

Finance

2.19.10. Decisions regarding finance and investment will ordinarily be made by each Party's Chief Finance Officer in accordance with its constitution (and as set out in Schedule 6 (Scheme of Delegation) of this Agreement).

Sub-groups

2.19.11. There shall be one sub-group, the Hear, See and Treat Board. The JSCB shall decide from time to time the membership of the Hear, See and Treat Board.

Conflicts of Interest

2.20. Each Lead Officer must abide by the conflicts of interest policy maintained by Wakefield CCG (the “Policy”), together with NHS England statutory guidance on managing conflicts of interest (the “Guidance”). If there is any conflict between the Policy and the Guidance then the provisions of the Guidance shall take precedence.

2.21. A register of interests for the JSCB Lead Officers will be maintained.

2.22. Where any Lead Officer or attendee has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, the Policy and the Guidance, whether or not that Lead Officer or attendee may participate in the discussion and/or vote, if relevant, in meetings (or parts of meetings) in which the relevant matter is discussed.

Relationship with the Parties

2.23. Minutes of meetings of the JSCB shall be sent to:

2.23.1. the Chair of each UECN for onward dissemination as appropriate; and

2.23.2. the Accountable Officer for every CCG for onward dissemination as appropriate.

Review

2.24. These terms of reference shall be reviewed by the JSCB at least annually.
SCHEDULE 5

LEAD COMMISSIONER / CONTRACTOR ROLE

1. Role of the Lead Commissioner / Contractor

1.1. The Lead Commissioner / Contractor’s role is to take Lead Commissioner / Contractor Decisions as detailed in Schedule 6 (Scheme of Delegation) on behalf of each of the Parties. The Lead Commissioner / Contractor Decisions will focus on transactional and contract management matters in relation to the Commissioning Contract, whereas the JSCB Decisions will focus on transformational and service redesign matters in respect of the Services as a whole, including the 999 Services.

1.2. In line with Schedule 6 (Scheme of Delegation), the Lead Commissioner / Contractor, will manage and maintain the Commissioning Contract, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services on behalf of the Parties. The Lead Commissioner / Contractor will act reasonably in undertaking its role and have regard to guidance from the JSCB as appropriate in exercising its delegated authority under this Agreement.

1.3. In performing its role, the Lead Commissioner / Contractor shall act reasonably and comply with the principles set out in Schedule 1, and aim to achieve the objectives set out in Schedule 2. The Lead Commissioner / Contractor shall chair the Contract Management Board, which shall be the primary mechanism through which the Lead Commissioner / Contractor will hold the Provider to account on behalf of the Parties and enact Lead Commissioner / Contractor Decisions, CCG Decisions and JSCB Decisions.
Appendix B

SCHEDULE 6
SCHEME OF DELEGATION

1. Introduction

1.1. Each Party must ensure that the matters below are properly delegated in accordance with the NHS Act 2006 and each Party's constitution and internal procedures.

1.2. The Parties acknowledge that the NHS Act 2006:

1.2.1. allows a CCG to delegate the exercise of functions of the CCG to the Governing Body;

1.2.2. does not allow a CCG to delegate the exercise of function of the CCG to a person employed by another CCG; and

1.2.3. allows the exercise of the functions of the Governing Body (which includes functions of the CCG delegated to the Governing Body) to be delegated to an individual of a description specified in its constitution.

1.3. The Parties acknowledge that the effect of paragraph 1.2 is that a Party cannot delegate authority to exercise JSCB Decisions that relate to functions of the Party (that are not delegated to the Governing Body) to the relevant Lead Officer if that Lead Officer is not an employee of that Party.

1.4. Where the relevant Lead Officer is an employee of a Party, that Party will ensure that the JSCB Decisions are delegated to that person.

1.5. Where the relevant Lead Officer is not an employee of that Party, that Party will ensure that:

1.5.1. the functions being exercised by the Lead Officers are functions of the party but have been delegated to that Party's Governing Body;

1.5.2. the Party's Governing Body delegates the exercise of the functions referred to in paragraph 1.5.1 to the relevant Lead Officer; and

1.5.3. the Party's constitution specifies a description of individuals that includes the relevant Lead Officer.

2. Urgent Primary medical Care Services

2.1. The following Parties commission urgent primary medical care services:

2.1.1. Wakefield CCG;

2.1.2. Leeds North CCG;

2.1.3. Leeds South and East CCG;

2.1.4. Leeds West CCG;

2.1.5. Bradford City CCG;

2.1.6. Bradford Districts CCG;

2.1.7. North Kirklees CCG;
2.1.8. Greater Huddersfield CCG;
2.1.9. Airedale, Wharfedale and Craven CCG; and
2.1.10. Calderdale CCG.

3. Minor Injury units services
3.1. The following Parties commission minor injury units services:
3.1.1. Leeds North CCG;
3.1.2. Leeds South and East CCG; and
3.1.3. Leeds West CCG.

4. CCG Decisions
4.1. The table below sets out the matters that the Parties have agreed are CCG Decisions which are reserved to each Party. The Parties agree that CCG Decisions will ordinarily be made by each Party’s Chief Finance Officer in accordance with its constitution.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiate and recommend the Finance schedule for 16-17 contract</td>
<td>Ratify variations to the Commissioning Contract that only affect that Party</td>
</tr>
<tr>
<td>Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend</td>
<td>Resolve issues between the Party and the Provider that do not impact on any other Party</td>
</tr>
<tr>
<td>Additional in year investment from CCGs</td>
<td>Final approval of the terms of the following year's Commissioning Contract</td>
</tr>
</tbody>
</table>

5. JSCB Decisions
5.1. The table below sets out the matters that the Parties have agreed are JSCB Decisions which are delegated to each Party’s Lead Officers. To avoid doubt, JSCB Decisions can be made by the relevant Lead Officers without reference back to each Party.

5.2. The financial limit for JSCB Decisions will be in total no greater than £200 million per financial year.

<table>
<thead>
<tr>
<th>Transformational</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree the range of services to be commissioned from the Provider and how they are to be commissioned</td>
<td>Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)</td>
</tr>
<tr>
<td>Agree medium to long term planning for the integration of the Service</td>
<td>Agree communications activity relating to matters governed by the Commissioning Contract</td>
</tr>
<tr>
<td>Consider and recommend service</td>
<td>Resolve issues in dispute between the</td>
</tr>
</tbody>
</table>
redesign proposals to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and UECN Delivery Plans

| Parties and issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party) |
| Approve proposals for CQUIN indicators |
| Agree actions if concerns are identified about actual and contracted activity levels |

5.3. The Lead Officers shall also take the following actions and make the following decisions relating to matters about the Agreement:

5.3.1. consideration of Variation Reports and agreeing such variations;

5.3.2. consideration and agreeing the joining of a clinical commissioning group to the Collaborative in accordance with Clause 13 (Joining the Collaborative);

5.3.3. termination of the Agreement or terminating a Defaulting Party's participation in the Agreement in accordance with Clause 14 (Termination);

5.3.4. consideration of, and agreeing resolutions to, any complaint relating to the content of this Agreement in accordance with Clause 23 (Complaints);

5.3.5. development and communication; and

5.3.6. engagement events.

6. Lead Commissioner / Contractor Decisions

6.1. The table below sets out the matters that the Parties have agreed are Lead Commissioner / Contractor Decisions which are delegated to the Lead Commissioner / Contractor. To avoid doubt, Lead Commissioner / Contractor Decisions can be made by the Lead Commissioner / Contractor without reference back to each Party or to the Lead Officers.

6.2. The financial limit for Lead Commissioner / Contractor Decisions will be set at: £2 million per financial year for SR monies and £5 million per financial year for CQUIN payments.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Quality</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award of additional central funding investment eg SRG monies</td>
<td>Approval of in-year evidence and make recommendation for payment</td>
<td>Issue of formal notices under the contract e.g. application of contractual sanctions</td>
</tr>
<tr>
<td>Approval of in-year agreement to pay CQUINs</td>
<td>Sign off of Serious Incidents</td>
<td>Co-ordination of contractual action and agreement of remedial action plans</td>
</tr>
<tr>
<td>Payment of costs related to commissioning and</td>
<td>Liaison with CQC/TDA</td>
<td>Liaison with TDA</td>
</tr>
<tr>
<td>contracting support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Quality schedules for each contract eg CQUINs</td>
<td>Issue of in-year contract variations</td>
<td></td>
</tr>
<tr>
<td>Agree measures to manage demand for services if demand is increasing</td>
<td>Contract negotiations</td>
<td></td>
</tr>
<tr>
<td>Agree actions if clinical quality concerns are identified</td>
<td>Resolve issues escalated from UECN meetings</td>
<td></td>
</tr>
<tr>
<td>Agree changes in clinical and quality assurance practice to enhance patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree actions relating to high level external enquiry reports if concerns are identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree action to be taken to address key issues in relation to incidents and serious incidents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE 7
VARIATIONS TO THIS AGREEMENT
SCHEDULE 8
SERVICE VARIATION PROCESS

1. Introduction

This Schedule sets out the process in relation to Service Variations that may be made to the Commissioning Contract.

2. Background

Through discussion with the Parties' Chief Officers and the Provider, it has been identified that there is a risk related to an individual Party or some of the Parties looking to substantially change or decommission service elements from within the Commissioning Contract. It was noted that a process was required in order to mitigate this risk and manage proposed Service Variations in a controlled way that minimises the impact on the Collaborative and wider services.

3. Process

3.1. The proposing Party must send a Variation Proposal (in the form of the Variation Proposal template set out at Annex 1 to this Schedule 8) to the Lead Commissioner / Contractor which shall forward it to the Lead Officers.

3.2. The Lead Officers will discuss the appropriateness of the wording and may make amendments as appropriate.

3.3. The Lead Officers may sign and serve the variation Proposal on the Provider in accordance with the terms of the Commissioning Contract or may require the Lead Commissioner / Contractor to sign and serve the Variation Proposal on the Provider.

3.4. The Provider will provide a response to the Variation Proposal within 10 Working Days to the Lead Commissioner / Contractor who shall circulate the response to the Lead Officers.

3.5. The Lead Officers (and the Provider, if necessary) shall consider the impact of the Variation Proposal and the response and, taking into account the nature of the matter and the potential impact on the Parties, determine whether:

3.5.1. to refer the variation to a Check and Challenge Meeting; or

3.5.2. the Lead Officers have delegated authority to approve the variation without referring the matter to the Parties.

3.6. Where the Lead Officers have delegated authority to approve the variation without referring the matter to the Parties pursuant to paragraph 3.5.2 the Lead Officers may approve the variation.

3.7. Where the variation is approved in accordance with paragraph 6 the Lead Officer may make such arrangements as necessary to notify formal acceptance of the variation to the Provider or may instruct the Lead Commissioner / Contractor to do so.

3.8. Where the Provider proposes a variation to the Commissioning Contract to the Lead Commissioner / Contractor or a Lead Officer, the recipient shall circulate copies to all Lead Officers who shall determine which action under paragraphs 3.5.1 to 3.5.2 above to take.
Check and Challenge Meetings

3.9. Where a matter is referred to a Check and Challenge Meeting, the persons in attendance shall meet within 20 Working Days of the receipt of the Provider’s response or the receipt of the Provider’s proposed variation to:

3.9.1. review and discuss the impact of the variation and/or any response;

3.9.2. consider the scale of the impact in terms of the Parties affected;

3.9.3. ensure that impacts are quantified and understood as much as possible and where possible they are jointly agreed between the Provider and the relevant Parties;

3.9.4. recommend agreement on the acceptability of the variation or clearly identify reasons agreement cannot be recommended;

3.9.5. if agreement is recommended, identify the appropriate decision making level to recommend whether to accept or reject the variation;

3.9.6. if agreement is not recommended, escalate the variation to the JSCB or identify any additional analysis that is required to provide further assurance agreeing clear timescales and ownership for delivery; and

3.9.7. where such additional analysis is provided, consider whether it provides further assurance and determine the appropriate action under this paragraph 3.9.

3.10. Check and Challenge meetings shall be called when required and shall be attended by:

3.10.1. 111 Contract Manager (who shall be Chair);

3.10.2. representative(s) from the proposing Party (if relevant);

3.10.3. representative(s) from the Provider;

3.10.4. the 111 Finance Manager; and

3.10.5. Lead Officer(s) from the UECN that include any Party affected by the variation.

3.11. The Check and Challenge Meeting attendees shall ensure that:

3.11.1. where agreement is recommended, the appropriate persons at the appropriate decision making levels are made aware of the Check and Challenge meetings considerations; or

3.11.2. where agreement is not recommended and escalation is required, that the matter is escalated to the JSCB.

Decision making levels

3.12. The appropriate decision making levels are:

3.12.1. the individual Parties (and such decisions will be CCG Decisions);

3.12.2. the Parties that make up one or more UECNs (and such decisions will be JSCB Decisions made by the appropriate Lead Officers); and
3.12.3. where the variation affects all Parties, the JSCB (and such decisions will be JSCB Decisions).

3.13. Where a variation is agreed pursuant to paragraph 3.12, the Lead Commissioner / Contractor will be notified and shall make such arrangements as necessary to notify formal acceptance of the variation.

3.14. Where a variation is not agreed, the matter shall be referred to dispute resolution.
ANNEX 1
SERVICE VARIATION PROPOSAL TEMPLATE
VARIATION PROPOSAL

Contract/Variation Reference:

Proposed by: Co-ordinating Commissioner on behalf of the NHS CB/Co-ordinating Commissioner on behalf of the Commissioners/Provider (delete as applicable)

Date of Proposal:

Capitalised words and phrases in this Variation Proposal have the meanings given to them in the Contract referred to above.

1. The Proposer proposes the Variation summarised below:

[and reflected in the revised draft Particulars and/or Service Conditions bearing the contract reference and variation number set out above and/or the revised General Conditions updated [     ] and/or the attached draft [insert title and reference of document]. (delete/complete as appropriate)]

2. The Proposer requires the proposed Variation to take effect on [         ].

3. The Proposer requires the Recipient to respond to this Variation Proposal in writing within 10 Operational Days, setting out whether:

• it accepts the proposed Variation; and/or
• it has any concerns with the contents of this Variation Proposal,

and any other comments it may have in relation to the proposed Variation.

SIGNED by

……………………………………………..

Signature

[INSERT AUTHORISED SIGNATORY’S NAME]  …………………………………………

Title

for and on behalf of [CO-ORDINATING COMMISSIONER/PROVIDER]
MEMORANDUM OF ADHERENCE

FOR THE

COLLABORATIVE COMMISSIONING OF 111 SERVICES

BETWEEN

CLINICAL COMMISSIONING GROUPS
THIS MEMORANDUM is dated the    day of                     2016

BETWEEN

(1) [insert name of CCG] whose principal office is at [insert principal office address] (“New Party”) and

(2) The clinical commissioning groups named in the Schedule as the existing parties in the collaborative commissioning arrangements (“Existing Parties”).

BACKGROUND

(A) This memorandum is entered into under Clause [insert number] of a memorandum of understanding dated [insert date], made between Existing Parties setting out the terms for operating the collaborative commissioning of 111 services as amended from time to time (the “MOU”).

(B) The New Party wishes to join the MOU.

IT IS AGREED:

1. DEFINITIONS AND INTERPRETATION

Words and expressions used in this memorandum shall, unless the context expressly requires otherwise, have the meaning given to them in the MOU. The Effective Date means the date of this memorandum.

2. CONFIRMATION AND UNDERTAKING

The New Party confirms that it has been supplied with a copy of the MOU. The New Party and each of the Existing Parties undertake with each other that, from the Effective Date, the New Party shall assume all of the rights and obligations under the MOU and shall observe, perform and be bound by the provisions of the MOU that contain obligations on the parties to the MOU as though the New Party was an original party to the MOU.

3. COUNTERPARTS

This memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

4. GOVERNING LAW AND JURISDICTION

4.1 The New Party and the Existing Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this memorandum shall be treated as an NHS Contract and shall not be legally enforceable.

4.2 This memorandum shall be governed by and construed in accordance with English Law and, subject to Clauses 4.1, the New Party and the Existing Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this memorandum.

This document has been signed and takes effect on the date stated at the beginning of it.

[INSERT NEW PARTY NAME]

AUTHORISED OFFICER    Date
NHS EAST RIDING OF YORKSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS HULL
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS VALE OF YORK
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS HARROGATE AND RURAL DISTRICT
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS SCARBOROUGH AND RYEDALE CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS WAKEFIELD
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS LEEDS NORTH
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS LEEDS SOUTH AND EAST
Appendix B

CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS BARNSLEY
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS ROTHERHAM
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS DONCASTER
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS BASSETLAW
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS NORTH LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer Date

NHS NORTH EAST LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer Date
## SCHEDULE 10

### EXISTING PARTIES

<table>
<thead>
<tr>
<th>Party</th>
<th>Address of principal office of Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Riding of Yorkshire Clinical Commissioning Group</td>
<td>Health House, Grange Park Lane, Willerby, East Yorkshire, HU10 6DT</td>
</tr>
<tr>
<td>NHS Hull Clinical Commissioning Group</td>
<td>2nd Floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY</td>
</tr>
<tr>
<td>NHS Vale of York Clinical Commissioning Group</td>
<td>West Offices, Station Rise, York, YO1 6GA</td>
</tr>
<tr>
<td>NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group</td>
<td>Hambleton District Council, Civic Centre, Stone Cross, Northallerton, North Yorkshire, DL6 2UU</td>
</tr>
<tr>
<td>NHS Harrogate and Rural District Clinical Commissioning Group</td>
<td>1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB</td>
</tr>
<tr>
<td>NHS Scarborough and Ryedale Clinical Commissioning Group</td>
<td>Scarborough Town Hall, St Nicholas Street, Scarborough, North Yorkshire, YO11 2HG</td>
</tr>
<tr>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>722 Prince of Wales Road, Darnall, Sheffield, South Yorkshire, S9 4EU</td>
</tr>
<tr>
<td>NHS Barnsley Clinical Commissioning Group</td>
<td>Hillder House, 49-51 Gawber Road, Barnsley, South Yorkshire, S75 2PY</td>
</tr>
<tr>
<td>NHS Rotherham Clinical Commissioning Group</td>
<td>Oak House, Moorhead Way, Bramley, Rotherham, South Yorkshire, S66 1YY</td>
</tr>
<tr>
<td>NHS Doncaster Clinical Commissioning Group</td>
<td>Sovereign House, Heavens Walk, Doncaster, South Yorkshire, DN4 5HZ</td>
</tr>
<tr>
<td>NHS Wakefield Clinical Commissioning Group</td>
<td>White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT</td>
</tr>
<tr>
<td>NHS Leeds North Clinical Commissioning Group</td>
<td>Leaffield House, 107-109 King Lane, Leeds, West Yorkshire, LS17 5BP</td>
</tr>
<tr>
<td>NHS Leeds South and East Clinical Commissioning Group</td>
<td>3200 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB</td>
</tr>
<tr>
<td>NHS Bradford City Clinical Commissioning Group</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
</tr>
<tr>
<td>NHS Bradford Districts Clinical</td>
<td>Douglas Mill, Bowling Old Lane, Bradford,</td>
</tr>
<tr>
<td>Commissioning Group</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>NHS North Kirklees Clinical Commissioning Group</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ</td>
</tr>
<tr>
<td>NHS Greater Huddersfield Clinical Commissioning Group</td>
<td>Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ</td>
</tr>
<tr>
<td>NHS Airedale, Wharfedale and Craven Clinical Commissioning Group</td>
<td>Millennium Business Park, Station Road, Steeton, West Yorkshire, BD2 6RB</td>
</tr>
<tr>
<td>NHS Calderdale Clinical Commissioning Group</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX</td>
</tr>
<tr>
<td>NHS Bassetlaw Clinical Commissioning Group</td>
<td>Retford Hospital, North Road, Retford, Nottinghamshire, DN22 7XF</td>
</tr>
<tr>
<td>NHS North Lincolnshire Clinical Commissioning Group</td>
<td>The Health Place, Wrawby Road, Brigg, South Humberside, DN20 8GS</td>
</tr>
<tr>
<td>NHS North East Lincolnshire Clinical Commissioning Group</td>
<td>Athena Building &amp; Olympia House, Saxon Court, Gilbey Road, Grimsby, South Humberside, DN31 2UJ</td>
</tr>
</tbody>
</table>
MEMORANDUM OF UNDERSTANDING
FOR THE
COLLABORATIVE COMMISSIONING OF 999 SERVICES
BETWEEN
CLINICAL COMMISSIONING GROUPS
ACROSS
YORKSHIRE AND HUMBER

[DRAFT VERSION 4 – 29 MARCH 2016]
# Appendix C

## CONTENTS

1. **DEFINITIONS AND INTERPRETATION** ..................................................................................... 4
2. **DURATION OF THE AGREEMENT** ........................................................................................... 7
3. **PRINCIPLES OF THE COLLABORATIVE** ............................................................................. 7
4. **OBJECTIVES OF THE COLLABORATIVE** ........................................................................... 7
5. **ROLES AND RESPONSIBILITIES** .......................................................................................... 8
6. **DECISION-MAKING ARRANGEMENTS** ............................................................................... 8
7. **INSPECTION** ..........................................................................................................................10
8. **COLLABORATIVE COSTS AND RESOURCES** ......................................................................10
9. **INDEMNITY** ...........................................................................................................................11
10. **VARIATION** ..........................................................................................................................11
11. **NOTICES** ...............................................................................................................................12
12. **DISPUTE RESOLUTION** .........................................................................................................12
13. **JOINING THE COLLABORATIVE** .......................................................................................13
14. **TERMINATION** .....................................................................................................................13
15. **CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING** ...........................14
16. **SURVIVAL** ............................................................................................................................14
17. **CONFIDENTIALITY** ...............................................................................................................14
18. **DATA PROTECTION** .............................................................................................................14
19. **FREEDOM OF INFORMATION** ............................................................................................15
20. **STATUS** ................................................................................................................................16
21. **ASSIGNMENT AND SUB-CONTRACTING** ........................................................................16
22. **THIRD PARTY RIGHTS** ........................................................................................................16
23. **COMPLAINTS** ......................................................................................................................16
24. **ENTIRE AGREEMENT** ...........................................................................................................17
25. **SEVERABILITY** .....................................................................................................................17
26. **WAIVER** ................................................................................................................................17
27. **COSTS AND EXPENSES** ......................................................................................................17
28. **GOVERNING LAW AND JURISDICTION** ..........................................................................17
29. **FAIR DEALINGS** .....................................................................................................................17
30. **COUNTERPARTS** ....................................................................................................................17

### SCHEDULES

- **SCHEDULE 1** ...........................................................................................................................21
- **PRINCIPLES OF THE COLLABORATION** .............................................................................21
- **SCHEDULE 2** ..........................................................................................................................22
- **OBJECTIVES** ..........................................................................................................................22
- **SCHEDULE 3** ..........................................................................................................................25
- **UECNS AND LEAD OFFICERS** ..........................................................................................25
- **SCHEDULE 4** ..........................................................................................................................28
- **JSCB - ROLE AND TERMS OF REFERENCE** ......................................................................28
- **SCHEDULE 5** ..........................................................................................................................32
Appendix C

LEAD COMMISSIONER / CONTRACTOR ROLE .................................................................................32
SCHEDULE 6 .........................................................................................................................................33
SCHEME OF DELEGATION ..................................................................................................................33
SCHEDULE 7 .........................................................................................................................................36
VARIATIONS TO THIS AGREEMENT .................................................................................................36
SCHEDULE 8 .........................................................................................................................................37
SERVICE VARIATION PROCESS .........................................................................................................37
SCHEDULE 9 .........................................................................................................................................41
MEMORANDUM OF ADHERENCE .......................................................................................................41
THIS AGREEMENT is dated the day of 2016

BETWEEN

The clinical commissioning groups listed in Schedule 10, each a "Party" and together the "Parties".

BACKGROUND

(A) Each Party is a signatory to a single contract with Yorkshire Ambulance Service NHS Trust for the provision of 999 services in each Party's area.

(B) This Agreement sets out a framework for collaborative decision-making by the Parties in relation to matters concerning the commissioning of those services.

(C) The Parties intend to establish a joint committee of the Parties to enable collaborative decision-making in respect of the Services. The provisional timescale for setting up such joint committee has been agreed as October 2016.

IT IS AGREED:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

"111 Commissioning Contract" the contract between the Parties (and further clinical commissioning groups) and the Provider for the provision of 111 call handling services, urgent primary medical care services and minor injury units services dated 1 April 2013;

"Agreement" this agreement between the Parties comprising these terms and conditions, together with all Schedules;

“CCG” a clinical commissioning group Party listed in Schedule 10;

"CCG Decisions" has the meaning set out in Clause 6.1.1;

"Collaborative" the collaborative commissioning arrangements set out in this Agreement;

"Commencement Date" 1 April 2016;

"Commissioning Contract" the contract between all the Parties as commissioners and the Provider for the provision of the Services dated 1 April 2016;

"Commissioning Contract Variation Report" has the meaning set out in Clause 10.10

"Defaulting Party" a Party that commits a persistent or material breach of this Agreement;

"Dispute Resolution" the process set out in Clause 12;

"DPA" the Data Protection Act 1998 as amended from time to time;

"Exiting Party" has the meaning in Clause 15.1;

"FOIA" the Freedom of Information Act 2000 as amended from time
"Functions" the statutory functions of each of the Parties in relation to the provision of, or making arrangements for the provision of, the Services;

"Guidance" any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Parties and/or the Provider have a duty to have regard (and whether specifically mentioned in the Commissioning Contract or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Parties and/or any relevant Regulatory or Supervisory Body;

"JSCB" the Joint Strategic Commissioning Board, the role and terms of reference for which are set out in Schedule 4;

"JSCB Decisions" has the meaning set out in Clause 5.1.2;

"Law" (i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;

(ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972;

(iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;

(iv) Guidance;

(v) National Standards; and

(vi) any applicable code,
in each case in force in England and Wales;

"Lead Officer" has the meaning set out in Clause 6.5.4;

"Lead Commissioner / Contractor" NHS Wakefield CCG;

"Lead Commissioner / Contractor Decisions" has the meaning set out in Clause 6.1.3;

"National Standards" those standards applicable to the Provider under the Law and/or Guidance as amended from time to time;

"Objectives" the objectives set out in Clause 4.1 and Schedule 2;

"Personal Data" has the meaning given to it in the DPA;

"Provider" Yorkshire Ambulance Service NHS Trust;

"Regulatory or Supervisory Body" any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party must comply or to which it must or should have regard, including:
(i) Care Quality Commission;
(ii) Monitor;
(iii) NHS Trust Development Authority;
(iv) NHS England;
(v) the Department of Health;
(vi) NICE; and
(vii) HealthWatch England;

"Service Variation" a variation to the Commissioning Contract which refers to the Service and reflects:

(i) the assessment by the Parties of pathway needs, the availability of alternative providers and demand for the Service; and/or
(ii) the joint assessment of the Provider and Parties of the quality and clinical viability of the Service and the Services Environment; and/or
(iii) the likely impact of any transformational need and/or reconfiguration of a care pathway that might affect the Service; and/or
(iv) a change to the Service that could potentially have a material impact on any or all of quality and safety, performance and activity and finance, such material impact not to be confined to the proposing Party and “material” is to be interpreted taking into account the potential impact on other Parties, the UECNs and the Commissioning Contract as a whole;

"Services" the 999 services provided by the Provider under the terms of the Commissioning Contract;

"Services Environment" has the meaning set out in the Commissioning Contract;

"Service Users" any individual for whose benefit the Services are provided;

"Term" one (1) year from the Commencement Date;

"Terminating Party" a Party exercising its rights to terminate this Agreement in accordance with Clauses 14.3 and 14.4;

"UECNs" the Urgent and Emergency Care Networks listed in Schedule 3, and “UECN” shall be construed accordingly;

"Variation" an addition, deletion or amendment to the Clauses of or the Schedules to this Agreement, agreed by the Parties in accordance with Clause 10 (Variation);

"Variation Report" has the meaning in Clause 10.3; and

"Working Day" any day other than Saturday, Sunday, a public or bank
holiday in England and Wales.

1.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

1.3 The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are clauses in this Agreement.

1.4 References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

1.5 References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

1.6 Words importing the singular number only shall include the plural.

1.7 Where anything in this Agreement requires the mutual agreement of the Parties, then unless the context otherwise provides, such agreement must be in writing.

1.8 If there is any conflict between the terms of this Agreement and the terms of the Commissioning Contract, the terms of the Commissioning Contract will prevail.

1.9 If there is any conflict between the Clauses of this Agreement and the provisions of any Schedule to this Agreement, the Clauses of this Agreement will prevail.

2. DURATION OF THE AGREEMENT

2.1 This Agreement comes into effect on the Commencement Date and shall remain in force until the end of the Term, subject to earlier termination in accordance with Clause 14 (Termination) and any extension agreed in accordance with Clause 2.2 below.

2.2 The Parties may agree in writing to extend the Term any number of times but each time by a period of up to twelve (12) months. The Agreement shall expire automatically without notice at the end of the Term (subject to earlier termination in accordance with Clause 14 (Termination)).

3. PRINCIPLES OF THE COLLABORATIVE

3.1 In performing their respective obligations under this Agreement, the Parties must act in accordance with the principles set out in Schedule 1.

4. OBJECTIVES OF THE COLLABORATIVE

4.1 The Parties agree that, with effect from the Commencement Date, the main objective of the Collaborative is to improve the provision of the Services through the arrangements set out in this Agreement.

4.2 The Parties agree that further objectives of the Collaborative in relation to the Services are as set out in Schedule 2 and the Parties agree to act in the furtherance of these Objectives.

4.3 The Parties agree to seek to achieve the Objectives of the Collaborative through:

4.3.1 planning for the provision and transformation of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Parties' respective commissioning intentions and ambitions;
4.3.2 agreeing the extent of the Services and negotiating the Commissioning Contract;

4.3.3 managing and maintaining the Commissioning Contract, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services; and

4.3.4 managing variations to the Commissioning Contract in accordance with national policy, the needs of Service Users and clinical developments.

5. **ROLES AND RESPONSIBILITIES**

5.1 Each Party must:

5.1.1 participate in discussions at meetings of the UECN of which they are a member;

5.1.2 agree with other members of the relevant UECN two representatives ("Lead Officers") to represent that UECN at meetings of the JSCB;

5.1.3 ensure the relevant Lead Officers have considered all documentation and are fully prepared to discuss matters at meetings of the JSCB;

5.1.4 make all reasonable efforts to require their Lead Officers to inform the other Lead Officers in advance if a relevant Lead Officer is unable to attend meetings of the JSCB;

5.1.5 ensure its Lead Officers engage with all other Lead Officers and attendees, if relevant, in matters related to this Agreement;

5.1.6 communicate openly and in a timely manner about concerns, issues or opportunities relating to this Agreement; and

5.1.7 respond promptly to all requests for, and promptly offer, information or proposals relevant to the operation of the Collaboration.

6. **DECISION-MAKING ARRANGEMENTS**

6.1 The Parties agree that, for matters relating to the Commissioning Contract and the achievement of the Objectives of the Collaborative, there are three different levels of decision-making (as set out in Schedule 6):

6.1.1 those decisions reserved to each Party ("CCG Decisions");

6.1.2 those decisions which are delegated by each Party to a Lead Officer acting in collaboration with the other Lead Officers ("JSCB Decisions"); and

6.1.3 those decisions which are delegated to the Lead Commissioner / Contractor by each Party ("Lead Commissioner / Contractor Decisions").

**CCG Decisions**

6.2 Each Party must ensure that the matters set out as CCG Decisions in Schedule 6 are reserved to the Party (or governing body or committee of the Party as appropriate). Each Party agrees that its Chief Finance Officer (or duly authorised alternative in their absence) shall be authorised to take CCG Decisions on its behalf, in accordance with that Party’s constitution and scheme of delegation.

6.3 The Parties agree that the Lead Commissioner / Contractor does not have delegated authority to make CCG Decisions.
6.4 Each Party shall put in place mechanisms to ensure CCG Decisions are notified to the Lead Commissioner / Contractor within 14 days of such CCG Decisions being taken for appropriate action to be taken in relation to the Commissioning Contract.

JSCB Decisions

6.5 The Parties acknowledge that:

6.5.1 the Parties are able to discuss matters related to JSCB Decisions at UECN meetings;
6.5.2 the Parties included in each UECN are set out in Schedule 3;
6.5.3 the Parties that are included in each UECN may send representatives to meetings of the UECN to represent that Party;
6.5.4 the Lead Officers take the recommendations of the Parties at UECNs to the JSCB to inform JSCB Decisions; and
6.5.5 the Lead Officers will consider the recommendations of the UECNs at meetings of the JSCB in making JSCB Decisions as appropriate.

6.6 Each Party agrees:

6.6.1 that the relevant Lead Officers indicated in Schedule 3 represent that Party at meetings of the JSCB;
6.6.2 that the relevant Lead Officers indicated in Schedule 3 make JSCB Decisions on behalf of that Party at meetings of the JSCB; and
6.6.3 the role and terms of reference of the JSCB that are set out in Schedule 4.

6.7 Each Party must

6.7.1 ensure that the matters set out as JSCB Decisions in Schedule 6 are delegated effectively and lawfully to the relevant Lead Officers indicated in Schedule 3 such that the Lead Officers have the appropriate power to bind that Party in relation to JSCB Decisions made at meetings of the JSCB;
6.7.2 ensure that the Lead Officers are sufficiently appraised of the scope of the delegation by the relevant Party to the Lead Officers in relation to JSCB Decisions; and
6.7.3 ensure the Lead Officers are able to give and receive notices and other communications that relate to the Collaborative.

6.8 The Parties agree that:

6.8.1 the JSCB is not a joint committee of the Parties and does not have delegated authority to make decisions that bind the Parties; and
6.8.2 it is the relevant Lead Officers that make JSCB Decisions which bind the Party represented by those Lead Officers; and
6.8.3 the Lead Commissioner / Contractor does not have delegated authority to make JSCB Decisions.

6.9 The Parties acknowledge that there needs to be unanimity across all Lead Officers in order for JSCB Decisions to be made in collaboration.

6.10 Where unanimity is not reached between the Lead Officers, the Parties agree that the matter may be referred to dispute resolution in accordance with Clause 12 (Dispute Resolution).
6.11 The Lead Officers shall agree mechanisms to ensure JSCB Decisions that are unanimously determined by the Lead Officers are notified to the Lead Commissioner / Contractor for appropriate action to be taken in relation to the Commissioning Contract.

Lead Commissioner / Contractor Decisions

6.12 Each Party must ensure that the matters set out as Lead Commissioner / Contractor Decisions in Schedule 6 are delegated effectively and lawfully to the Lead Commissioner / Contractor.

6.13 Subject to Clause 6.12, the Parties acknowledge that the Lead Commissioner / Contractor is able to:

6.13.1 make Lead Commissioner / Contractor Decisions and such decisions will bind all of the Parties;

6.13.2 take appropriate action under the Commissioning Contract in relation to Lead Commissioner / Contractor Decisions without reference to the Parties or the Lead Officers.

6.14 The Lead Commissioner / Contractor shall chair meetings of the Contract Management Board, through which the Provider shall be held to account (the terms of reference for which are set out in Schedule 5). The Contract Management Board shall not have any authority in and of itself to make decisions which bind the Parties; it is a forum in which:

6.14.1 Lead Commissioner / Contractor Decisions may be made and/or implemented by the Lead Commissioner / Contractor; and

6.14.2 JSCB Decisions and/or CCG Decisions may be implemented by the Lead Commissioner / Contractor.

7. INSPECTION

The Parties shall co-operate with any investigation undertaken by any Regulatory or Supervisory Body in respect of the Services.

8. COLLABORATIVE COSTS AND RESOURCES

8.1 The Parties agree that payments due under the Commissioning Contract shall be made in accordance with the provisions of the Commissioning Contract.

8.2 Each Party agrees to set aside £20,000 per year to reimburse costs incurred by the Lead Commissioner / Contractor associated with the purposes set out in Clause 8.3 and the costs associated with the purposes set out in the 111 Commissioning Contract.

8.3 The Lead Commissioner / Contractor shall be authorised by all Parties to agree and pay the following costs in respect of the Collaborative:

8.3.1 audit fees;

8.3.2 fees for consultancy fees including expenses;

8.3.3 booking of facilities for meetings of the JSCB; and

8.3.4 fees relating to initiatives and contributions to support the National Ambulance Commissioners Network.

8.4 The Lead Commissioner / Contractor shall pay such costs incurred as set out in Clause 8.3 and recharge each Party its share of the costs proportionately according to the relevant Party’s CCG population as a proportion of the total population of all of the CCGs combined.
8.5 Staff costs associated with the management of the Commissioning Contract will be managed separately to the costs set out in Clause 8.3 and each Party agrees to pay their share of the costs proportionately according to the relevant Party’s CCG population as a proportion of the total population of all of the CCGs.

8.6 The Parties shall ensure prompt payment of their share of such costs set out in this Clause 8 to the Lead Commissioner / Contractor and in any event shall pay such shares within 30 days of receipt of a claim for payment from the Lead Commissioner / Contractor.

9. INDEMNITY

9.1 Nothing in this Agreement shall affect the liabilities of the Parties to the Service Users in respect of their Functions.

9.2 Each Party undertakes to indemnify each other Party against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses, whether arising in tort (including negligence) or as a result of default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of the indemnifying Party (or its employees, agents or sub-contractors), except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the indemnified Party or (or its employees, agents or sub-contractors).

9.3 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer’s liability, liability to third parties and all other potential liability under this Agreement.

10. VARIATION

10.1 If at any time during the term of this Agreement any Party requests in writing any Variation to this Agreement (which may include changes required as a result of a change in law), Clauses 10.3 to 10.7 shall apply.

10.2 If at any time during the term of this Agreement any Party requests in writing any variation to the Commissioning Contract, Clauses 10.8 to 10.12 shall apply.

Variations to this Agreement

10.3 The Party proposing the Variation shall provide a report in writing to the other Parties (the “Variation Report”) setting out:

10.3.1 the Variation proposed;
10.3.2 the date upon which the Variation is to take effect;
10.3.3 a statement of the impact the Variation will have on, and any change required to, the Schedules;
10.3.4 a statement on the individual responsibilities of the Parties for any implementation of the Variation; and
10.3.5 details of any proposed staff and employment implications.

10.4 Following receipt by the receiving Parties of the Variation Report and allowing twenty (20) Working Days in which to consider the Variation Report, the Parties shall meet to discuss the proposed Variation and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

10.5 Where the Parties are unable to agree on the terms of the Variation then any Party may refer the matter to dispute resolution under Clause 12 (Dispute Resolution).
10.6 All Variations made to this Agreement shall be agreed between the Parties. Such Variations to this Agreement are only to be effective if made in writing and signed by all the Parties.

10.7 Variations to this Agreement shall be appended to this Agreement at Schedule 7.

**Variations to the Commissioning Contract**

10.8 Where a variation to the Commissioning Contract is a Service Variation, the process set out in Schedule 8 shall be followed.

10.9 Where a variation to the Commissioning Contract is not a Service Variation, the process set out in Clauses 10.10 to 10.12 shall be followed.

10.10 The Party proposing any variation to the Commissioning Contract shall provide a report in writing to the Lead Commissioner / Contractor (the "Commissioning Contract Variation Report") setting out:

10.10.1 the variation proposed;
10.10.2 the date upon which the variation is to take effect; and
10.10.3 a statement on the individual responsibilities of the Parties for any implementation of the variation;

10.11 Following receipt by the Lead Commissioner / Contractor of the Commissioning Contract Variation Report, the JSCB shall meet to hear the Lead Commissioner / Contractor’s recommendations on the proposed variation and acting reasonably and in good faith shall use reasonable endeavours to agree the variation.

10.12 Where the variation is agreed by the JSCB, the Lead Commissioner / Contractor shall make the necessary arrangements to implement the variation in accordance with the relevant provisions of the Commissioning Contract.

11. **NOTICES**

11.1 Any notices to be given under this Agreement must be in writing and served on the Lead Officers either by hand, post, or e-mail to the address for that Lead Officer as set out in Schedule 3.

11.2 Notices:

11.2.1 by post will be effective upon the earlier of actual receipt, or five (5) Working Days after mailing;
11.2.2 by hand will be effective upon delivery;
11.2.3 by e-mail will be effective when sent in legible form subject to no automated response being received.

11.3 The Lead Officers shall circulate such notices as soon as reasonably practicable to the Parties they represent.

11.4 Any notices to be given under the Commissioning Contract shall be served in accordance with the provisions of the Commissioning Contract.

12. **DISPUTE RESOLUTION**

12.1 Where any dispute arises between the Parties (including the Lead Commissioner / Contractor) or where a decision of the JSCB is not unanimous, the Parties, through the relevant Lead Officers, must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the JSCB.
12.2 Where any matter referred to dispute resolution is not resolved under Clause 12.1, any Lead Officer may request an emergency meeting of the JSCB and use their best endeavours to resolve that dispute on an informal basis.

12.3 If any dispute is not resolved under Clauses 12.1 and 12.2, any Party in dispute may refer the dispute to the Chief Officers of the relevant Parties, who will co-operate in good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

12.4 Where any dispute is not resolved under Clauses 12.1 to 12.3, any Party in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the Parties in dispute.

13. **JOINING THE COLLABORATIVE**

**Joining**

13.1 A clinical commissioning group that wishes to join the Collaboration may do so, subject to:

13.1.1 that Party agreeing to be bound by the terms of this Agreement; and

13.1.2 the agreement of all the existing Parties.

13.2 If a clinical commissioning group becomes a Party to this Agreement, that clinical commissioning group must sign a memorandum of adherence in the form set out in Schedule 9.

13.3 The Parties agree that statutory successor bodies to any one or more of the Parties shall be deemed to be Parties to this Agreement and the agreement of the remaining Parties in accordance with Clause 13.1 is not required. For the avoidance of doubt, this includes an organisation formed as a result of a statutory merger of two or more Parties.

14. **TERMINATION**

**Termination of this Agreement**

14.1 The Parties may agree in writing at any time to terminate this Agreement from such date as may be agreed between the Parties.

**Termination of a Defaulting Party**

14.2 The remaining Parties acting in agreement may, at any time terminate a Defaulting Party's participation in the Agreement by notice in writing to the Defaulting Party where such default is not capable of remedy or, where capable of remedy, has not been remedied within two (2) weeks of the Defaulting Party receiving notification of such default.

**Termination of a Party in relation to the Service**

14.3 Where a Party terminates its participation in the Commissioning Contract, that Party's participation in this Agreement shall automatically terminate on the same date.

**Termination of a Party's participation in the Agreement**

14.4 Any Party may terminate its participation in this Agreement by giving the other Parties notice in writing if that Party's fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of State, regulations or legislation issued or enacted after the Commencement Date.

14.5 Upon termination in accordance with Clauses 14.2 to 14.4, this Agreement shall partially terminate as between the remaining Parties and the Defaulting Party or
Terminating Party (as the case may be) only. For the avoidance of doubt, this Agreement shall continue in force as between the remaining Parties notwithstanding any partial termination in respect of any one or more Parties and the remaining Parties shall effect such amendments to this Agreement as may be necessary in accordance with Clause 10 (Variation).

15. **CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING**

15.1 In the event that this Agreement expires, is terminated (whether in full or in part) or a Party leaves the Collaborative (the "Exiting Party"), the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement and the following provisions shall (unless agreed otherwise by the Parties) have effect:

15.1.1 each Party shall ensure or procure the continued provision of the Services related to its Functions;

15.1.2 insofar as it is necessary, each Party shall use its reasonable endeavours to arrange and ensure the novation of any relevant contracts which are necessary to be novated from an Exiting Party to a remaining Party who shall accept such novation.

15.2 The Parties shall at all times act in such a manner as not to adversely affect the delivery of the Services.

16. **SURVIVAL**

16.1 The provisions of this Agreement which are expressly stated to survive its termination or expiry or which are intended by their nature to survive termination or expiry shall continue in force (including but not limited to Clauses 7, 8, 9, 12, 15, 16, 17, 18 and 28 together with those other Clauses, the survival of which is necessary for the interpretation or enforcement of this Agreement).

16.2 Termination or expiry of this Agreement does not affect any accrued rights or remedies under this Agreement or any other agreement between the Parties.

17. **CONFIDENTIALITY**

17.1 Except as required by law and specifically pursuant to Clause 19 (Freedom of Information), each Party agrees at all times during the continuance of this Agreement and after its termination or expiry to keep confidential any and all information, data and material of any nature which that Party may receive or obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of another Party, its employees, agents and/or any other person with whom it has dealings. For the avoidance of doubt this Clause shall not affect the rights of any workers under section 43 A-L of the Employment Rights Act 1996.

17.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions and concerning Service User information relating to users of the Services (including material affected by the DPA in force at the relevant time) to enable the efficient operation of the Collaborative.

18. **DATA PROTECTION**

18.1 The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

18.2 To the extent that a Party is acting as a Data Processor (as such term is defined in the DPA) on behalf of one or more of the other Parties, that Party shall, in particular, but without limitation:
18.2.1 only process such Personal Data as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the other Party or Parties under this Agreement;

18.2.2 put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in Clause 18.3.3 below, the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

18.2.3 take reasonable steps to ensure the reliability of employees who will have access to such Personal Data, and ensure that such employees are aware of and trained in the policies and procedures identified in Clauses 18.3.4, 18.3.5 and 18.3.6 below; and

18.2.4 not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the other Party or Parties (as relevant).

18.3 The Parties shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation, which shall include without limitation the obligation to:

18.3.1 perform an annual information governance self-assessment;

18.3.2 have an information guardian able to communicate with the other Parties, who will take the lead for information governance and from whom the other Parties shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches;

18.3.3 (where transferred electronically) only transfer essential data that is (i) necessary for direct care of users of the Services; and (ii) encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes);

18.3.4 have policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data;

18.3.5 have agreed protocols for sharing Personal Data with other NHS organisations and non-NHS organisations; and

18.3.6 have a system in place and a policy for the recording of any telephone calls, where appropriate, in relation to the Services, including the retention and disposal of such recordings.

19. **FREEDOM OF INFORMATION**

19.1 Each Party acknowledges that the other Parties are subject to the requirements of the FOIA and each Party shall assist and co-operate with the others (at their own expense) to enable the other Parties to comply with their information disclosure obligations.

19.2 Where a Party receives a "request for information" (as defined in the FOIA) in relation to information which it is holding on behalf of another Party, it shall (and shall procure that its sub-contractors shall):
19.2.1 transfer the request for information to the other Party as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information;

19.2.2 provide the other Party with a copy of all information in its possession or power in the form that the other Party requires within five (5) Working Days (or such other period as may be agreed) of the other Party requesting that information; and

19.2.3 provide all necessary assistance as reasonably requested to enable the other Party to respond to the request for information within the time for compliance set out in section 10 of the FOIA.

19.3 Where a Party receives a request for information which relates to the Agreement, it shall inform the other Parties of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information.

19.4 If any Party determines that information must be disclosed pursuant to Clause 19.3, it shall notify the other Parties of that decision at least two (2) Working Days before disclosure.

19.5 Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

19.6 Each Party acknowledges that the other Parties may be obliged under the FOIA to disclose information:

19.6.1 without consulting with the other Parties; or

19.6.2 following consultation with the other Parties and having taken their views into account.

20. STATUS

20.1 The Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this Agreement shall be treated as an NHS Contract and shall not be legally enforceable.

20.2 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render any Party directly liable to any third party for the debts, liabilities or obligations of any other Party.

20.3 Save as specifically authorised under the terms of this Agreement, a Party shall not hold itself out as the agent of any other Party.

21. ASSIGNMENT AND SUB-CONTRACTING

This Agreement, and any right and conditions contained in it, may not be assigned or transferred by any Party without the prior written consent of the other Parties, except to any statutory successor to the relevant function.

22. THIRD PARTY RIGHTS

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

23. COMPLAINTS

23.1 Any complaints relating to a Party's Functions shall be dealt with in accordance with the statutory complaints procedure of that Party.
23.2 Insofar as any complaint may relate to the content of this Agreement such complaints shall be referred to the meetings of the JSCB. The Parties shall co-operate as to the resolution of complaints.

23.3 In the event that a complaint arises about the Commissioning Contract, that complaint should be dealt with in accordance with the procedure set out in the Commissioning Contract.

24. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Agreement.

25. SEVERABILITY

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

26. WAIVER

No failure or delay by a Party to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

27. COSTS AND EXPENSES

Each Party shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

28. GOVERNING LAW AND JURISDICTION

This Agreement shall be governed by and construed in accordance with English Law and, subject to Clauses 12 (Dispute Resolution) and 20.1 (Status), the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

29. FAIR DEALINGS

The Parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any of them and that if in the course of the performance of this Agreement, unfairness to any of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

30. COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Parties shall constitute a full original of this Agreement for all purposes.

This Agreement is effective on the date stated at the beginning of it.

IN WITNESS OF WHICH the Parties have signed this Agreement on the date shown below.
NHS EAST RIDING OF YORKSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS HULL
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS VALE OF YORK
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS SCARBOROUGH AND RYEDALE CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS WAKEFIELD CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS LEEDS NORTH CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS LEEDS SOUTH AND EAST
Appendix C

CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS LEEDS WEST
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BRADFORD CITY
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BRADFORD DISTRICTS
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS NORTH KIRKLEES
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS GREATER HUDDERSFIELD
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS AIREDALE, WHARFEDALE AND
CRAVEN CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS CALDERDALE
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date
NHS SHEFFIELD
CLINICAL COMMISSIONING GROUP
Authorised Officer

NHS BARNSLEY
CLINICAL COMMISSIONING GROUP
Authorised Officer

NHS ROTHERHAM
CLINICAL COMMISSIONING GROUP
Authorised Officer

NHS DONCASTER
CLINICAL COMMISSIONING GROUP
Authorised Officer
SCHEDULE 1
PRINCIPLES OF THE COLLABORATION

1. **Principles of the Collaboration**

   1.1. In performing their respective obligations under this Agreement, the Parties must:

   1.1.1. act in the best interests of patients and the public;

   1.1.2. at all times act in good faith towards each other;

   1.1.3. collaborate and co-operate to work towards ensuring that the commissioning ambitions and intentions of each of the Parties are met with the aim of achieving fairness and equity between the Parties as to the costs and quality of the Services provided;

   1.1.4. act in a timely manner and recognise the time-critical nature of the Commissioning Contract and respond accordingly to requests for support;

   1.1.5. be accountable by taking on, managing and accounting to the other Parties for the performance of their respective roles and responsibilities set out in this Agreement;

   1.1.6. learn from best practice of other commissioning organisations and seek to develop as a collaborative to achieve the full potential of the relationship;

   1.1.7. share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

   1.1.8. adopt a positive outlook and behave in a positive, proactive manner;

   1.1.9. act in an inclusive manner with regards to collaboration;

   1.1.10. adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information;

   1.1.11. manage internal and external stakeholders effectively;

   1.1.12. work toward a reduction in health inequality and improvement in health and well-being;

   1.1.13. focus on quality;

   1.1.14. seek best value for money, productivity and effectiveness;

   1.1.15. develop towards a level of commissioning that is equal to best international practice; and promote innovation.
SCHEDULE 2

OBJECTIVES

1. Objectives

1.1. The further objectives of the Collaborative in relation to the Services are to:

1.1.1. regulate the respective rights and duties of the Parties in relation to the Commissioning Contract, in particular:

   a) the sharing of liabilities arising from a breach of, or any costs payable in terms of, the Commissioning Contract;

   b) compensating the Lead Commissioner / Contractor for the costs or liabilities incurred by the Lead Commissioner / Contractor in relation to the Commissioning Contract;

1.1.2. manage the performance of the Commissioning Contract by the Provider generally and, in particular, ensure that the Provider’s performance is closely monitored so that the Services are provided to the specifications and service levels contained in the Commissioning Contract;

1.1.3. co-ordinate the respective requirements of the Parties for the Services;

1.1.4. act collaboratively in the planning, securing and monitoring of the Services so as to:

   a) plan (including needs assessment), procure and performance monitor services (as defined and agreed by the Parties) to meet the health needs of the local population;

   b) undertake reviews of the Services, manage the introduction of new services, drugs and technologies and oversee the implementation of NICE and/or other national guidance or standards relating to the Services;

   c) agree the range of the Services;

   d) conduct market management and service design;

   e) provide a coordinated approach to commissioning input to clinical networks, local commissioning fora and partnerships;

   f) engage with patients and service users and their carers and families;

   g) monitor and review the effectiveness of the Collaborative;

   h) set quality standards;

   i) design demand management processes;

   j) obtain best performance, quality and value from the Services by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

   k) ensure the Services meet patients’ rights under the NHS Constitution including Service User booking, patient choice and waiting time standards;

   l) ensure the Services are reviewed for cost effectiveness and represent best value for money;
m) from time to time negotiate and agree variations of specifications and contract terms;

n) co-ordinate and plan for demand, financial and investment needs of the Parties during the life of the Commissioning Contract;

o) implement in-year financial adjustments required under the Commissioning Contract with the Provider, and consequential adjustments between the Parties;

p) carry out annual or other reviews with the Provider, as required under the Commissioning Contract;

q) agree referral, discharge and other protocols with the Provider under the Commissioning Contract;

r) establish the arrangements for managing the day to day contact in the Commissioning Contract;

s) co-ordinate the Parties' proposals for, and plan with the Provider, the development of the Services and undertake or commission related research;

t) monitor and control disclosure of NHS confidential information to the Providers, and use of the Provider's confidential information by the Parties and within the NHS, as required by Law or the Commissioning Contract;

u) co-ordinate proposals of the Parties to move provision of the Services from the Provider to others as part of service or pathway reconfiguration;

v) participate in and monitor clinical networks;

w) deliver the Ambulance Commissioning Strategy;

x) enable the Parties to have a strategic view of key relevant issues impacting across respective populations to ensure a clear focus on patient and health outcomes;

y) enable robust working relationships between the Parties and the Provider and share early thinking on key issues;

z) ensure that the cumulative impacts of service reviews/development are identified and managed;

aa) enable the benefit of working together on achieving best value for money and optimising productivity and efficiency;

bb) establish any links and/or reporting networks with other patient care commissioning groups, as may from time to time be convenient;

c) participate in Quality Surveillance and Assurance Groups;

d) provide management information to the Parties on both the cumulative overview and each Party's local perspective;

e) establish clear reporting and escalation protocols regarding quality, safety and performance issues for each Party and review these on a regular basis;
ff) work within the Quality Surveillance principles and processes; and

gg) work towards adopting a joint committee approach to collaborative commissioning of the Services by October 2016.
### SCHEDULE 3

**UECNs and Lead Officers**

1. **Parties**

   1.1. The table below sets out:

      1.1.1. the UECNs;

      1.1.2. the relevant Lead Officers (and contact details of the Lead Officers) for each UECN; and

      1.1.3. the Parties (and address of the principal office of the Parties) that are included in each UECN and represented by the Lead Officers:

<table>
<thead>
<tr>
<th>UECN</th>
<th>Lead Officers</th>
<th>Contact details of Lead Officers</th>
<th>Party</th>
<th>Address of principal office of Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>and Humber</td>
<td></td>
<td>Email: [insert] Address: [insert]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[insert]</td>
<td>Name: [insert] Tel: [insert]</td>
<td>NHS Hull Clinical Commissioning Group (&quot;Hull CCG&quot;)</td>
<td>2nd Floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: [insert] Address: [insert]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Vale of York Clinical Commissioning Group (&quot;Vale of York CCG&quot;)</td>
<td>West Offices, Station Rise, York, YO1 6GA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (&quot;Hambleton, Richmondshire and Whitby CCG&quot;)</td>
<td>Hambleton District Council, Civic Centre, Stone Cross, Northallerton, North Yorkshire, DL6 2UU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS Harrogate and Rural District Clinical Commissioning Group (&quot;Harrogate and Rural District&quot;)</td>
<td>1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB</td>
</tr>
</tbody>
</table>
### South Yorkshire

<table>
<thead>
<tr>
<th>Name: [insert]</th>
<th>Tel: [insert]</th>
<th>Email: [insert]</th>
<th>Address: [insert]</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Sheffield Clinical Commissioning Group (&quot;Sheffield CCG&quot;)</td>
<td>722 Prince of Wales Road, Darnall, Sheffield, South Yorkshire, S9 4EU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Barnsley Clinical Commissioning Group (&quot;Barnsley CCG&quot;)</td>
<td>Hiller House, 49-51 Gawber Road, Barnsley, South Yorkshire, S75 2PY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Rotherham Clinical Commissioning Group (&quot;Rotherham CCG&quot;)</td>
<td>Oak House, Moorhead Way, Bramley, Rotherham, South Yorkshire, S66 1YY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Doncaster Clinical Commissioning Group (&quot;Doncaster CCG&quot;)</td>
<td>Sovereign House, Heavens Walk, Doncaster, South Yorkshire, DN4 5HZ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### West Yorkshire

<table>
<thead>
<tr>
<th>Name: [insert]</th>
<th>Tel: [insert]</th>
<th>Email: [insert]</th>
<th>Address: [insert]</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Wakefield Clinical Commissioning Group (&quot;Wakefield CCG&quot;)</td>
<td>White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Leeds North Clinical Commissioning Group (&quot;Leeds North CCG&quot;)</td>
<td>Leafield House, 107-109 King Lane, Leeds, West Yorkshire, LS17 5BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Leeds South and East Clinical Commissioning Group (&quot;Leeds South and East CCG&quot;)</td>
<td>3200 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Leeds West Clinical</td>
<td>Suites 2-4, Wira House, Wira</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioning Group (&quot;Leeds West CCG&quot;)</td>
<td>Business Park, Leeds, West Yorkshire, LS16 6EB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Bradford City Clinical Commissioning Group &quot;Bradford City CCG&quot;&quot;)</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Bradford Districts Clinical Commissioning Group (&quot;Bradford Districts CCG&quot;)</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS North Kirklees Clinical Commissioning Group (&quot;North Kirklees CCG&quot;)</td>
<td>4th Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Greater Huddersfield Clinical Commissioning Group (&quot;Greater Huddersfield CCG&quot;)</td>
<td>Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Airedale, Wharfedale and Craven Clinical Commissioning Group (&quot;Airedale, Wharfedale and Craven CCG&quot;)</td>
<td>Millennium Business Park, Station Road, Steeton, West Yorkshire, BD20 6RB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Calderdale Clinical Commissioning Group (&quot;Calderdale CCG&quot;)</td>
<td>5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE 4

JSCB - ROLE AND TERMS OF REFERENCE

1. ROLE OF THE JSCB

1.1. The primary role of the JSCB shall be to determine transformational decisions regarding the Services, including:

1.1.1. the range of services to be commissioned from the Provider;

1.1.2. how the Services are to be commissioned;

1.1.3. the medium to long term planning for the integration of the Service; and

1.1.4. service redesign to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and Urgent and Emergency Care Network Delivery plans of the Parties.

1.2. Patient transport services are excluded from the remit of the JSCB.

2. TERMS OF REFERENCE OF THE JSCB

Frequency and types of meetings

2.1. Meetings shall be held as and when required by the Lead Officers; usually quarterly.

2.2. Meetings may be held by telephone or video-conference. Members may participate (and count towards quorum) in a face-to-face meeting via telephone.

2.3. The Chair shall set the agenda and arrange for the circulation of any papers to be considered at least five Working Days prior to the meeting.

Members

2.4. The Lead Officers (two people nominated by each Urgent and Emergency Care Network in accordance with Clause 5.1.2) shall be members of the JSCB.

2.5. In addition, if either of the two Chief Officers of the two Lead Commissioner / Contractors (for 999 Services and 111 Services respectively) are not appointed as Lead Officers they will be a non-voting member of the JSCB.

<table>
<thead>
<tr>
<th>Appointed By:</th>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Yorkshire and York and Humber Urgent and Emergency Care Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Yorkshire and York and Humber Urgent and Emergency Care Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Yorkshire Urgent and Emergency Care Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
South Yorkshire Urgent and Emergency Care Network

West Yorkshire Urgent and Emergency Care Network

West Yorkshire Urgent and Emergency Care Network

Quorum

2.6. Meetings shall be quorate when all Lead Officers and the Chair are present.

2.7. In circumstances where a Lead Officer be unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the Chair of their nominating UECN may send to a meeting of the JSCB a deputy (a "Deputy") to take the place of a Lead Officer. Where a Deputy is sent to take the place of the Lead Officer, references in these terms of reference to Lead Officer shall be read as references to the Deputy.

Attendees

2.8. The following representatives from the Parties may be invited to meetings:

2.8.1. Director with responsibility for Clinical Quality, NHS Wakefield CCG (Lead Commissioner / Contractor 999) or named deputy; and

2.8.2. Director with responsibility for Clinical Quality, NHS Greater Huddersfield CCG (Lead Commissioner / Contractor 111) or named deputy.

2.9. The following representatives from the Provider may be invited to attend:

2.9.1. Chief Executive Officer;

2.9.2. Director – Business Development; and

2.9.3. Associate Medical Director (Vanguard Lead).

2.10. Other persons may be invited to attend by the Chair of the JSCB or agreed by all Lead Officers.

2.11. No such persons invited to attend meetings shall be able to vote on a matter.

Voting

2.12. Each two Lead Officers from each UECN shall have one vote between them.

2.13. If the Chief Officers of the two Lead Commissioner / Contractors are members of the JSCB (but not Lead Officers) then they will not have a vote.

2.14. The Parties acknowledge that there needs to be unanimity across all Lead Officers in order for JSCB Decisions to be determined.

2.15. Where unanimity is not reached, the Parties agree that the matter will be referred to dispute resolution.

Chair

2.16. The JSCB will appoint one of the Lead Officers to act as Chair. In addition the JSCB will appoint one of the Lead Officers to act as Deputy Chair.
2.17. The Chair shall ensure that administrative support and advice is provided to the JSCB including but not limited to:

2.17.1. taking of the minutes and keeping a record of matters arising and issues to be carried forward;
2.17.2. maintaining a register of interests for the JSCB (Lead Officers); and
2.17.3. advising the Lead Officers and attendees if relevant as appropriate on best practice, national guidance and other relevant documents.

**Duties**

2.18. The JSCB will:

2.18.1. make JSCB Decisions;
2.18.2. undertake actions as set out in this Agreement; and
2.18.3. undertake the actions set out in paragraph 2.19 below to support the making of JSCB Decisions.

2.19. In accordance with this Agreement the JSCB will undertake the following actions:

**Transformation**

2.19.1. Planning for the provision and transformation of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Sustainability and Transformation Plan respective commissioning intentions and ambitions;

2.19.2. Oversight of Strategic Commissioning Intentions of the CCGs in Yorkshire and the Humber in relation to work undertaken around Urgent and Emergency care Networks, including Ambulance Services;

2.19.3. Ensure that strategic intent agreed by the CCGs in Yorkshire and the Humber is captured and reflected contractually; and

2.19.4. Consider different delivery models to seek to provide equity of performance across both urban and rural area.

**Commissioning Contract**

2.19.5. Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party);

2.19.6. Agree communications activity relating to matters governed by the Commissioning Contract;

2.19.7. Resolve issues in dispute between the Parties and issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party);

2.19.8. Approve proposals for CQUIN indicators; and,

2.19.9. Agree actions if concerns are identified about actual and contracted activity levels.
Finance

2.19.10. Decisions regarding finance and investment will ordinarily be made by each Party’s Chief Finance Officer in accordance with its constitution (and as set out in Schedule 6 (Scheme of Delegation) of this Agreement).

Sub-groups

2.19.11. There shall be one sub-group, the Hear, See and Treat Board. The JSCB shall decide from time to time the membership of the Hear, See and Treat Board.

Conflicts of Interest

2.20. Each Lead Officer must abide by the conflicts of interest policy maintained by Wakefield CCG (the “Policy”), together with NHS England statutory guidance on managing conflicts of interest (the “Guidance”). If there is any conflict between the Policy and the Guidance then the provisions of the Guidance shall take precedence.

2.21. A register of interests for the JSCB Lead Officers will be maintained.

2.22. Where any Lead Officer or attendee has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, the Policy and the Guidance, whether or not that Lead Officer or attendee may participate in the discussion and/or vote, if relevant, in meetings (or parts of meetings) in which the relevant matter is discussed.

Relationship with the Parties

2.23. Minutes of meetings of the JSCB shall be sent to:

2.23.1. the Chair of each UECN for onward dissemination as appropriate; and

2.23.2. the Accountable Officer for every CCG for onward dissemination as appropriate.

Review

2.24. These terms of reference shall be reviewed by the JSCB at least annually.
SCHEDULE 5

LEAD COMMISSIONER / CONTRACTOR ROLE

1. ROLE OF THE LEAD COMMISSIONER / CONTRACTOR

   1.1. The Lead Commissioner / Contractor’s role is to take Lead Commissioner / Contractor Decisions as detailed in Schedule 6 (Scheme of Delegation) on behalf of each of the Parties. The Lead Commissioner / Contractor Decisions will focus on transactional and contract management matters in relation to the Commissioning Contract, whereas the JSCB Decisions will focus on transformational and service redesign matters in respect of the Services as a whole, including the 111 Services.

   1.2. In line with Schedule 6 (Scheme of Delegation), the Lead Commissioner / Contractor, will manage and maintain the Commissioning Contract, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services on behalf of the Parties. The Lead Commissioner / Contractor will act reasonably in undertaking its role and have regard to guidance from the JSCB as appropriate in exercising its delegated authority under this Agreement.

   1.3. In performing its role, the Lead Commissioner / Contractor shall act reasonably and comply with the principles set out in Schedule 1, and aim to achieve the objectives set out in Schedule 2. The Lead Commissioner / Contractor shall chair the Contract Management Board, which shall be the primary mechanism through which the Lead Commissioner / Contractor will hold the Provider to account on behalf of the Parties and enact Lead Commissioner / Contractor Decisions, CCG Decisions and JSCB Decisions.
SCHEDULE 6
SCHEME OF DELEGATION

1. INTRODUCTION

1.1. Each Party must ensure that the matters below are properly delegated in accordance with the NHS Act 2006 and each Party's constitution and internal procedures.

1.2. The Parties acknowledge that the NHS Act 2006:

1.2.1. allows a CCG to delegate the exercise of functions of the CCG to the Governing Body;

1.2.2. does not allow a CCG to delegate the exercise of function of the CCG to a person employed by another CCG; and

1.2.3. allows the exercise of the functions of the Governing Body (which includes functions of the CCG delegated to the Governing Body) to be delegated to an individual of a description specified in its constitution.

1.3. The Parties acknowledge that the effect of paragraph 1.2 is that a Party cannot delegate authority to exercise JSCB Decisions that relate to functions of the Party (that are not delegated to the Governing Body) to the relevant Lead Officer if that Lead Officer is not an employee of that Party.

1.4. Where the relevant Lead Officer is an employee of a Party, that Party will ensure that the JSCB Decisions are delegated to that person.

1.5. Where the relevant Lead Officer is not an employee of that Party, that Party will ensure that:

1.5.1. the functions being exercised by the Lead Officers are functions of the party but have been delegated to that Party's Governing Body;

1.5.2. the Party's Governing Body delegates the exercise of the functions referred to in paragraph 1.5.1 to the relevant Lead Officer; and

1.5.3. the Party's constitution specifies a description of individuals that includes the relevant Lead Officer.

2. CCG DECISIONS

2.1. The table below sets out the matters that the Parties have agreed are CCG Decisions which are reserved to each Party. The Parties agree that CCG Decisions will ordinarily be made by each Party’s Chief Finance Officer in accordance with its constitution.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment of Extra Contractual Journeys</td>
<td>Ratify variations to the Commissioning Contract</td>
</tr>
<tr>
<td>ECJs that relate only to that Party</td>
<td>that only affect that Party</td>
</tr>
<tr>
<td>Negotiate and recommend the Finance</td>
<td>Resolve issues between the Party and the</td>
</tr>
<tr>
<td>schedule for the annual Commissioning</td>
<td>Provider that do not impact on any</td>
</tr>
</tbody>
</table>
### Appendix C

<table>
<thead>
<tr>
<th>Contract</th>
<th>other Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend</td>
<td>Final approval of the terms of the following year's Commissioning Contract</td>
</tr>
<tr>
<td>Additional in year investment from CCGs</td>
<td></td>
</tr>
</tbody>
</table>

### 3. JSCB DECISIONS

3.1. The table below sets out the matters that the Parties have agreed are JSCB Decisions which are delegated to each Party's Lead Officers. To avoid doubt, JSCB Decisions can be made by the relevant Lead Officers without reference back to each Party.

3.2. The financial limit for JSCB Decisions will be in total no greater than £200 million per financial year.

<table>
<thead>
<tr>
<th>Transformational</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree the range of services to be commissioned from the Provider and how they are to be commissioned</td>
<td>Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)</td>
</tr>
<tr>
<td>Agree medium to long term planning for the integration of the Service</td>
<td>Agree communications activity relating to matters governed by the Commissioning Contract</td>
</tr>
<tr>
<td>Consider and recommend service redesign proposals to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and UECN Delivery Plans</td>
<td>Resolve issues in dispute between the Parties and issues in dispute between the Parties and the Provider (excluding issues that relates to only a single Party)</td>
</tr>
<tr>
<td></td>
<td>Approve proposals for CQUIN indicators</td>
</tr>
<tr>
<td></td>
<td>Agree actions if concerns are identified about actual and contracted activity levels</td>
</tr>
</tbody>
</table>

3.3. The Lead Officers shall also take the following actions and make the following decisions relating to matters about the Agreement:

3.3.1. consideration of Variation Reports and agreeing such variations;

3.3.2. consideration and agreeing the joining of a clinical commissioning group to the Collaborative in accordance with Clause 13 (Joining the Collaborative);

3.3.3. termination of the Agreement or terminating a Defaulting Party's participation in the Agreement in accordance with Clause 14 (Termination);
3.3.4. consideration of, and agreeing resolutions to, any complaint relating to the content of this Agreement in accordance with Clause 23 (Complaints);

3.3.5. development and communication; and

3.3.6. engagement events.

4. LEAD COMMISSIONER / CONTRACTOR DECISIONS

4.1. The table below sets out the matters that the Parties have agreed are Lead Commissioner / Contractor Decisions which are delegated to the Lead Commissioner / Contractor. To avoid doubt, Lead Commissioner / Contractor Decisions can be made by the Lead Commissioner / Contractor without reference back to each Party or to the Lead Officers.

4.2. The financial limit for Lead Commissioner / Contractor Decisions will be set at: £2 million per financial year for SR monies and £5 million per financial year for CQUIN payments.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Quality</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award of additional central funding investment eg SR monies</td>
<td>Approval of in-year evidence and make recommendation for payment</td>
<td>Issue of formal notices under the contract e.g. application of contractual sanctions</td>
</tr>
<tr>
<td>Approval of in-year agreement to pay CQUINs</td>
<td>Sign off of Serious Incidents</td>
<td>Co-ordination of contractual action and agreement of remedial action plans</td>
</tr>
<tr>
<td>Payment of costs related to commissioning and contracting support</td>
<td>Liaison with CQC/TDA</td>
<td>Liaison with TDA</td>
</tr>
<tr>
<td></td>
<td>Quality schedules for each contract eg CQUINs</td>
<td>Issue of in-year contract variations</td>
</tr>
<tr>
<td></td>
<td>Agree measures to manage demand for services if demand is increasing</td>
<td>Contract negotiations</td>
</tr>
<tr>
<td></td>
<td>Agree actions if clinical quality concerns are identified</td>
<td>Resolve issues escalated from UECN meetings</td>
</tr>
<tr>
<td></td>
<td>Agree changes in clinical and quality assurance practice to enhance patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree actions relating to high level external enquiry reports if concerns are identified</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree action to be taken to address key issues in relation to incidents and serious incidents</td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE 7

VARIATIONS TO THIS AGREEMENT
SCHEDULE 8
SERVICE VARIATION PROCESS

1. INTRODUCTION

1.1. This Schedule sets out the process in relation to Service Variations that may be made to the Commissioning Contract.

2. BACKGROUND

2.1. Through discussion with the Parties' Chief Officers and the Provider, it has been identified that there is a risk related to an individual Party or some of the Parties looking to substantially change or decommission service elements from within the Commissioning Contract. It was noted that a process was required in order to mitigate this risk and manage proposed Service Variations in a controlled way that minimises the impact on the Collaborative and wider services.

3. PROCESS

3.1. The proposing Party must send a Variation Proposal (in the form of the Variation Proposal template set out at Annex 1 to this Schedule 8) to the Lead Commissioner / Contractor which shall forward it to the Lead Officers.

3.2. The Lead Officers will discuss the appropriateness of the wording and may make amendments as appropriate.

3.3. The Lead Officers may sign and serve the variation Proposal on the Provider in accordance with the terms of the Commissioning Contract or may require the Lead Commissioner / Contractor to sign and serve the Variation Proposal on the Provider.

3.4. The Provider will provide a response to the Variation Proposal within 10 Working Days to the Lead Commissioner / Contractor who shall circulate the response to the Lead Officers.

3.5. The Lead Officers (and the Provider, if necessary) shall consider the impact of the Variation Proposal and the response and, taking into account the nature of the matter and the potential impact on the Parties, determine whether:

3.5.1. to refer the variation to a Check and Challenge Meeting; or

3.5.2. the Lead Officers have delegated authority to approve the variation without referring the matter to the Parties.

3.6. Where the Lead Officers have delegated authority to approve the variation without referring the matter to the Parties pursuant to paragraph 3.5.2 the Lead Officers may approve the variation.

3.7. Where the variation is approved in accordance with paragraph 6 the Lead Officer may make such arrangements as necessary to notify formal acceptance of the variation to the Provider or may instruct the Lead Commissioner / Contractor to do so.

3.8. Where the Provider proposes a variation to the Commissioning Contract to the Lead Commissioner / Contractor or a Lead Officer, the recipient shall circulate copies to all Lead Officers who shall determine which action under paragraphs 3.5.1 to 3.5.2 above to take.
Check and Challenge Meetings

3.9. Where a matter is referred to a Check and Challenge Meeting, the persons in attendance shall meet within 20 Working Days of the receipt of the Provider’s response or the receipt of the Provider’s proposed variation to:

3.9.1. review and discuss the impact of the variation and/or any response;

3.9.2. consider the scale of the impact in terms of the Parties affected;

3.9.3. ensure that impacts are quantified and understood as much as possible and where possible they are jointly agreed between the Provider and the relevant Parties;

3.9.4. recommend agreement on the acceptability of the variation or clearly identify reasons agreement cannot be recommended;

3.9.5. if agreement is recommended, identify the appropriate decision making level to recommend whether to accept or reject the variation;

3.9.6. if agreement is not recommended, escalate the variation to the JSCB or identify any additional analysis that is required to provide further assurance agreeing clear timescales and ownership for delivery; and

3.9.7. where such additional analysis is provided, consider whether it provides further assurance and determine the appropriate action under this paragraph 3.9.

3.10. Check and Challenge meetings shall be called when required and shall be attended by:

3.10.1. 999 Contract Manager (who shall be Chair);

3.10.2. representative(s) from the proposing Party (if relevant);

3.10.3. representative(s) from the Provider;

3.10.4. the 999 Finance Manager; and

3.10.5. Lead Officers from the UECN that include any Party affected by the variation.

3.11. The Check and Challenge Meeting attendees shall ensure that:

3.11.1. where agreement is recommended, the appropriate persons at the appropriate decision making levels are made aware of the Check and Challenge meetings considerations; or

3.11.2. where agreement is not recommended and escalation is required, that the matter is escalated to the JSCB.

Decision making levels

3.12. The appropriate decision making levels are:

3.12.1. the individual Parties (and such decisions will be CCG Decisions);

3.12.2. the Parties that make up one or more UECNs (and such decisions will be JSCB Decisions made by the appropriate Lead Officers); and
3.12.3. where the variation affects all Parties, the JSCB (and such decisions will be JSCB Decisions).

3.13. Where a variation is agreed pursuant to paragraph 3.12, the Lead Commissioner / Contractor will be notified and shall make such arrangements as necessary to notify formal acceptance of the variation.

3.14. Where a variation is not agreed, the matter shall be referred to dispute resolution.
ANNEX 1

SERVICE VARIATION PROPOSAL TEMPLATE

VARIATION PROPOSAL

Contract/Variation Reference:

Proposed by: Co-ordinating Commissioner on behalf of the NHS C B/Co-ordinating Commissioner on behalf of the Commissioners/Provider (delete as applicable)

Date of Proposal:

Capitalised words and phrases in this Variation Proposal have the meanings given to them in the Contract referred to above.

1. The Proposer proposes the Variation summarised below:

[and reflected in the revised draft Particulars and/or Service Conditions bearing the contract reference and variation number set out above and/or the revised General Conditions updated [     ] and/or the attached draft [insert title and reference of document]. (delete/complete as appropriate)]

2. The Proposer requires the proposed Variation to take effect on [         ].

3. The Proposer requires the Recipient to respond to this Variation Proposal in writing within 10 Operational Days, setting out whether:

• it accepts the proposed Variation; and/or
• it has any concerns with the contents of this Variation Proposal,

and any other comments it may have in relation to the proposed Variation.

SIGNED by

..............................................................
Signature

[INSERT AUTHORISED SIGNATORY’S NAME] ..............................................................
Title

for and on behalf of [CO-ORDINATING COMMISSIONER/PROVIDER]
SCHEDULE 9
MEMORANDUM OF ADHERENCE

Dated__________________________________________

MEMORANDUM OF ADHERENCE
FOR THE
COLLABORATIVE COMMISSIONING OF 999 SERVICES
BETWEEN
CLINICAL COMMISSIONING GROUPS
THIS MEMORANDUM is dated the day of 2016

BETWEEN

(1) [insert name of CCG] whose principal office is at [insert principal office address] ("New Party")

and

(2) The clinical commissioning groups named in the Schedule as the existing parties in the collaborative commissioning arrangements ("Existing Parties").

BACKGROUND

(A) This memorandum is entered into under Clause [insert number] of a memorandum of understanding dated [insert date], made between Existing Parties setting out the terms for operating the collaborative commissioning of 999 services as amended from time to time (the "MOU").

(B) The New Party wishes to join the MOU.

IT IS AGREED:

1. DEFINITIONS AND INTERPRETATION

1.1 Words and expressions used in this memorandum shall, unless the context expressly requires otherwise, have the meaning given to them in the MOU. The Effective Date means the date of this memorandum.

2. CONFIRMATION AND UNDERTAKING

2.1 The New Party confirms that it has been supplied with a copy of the MOU. The New Party and each of the Existing Parties undertake with each other that, from the Effective Date, the New Party shall assume all of the rights and obligations under the MOU and shall observe, perform and be bound by the provisions of the MOU that contain obligations on the parties to the MOU as though the New Party was an original party to the MOU.

3. COUNTERPARTS

3.1 This memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

4. GOVERNING LAW AND JURISDICTION

4.1 The New Party and the Existing Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this memorandum shall be treated as an NHS Contract and shall not be legally enforceable.

4.2 This memorandum shall be governed by and construed in accordance with English Law and, subject to Clauses 4.1, the New Party and the Existing Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this memorandum.

This document has been signed and takes effect on the date stated at the beginning of it.

[INSERT NEW PARTY NAME]

AUTHORISED OFFICER Date

NHS EAST RIDING OF YORKSHIRE
Authorised Officer     Date

NHS LEEDS WEST
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BRADFORD CITY
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS BRADFORD DISTRICTS
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS NORTH KIRKLEES
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS GREATER HUDDERSFIELD
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS AIREDALE, WHARFEDALE AND CRAVEN CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS CALDERDALE
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS SHEFFIELD
CLINICAL COMMISSIONING GROUP
Appendix C

Authorised Officer     Date

NHS BARNSLEY
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS ROTHERHAM
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date

NHS DONCASTER
CLINICAL COMMISSIONING GROUP
Authorised Officer     Date
### SCHEDULE 10
### EXISTING PARTIES

<table>
<thead>
<tr>
<th>Party</th>
<th>Address of principal office of Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Riding of Yorkshire Clinical Commissioning Group</td>
<td>Health House, Grange Park Lane, Willerby, East Yorkshire, HU10 6DT</td>
</tr>
<tr>
<td>NHS Hull Clinical Commissioning Group</td>
<td>2nd Floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY</td>
</tr>
<tr>
<td>NHS Vale of York Clinical Commissioning Group</td>
<td>West Offices, Station Rise, York, YO1 6GA</td>
</tr>
<tr>
<td>NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group</td>
<td>Hambleton District Council, Civic Centre, Stone Cross, Northallerton, North Yorkshire, DL6 2UU</td>
</tr>
<tr>
<td>NHS Harrogate and Rural District Clinical Commissioning Group</td>
<td>1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB</td>
</tr>
<tr>
<td>NHS Scarborough and Ryedale Clinical Commissioning Group</td>
<td>Scarborough Town Hall, St Nicholas Street, Scarborough, North Yorkshire, YO11 2HG</td>
</tr>
<tr>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>722 Prince of Wales Road, Darnall, Sheffield, South Yorkshire, S9 4EU</td>
</tr>
<tr>
<td>NHS Barnsley Clinical Commissioning Group</td>
<td>Hillder House, 49-51 Gawber Road, Barnsley, South Yorkshire, S75 2PY</td>
</tr>
<tr>
<td>NHS Rotherham Clinical Commissioning Group</td>
<td>Oak House, Moorhead Way, Bramley, Rotherham, South Yorkshire, S66 1YY</td>
</tr>
<tr>
<td>NHS Doncaster Clinical Commissioning Group</td>
<td>Sovereign House, Heavens Walk, Doncaster, South Yorkshire, DN4 5HZ</td>
</tr>
<tr>
<td>NHS Wakefield Clinical Commissioning Group</td>
<td>White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT</td>
</tr>
<tr>
<td>NHS Leeds North Clinical Commissioning Group</td>
<td>Leaffield House, 107-109 King Lane, Leeds, West Yorkshire, LS17 5BP</td>
</tr>
<tr>
<td>NHS Leeds South and East Clinical Commissioning Group</td>
<td>3200 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB</td>
</tr>
<tr>
<td>NHS Bradford City Clinical Commissioning Group</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
</tr>
<tr>
<td>NHS Bradford Districts Clinical Commissioning Group</td>
<td>Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR</td>
</tr>
<tr>
<td>NHS North Kirklees Clinical Commissioning</td>
<td>4th Floor, Empire House, Wakefield Old</td>
</tr>
<tr>
<td>Group</td>
<td>Address</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NHS Greater Huddersfield Clinical Commissioning Group</td>
<td>Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ</td>
</tr>
<tr>
<td>NHS Airedale, Wharfedale and Craven Clinical Commissioning Group</td>
<td>Millennium Business Park, Station Road, Steeton, West Yorkshire, BD20 6RB</td>
</tr>
<tr>
<td>NHS Calderdale Clinical Commissioning Group</td>
<td>5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX</td>
</tr>
</tbody>
</table>
Commissioners Working Together Programme: Communications and Engagement Update
NHS Doncaster CCG is one of the partners within The Commissioners Working Together Programme (CWTP) which is a collaborative of eight clinical commissioning groups (CCGs) across South and Mid Yorkshire, Bassetlaw and North Derbyshire and NHS England.

Over 2015-16, CWTP has focused on some key priority service areas, which included reviewing both hyper acute stroke and children’s surgery and anaesthesia services.

The purpose of this paper is to update Governing Body on the communications and engagement approach being taken within these particular service reviews; specifically in relation to:

- The results of engagement work done with patients and the public between January and April 2016 (Appendix 1), and
- The proposed strategic approach to communications and engagement (including formal consultation) going forward (Appendix 2)

Governing Body is asked to:

- Note the CWTP Pre-Consultation Communications and Engagement Report (Appendix 1)
- Give comments on the proposed CWTP Communications and Engagement Strategy (Appendix 2)
### Impact analysis

<table>
<thead>
<tr>
<th>Assurance Framework</th>
<th>4.1,4.2,4.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk analysis</strong></td>
<td>Potential risk to CCG internal communications and engagement capacity, in delivering the role defined for the CCG in the action plans</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>The strategy incorporates equality impact assessment regarding the communication and engagement methodology</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Costs covered within CCG’s contribution to CWTP hub</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Formal consultation is a legal requirement of service reconfiguration</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong></td>
<td>As per the paper</td>
</tr>
</tbody>
</table>
Communications and engagement report: pre-consultation for children’s surgery and anaesthesia and hyper acute stroke services

April 2016

1. Introduction

As Commissioners Working Together (CWT), we are a collaborative of eight clinical commissioning groups (CCGs) across South and Mid Yorkshire, Bassetlaw and North Derbyshire and NHS England.

Some people have better experiences, better outcomes and better access to services than others – and to ensure that everyone experiences the highest quality and safest service possible, we are working with all local hospitals and care providers, staff and patient groups to understand how best to do this for the benefit of everyone in the region.

Over the last year, we have focused on four key areas – reviewing both hyper acute stroke and children’s surgery and anaesthesia services, urgent and emergency care and have also developed a partnership with Macmillan for people living with and beyond cancer.

Between January and April 2016, we held an open pre-consultation for the review of children’s surgery and anaesthesia services and also hyper acute critical care services across the region.

The purpose of the pre-consultation communications and engagement work was to gather views and input to inform plans and the development of the options for future service configuration. These options will inform our consultation that will be opening to the public in September 2016.

2. Methods and approach

During pre-consultation, we focused our efforts on three key groups:

- Patients, carers, families and the wider public
- Clinicians and staff working in the services
- Place-based stakeholders such as Overview and Scrutiny Committees (OSCs), Health and Wellbeing Boards, MPs and other interested groups.

A comprehensive stakeholder map – developed with input from all CCGs – helped to shape and inform the approach and develop appropriate methods and ways of connecting with our identified audiences.
We followed the NHS England Planning, Assuring and Delivering Service Change for Patients Guidance (November 2015) and had conversations with and learned from colleagues in parts of the country where successful, large-scale engagement has already taken place (eg Manchester and Wakefield).

Our approach was inclusive and included:

- Overarching strategic communications and engagement from the Commissioners Working Together team
- CCG-led local conversations and awareness raising based on comprehensive, place-based communications and engagement plans
- Regionally-led clinical and managerial engagement
- Clinically informed materials
- Clinically led communications materials
- Patient and public involvement in development of materials

Our methods have included:

- Digital communications and engagement through our website, with background about why changes are being considered and materials. This was the central point for signposting and survey responses
- An online survey, asking the questions:
  
  What matters to you when accessing children’s surgery and anaesthesia services?
  
  What matters to you when accessing critical care for people who have had a stroke?

- Social media – Twitter and Facebook led
- Events, supported by the same toolkit (presentation, topline messages and Q&A)
- Broadcast and print media releases and conversations
- One to one briefings and updates with place-based stakeholders, via regular chief officer briefings
- Briefings with Healthwatch
- Setting up a Joint Health Overview and Scrutiny Committee

A working group with all communications and engagement leads from our eight CCG’s, along with communications leads from the region’s acute provider organisations and NHS England has been meeting regularly since June 2015. As well as helping to shape the communications and engagement approach, the group has met to discuss what materials were needed to support local conversations (which were subsequently developed by the core team) and update on engagement progress.
As well as promoting the pre-consultation, each CCG has been leading on local conversations with local groups and communities – ranging from established patient and public participation groups to health ambassadors (representing community and interest groups such as the homeless, asylum seekers and the deaf community), parent and carer groups (including a group for parents with children who have autism), stroke groups, disability networks and local employers. These have been complemented by regional events with clinicians, staff involved in the services and patient and public representatives.

3. Overview of communications and engagement activity

The pre-consultation period started in January 2016 and since early February, the website has seen a significant increase in traffic, with 6,756 page views between 1 February and 15 April. The top three page destinations throughout pre-consultation were:

- /what-we-do/childrens-surgery/share-your-thoughts
- /what-we-do/critical-care-stroke-patients
- /what-we-do/childrens-surgery

Interest in the Commissioners Working Together Twitter and Facebook presence has also grown – with Twitter followers increasing at a rate of around 50 a month and tweet impressions averaging around 15,000. Profile visits reached almost 1,300 in February and over 1,100 in March. Facebook has also helped raise awareness of the pre-consultations, with videos of the clinical leads and patients reaching more than 700 users. A blog from the clinical lead for children’s surgery services was read by 140 individual users with Twitter being the main source of traffic.

For further awareness raising, contact was made with the region’s key media with briefings given and a press release issued. This also resulted in an article in the Health Service Journal (HSJ) – a national trade publication.

Collectively, as a core team and as individual CCG’s we have held, attended and shared information at 22 events. This includes patient and public participation groups, parent and carer forums and stroke support groups. Attendance at the events has varied from audiences of 15 to over 200.

We have also been gathering views on a one-to-one basis in outpatient clinics, local authority settings, sixth form colleges, stroke groups and parent and carer forums.

By the end of the pre-consultation phase, we received 247 online responses as well as written feedback from each of the events. We estimate that more than 500 face to face conversations have taken place; though the awareness of the need to look at changing the two service areas has reached many thousands.

3.1 Overview of clinical engagement
In establishing the workstreams and subsequent pre-consultations, clinical spokespeople were identified and have been involved in helping shape the messaging for our various communications and engagement methods and materials.

At least five clinical workshops were held centrally throughout the pre-consultation phase and Commissioners Working Together workstream leads continue to work with clinical representatives from each commissioning and provider organisation in South and Mid Yorkshire, Bassetlaw and North Derbyshire to ensure all plans and developments are clinically-sound and sustainable.

We have also actively engaged with and worked alongside a number regional clinical experts from the Yorkshire and Humber Strategic Clinical Network throughout this process, where they have attended events, acted as spokespeople and been kept informed through regular e-bulletins and face to face meetings.

3.2 Overview of MP engagement

Building on existing relationships, each individual clinical commissioning group held the responsibility for communicating and engaging with their local MPs through regular briefings with the respective Chief Officers.

4. Overview of communications and engagement activity by area

Complementing the overarching communications and engagement activity and support from the core team, local CCG based activity was also carried out. Each CCG followed similar methods and approaches for engaging with their respective stakeholders and local populations.

4.1 NHS Barnsley Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group (Barnsley CCG) carried out various communications and engagement activity for the two workstreams, alongside promoting the pre-consultations, and how to get involved, via their website which was supported by social media signposting from their Facebook and Twitter accounts (over 9,700 followers).

Quantitative communications included the promotion of the pre-consultations via e-bulletins to various partner organisations and patient and public groups from across Barnsley. This included information being distributed to their patient council, OPEN (a public engagement network of around 200 members), GP patient reference groups (PRG’s) and to local partners from across health and social care, as well as their local authority and voluntary sector organisations.

Patient and public communications and engagement

Qualitative engagement in Barnsley with patients and the public included the pre-consultations being discussed at the Barnsley Patient Council meeting on 24 February 2016. The meeting was attended by members of local GP patient reference groups from across Barnsley with a presentation given by a member of the CWT core team alongside open,
participatory discussion on the pre-consultations. Feedback from this meeting has been incorporated into the overall themes.

Further qualitative engagement for the pre-consultation into hyper acute stroke services included attendance at an Afternoon Tea Party and Dance held by the Rotary Clubs of Barnsley, which provided an afternoon of company, discussions and entertainment for lonely, elderly and socially isolated people from across the borough. Over 200 people were in attendance and took part in a number of informal, face to face discussions. Again, the feedback was then incorporated centrally.

**Staff and partner communications and engagement**

Qualitative engagement with partner organisations, which did also include some patient groups and representatives, was the presentation of and discussions on the work of Commissioners Working Together and the pre-consultations at Barnsley CCG’s Commissioning Plans Event on 12 February 2016. As well as having a stand with information to take away, round table discussions on the workstreams were had with the 50+ people in attendance.

Barnsley CCG built on their strong relationships with their partner and provider organisations for further quantitative communications and engagement activity. Promotion of the pre-consultations and the opportunities to get involved was included in:

- Voluntary Action Barnsley’s weekly e-bulletin as well as through social and digital media (their own website and Facebook and Twitter accounts)
- South West Yorkshire Partnership NHS Foundation Trust circulated the information to all practice governance coaches in Barnsley, including physical and community services as well as mental health. Information was also sent widely to staff within physical and community services, including district nurses.
- Barnsley Hospital NHS Foundation Trust promoted the pre-consultations via their own existing networks, including Barnsley Parents and Carers Forum.
- Via their volunteering and engagement team, Barnsley Metropolitan Council promoted the pre-consultations to their staff, area teams and through their Service User and Carer Groups database (of which there are over 200 members).

**Communications and engagement with seldom heard groups and those in protected characteristics**

As well as qualitative engagement at the Rotary Club event for elderly and socially isolated people, Barnsley CCG targeted the following groups for promotion of and involvement in the pre-consultations:

- Barnsley BME Women and Children Forum
- Healthwatch Children and Young People
- Barnsley Maternity Service User Group
4.2 NHS Bassetlaw Clinical Commissioning Group

NHS Bassetlaw Clinical Commissioning Group (Bassetlaw CCG) posted information on the pre-consultations and the links to the central online surveys on their own website and supported the awareness raising via their social media accounts (over 2,900 followers on Twitter and 50 on Facebook).

Patient and public communications and engagement

Qualitative engagement by Bassetlaw CCG throughout the pre-consultation phase included attendance at their Patient Experience Steering Group. The group, consisting of patient representatives from across Bassetlaw, received a presentation on the two pre-consultations with the opportunity for follow up, participatory discussion.

Quantitative communications and engagement included the dissemination of pre-consultation information through various community and voluntary sector organisations in the area. These included:

- Bassetlaw Action Centre
- Advice Bureau, and;
- Bassetlaw Community Voluntary Services.

Staff and partner communications and engagement

Further awareness raising included the dissemination of information through Bassetlaw CCG’s Working Voices project. This is an ongoing partnership project between the CCG and the workforce of five local employers – Eatons Electrical, Ryton Park Primary School, BPL, North Nottinghamshire College and Bassetlaw CAB.

Regular updates on the work of Commissioners Working Together and the pre-consultations were also given at Bassetlaw CCG’s Governing Body meetings throughout the phase.

4.3 NHS Doncaster Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group (Doncaster CCG) actively promoted the pre-consultations, engaging with a wide range of local communities for involvement in the two pre-consultations. This was complemented by hosting locally tailored online surveys on their website which was signposted to from their own Twitter account of over 9,500 followers.

The former chair of Doncaster CCG also promoted the pre-consultations through his regular comment piece in the Doncaster Star.

Patient and public communications and engagement

Qualitative engagement for the pre-consultation into children’s surgery and anaesthesia services included attendance at seven participatory events with various patient and public groups including; two local colleges, Doncaster Parent’s Voice, Doncaster’s patient and participation group network and Happy Hands, Doncaster’s Deaf Parent Group.
Similarly, qualitative engagement for the hyper acute stroke services pre-consultation included attendance at three participatory events with a local stroke group, Doncaster Speakability and the Doncaster Stroke Support Group.

Vox pop sessions were also carried out at the Civic Building in Doncaster, engaging members of the public in 1:1 conversations about the two pre-consultations and feeding their views into the overall feedback.

Quantitative engagement on the two workstreams included the distribution of information, including how to get involved to targeted patient and public groups across Doncaster, including children’s centres, parent partnerships, carers’ services and charities.

**Staff and partner communications and engagement**

Quantitative communications and engagement activity was carried out with Doncaster CCG’s partner organisations through the distribution of information and survey questions for all internal and external publications of the following:

- Doncaster Metropolitan Borough Council
- Public Health
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- The Doncaster Chamber of Commerce
- St Leger Homes (who provide housing services for the 21,000 council-owned homes in Doncaster)

The online survey was also distributed to a number of BME community groups and to the CCG’s Health Ambassadors who represent a range of seldom heard community groups such as the homeless and asylum seekers.

**Communications and engagement with seldom heard groups and those in protected characteristics**

Through their various communications and engagement activity, Doncaster CCG also targeted the below groups with information and opportunities to get involved:

- Doncaster Men’s Group
- Doncaster Age UK
- Doncaster Mencap
- Doncaster Mind
- Doncaster Autistic Society
- Doncaster Deaf Parent and Toddler Group
- The LADDER group (supporting young people across Doncaster with a range of disabilities)

4.4 NHS Hardwick and NHS North Derbyshire Clinical Commissioning Groups

NHS Hardwick and NHS North Derbyshire Clinical Commissioning Groups (CCGs) submitted joint communications and engagement activity plans and reports and worked jointly to target their respective populations and audiences.

Information on the pre-consultations was posted on their individual websites and supported by social media signposting through their respective Twitter accounts (over 3,700 combined followers).

**Patient and public communications and engagement**

Qualitative engagement covering the two CCGs included attendance at two participatory events and meetings where information was shared and discussions had on the two pre-consultations. This included a focus group at the Derbyshire Stroke Centre on Thursday 17 March 2016. Feedback from this group has been incorporated into the central themes.

Quantitative communications and engagement by the two CCGs included the contacting of and dissemination of information to at least ten specific patient and public groups relevant to each service. The opportunity to have a face to face discussion with a member of either Hardwick or North Derbyshire CCG was also offered to these groups, which included, the North Derbyshire Stroke Club, Dales and High Peak Council for Voluntary Service, the Derbyshire Parent forum and Cypress Parent Support Group.

**Staff and partner communications and engagement**

Quantitative communications and engagement across the two areas included the mass communication of pre-consultation information through each CCG’s internal and external publications, chief officer blogs, GP newsletters and information shared with the provider organisations in the region, Chesterfield Royal Hospitals NHS Foundation Trust and Derbyshire Community Health Services.

Due to the engagement with and by building on their relationships with partners, information was then cascaded independently via the local Healthwatch and NVDA (a registered charity supporting health related voluntary organisations across Derbyshire) to their own stakeholders and audiences.

The executive teams of each CCG provided regular updates to the region’s Health and Wellbeing Board and information was also shared amongst all Patient Participation Groups (PPGs) and practice managers in the region.

4.5 NHS Rotherham Clinical Commissioning Group

Overarching communications and engagement methods carried out by NHS Rotherham Clinical Commissioning Group (Rotherham CCG) included the publishing of the pre-consultations on their website with links to the central feedback surveys on the Commissioners Working Together site. This was supported by further digital and social
media engagement with signposting from the CCG’s Twitter account (to over 7000 followers).

Quantitative communications also included the inclusion of the pre-consultations in emails out to all 31 Rotherham GP practices as part of their regular GP e-bulletin, alongside articles printed in internal and external partner publications and newsletters, for example, those of The Rotherham NHS Foundation Trust and Rotherham Metropolitan Borough Council.

Patient and public communications and engagement

Rotherham CCG had a strong focus on qualitative engagement with various face to face conversations having taken place throughout the pre-consultation phase. These conversations included targeted engagement with local groups for stroke survivors and those having suffered from other neurological conditions. Presentations on the two workstreams were given to these individual groups in February and March 2016 with discussions then feeding into the overall pre-consultation feedback.

For the children’s surgery and anaesthesia workstream, qualitative engagement was carried out with the Rotherham Parent’s Forum. The forum is an active group of parents and carers who work with health and care organisations who provide services for disabled children and their families in Rotherham.

Further qualitative engagement with patients and the public included presentations to and discussions with the Rotherham PPG network, made up of patient and public representatives from across all GP practices in the area. Workstream leads from the central Commissioners Working Together team also attended this participatory event and were able to discuss the pre-consultations and also answer any questions the audience had.

Staff and partner communications and engagement

Information on the work of Commissioners Working Together and how to get involved with the two pre-consultations was also shared via qualitative engagement with a number of Rotherham CCG’s partner organisations. For example, the CCG had regular catch ups with Healthwatch Rotherham throughout the pre-consultation period as well as chief officer and chair conversations with the local health overview and scrutiny committee.

Communications and engagement with seldom heard groups and those in protected characteristics

Communications and engagement targeted to groups as identified in the protected characteristics included the sending of information, including how to get involved and respond to the pre-consultations, to the Rotherham Disability Network and Older People’s Forum with an offer of attendance at participatory events and focus groups.

4.6 NHS Sheffield Clinical Commissioning Group

Complementing the various methods used by NHS Sheffield Clinical Commissioning Group (Sheffield CCG) during the pre-consultation phase was their overarching use of digital engagement and social media. Information on both Commissioners Working Together workstreams was published on the CCG’s website which included links and information on
how to get involved via the CWT main site. This was supported by signposting from their Twitter account (to over 9,500 followers).

Patient and public communications and engagement

In terms of qualitative engagement, Sheffield CCG built on their strong links with their largest provider organisation, Sheffield Teaching Hospitals NHS Foundation Trust (STH) where the pre-consultation questions for hyper acute stroke services were incorporated into the stroke service’s own patient feedback survey. A dedicated volunteer attended the hospital based six-week review clinic and talked through the questionnaire and pre-consultation information with all patients and carers who accessed the stroke service within the pre-consultation phase. From this, 63 1:1 patient conversations were had by STH’s stroke service and fed into our patient and public feedback.

Qualitative engagement for the children’s surgery pre-consultation included attendance at and conversations with the Sheffield Parent Carer forum and attendance at Sheffield Children’s Hospital NHS Foundation Trust’s outpatient department for 1:1 conversations with parents and carers of children who either needed or had gone for a follow up appointment following elective surgery.

Quantitative communications and engagement activity in Sheffield for both pre-consultations included the signposting to the central online surveys in multiple and various online forums including; Involve Me, Citizen Space, Mumsnet, the Health and Wellbeing Board, Healthwatch and a mail out to Voluntary Action Sheffield and members of various voluntary and community groups in the city.

Staff and partner communications and engagement

Qualitative engagement with Sheffield CCG’s partner organisation’s boards included regular updates to Sheffield’s Health and Wellbeing Board with partners providing support and feedback. Ongoing, face to face updates and information on the pre-consultations, with opportunities for feedback, were also given to the joint overview and scrutiny committee. Information and plans for the pre-consultations were also shared by the CCG at the Sheffield Engagement Leads Group which includes communications and engagement representatives from Sheffield City Council, NHS provider organisations and Healthwatch. It was from linking with this group that STH then incorporated the pre-consultation questions into their stroke service patient feedback survey.

Sheffield CCG also contacted each of the GP practices (of which there are 88 in Sheffield), practice managers and patient participation groups across the city to raise awareness of Commissioners Working Together, our work and how to get involved in the pre-consultations.

Communications and engagement with seldom heard groups and those in protected characteristics

In Sheffield, information on the pre-consultations, including how to get involved, was disseminated through the Equality Hub Network representing the following groups across the city:
• Age hub for younger and older people
• BME hub
• Carers’ hub
• Disability hub
• LGBT hub
• Religion/belief hub (including those of no religion)
• Women’s hub

4.7 NHS Wakefield Clinical Commissioning Group

NHS Wakefield Clinical Commissioning Group (Wakefield CCG) also supported their more targeted communications and engagement activity through the use of social and digital media. The online surveys, and links to the Commissioners Working Together site, were posted on their website and signposted to via their own Twitter account of over 8,400 followers.

Patient and public communications and engagement

Qualitative engagement with patients and the public included the attendance at two participatory events, one of PIPEC (the CCG’s patient group) and the other, a patient reference group network meeting with representatives from across Wakefield’s patient groups. Presentations were given on the two pre-consultations, followed by discussions with the groups and feedback given centrally.

Quantitative patient and public communications and engagement included contact being made with and the dissemination of pre-consultation information to a number of targeted groups relevant to each workstream. These included:

• Individual members of a former Wakefield Stroke Group
• St George’s Stroke Survivor Group
• Age UK
• Carers Wakefield
• Healthwatch
• Young Lives consortium
• NOVA (an umbrella voluntary and community sector forum)

Staff and partner communications and engagement

Staff and partners of Wakefield CCG were also targeted through a variety of communications and engagement methods. This included CCG staff briefings, internal and external bulletins, including GP newsletters and information on the pre-consultations was
shared with the CCG’s provider organisations, public health colleagues and board updates to the overview and scrutiny committee.

Communications and engagement with seldom heard groups and those in protected characteristics

In terms of targeted communications and engagement activity to seldom heard groups and those within protected characteristics, Wakefield CCG’s stakeholder engagement database is based on the nine protected characteristics with information cascaded to all groups, including voluntary, community and other interested groups and sectors. Information on the pre-consultations and how to get involved was also sent specifically to:

- The Wakefield District Disabled Patient Partnership Support group, and;
- DIAL – the disabled information and advice service.

5. Themes emerging throughout the pre-consultation

5.1 Children’s surgery and anaesthesia pre-consultation

The following points were consistent in the feedback in terms of what people said mattered to them. The top three strongest themes are highlighted:

- Safe, caring, quality care and treatment.
- Access to specialist care.
- Care close to home.
  Communication – between children, parents, carers and their clinicians – and also between hospitals.
  Being seen as soon as possible.

The following points were also raised:

- Having appropriate facilities, especially for parents and carers who need to stay over.
- Successful operations.
- A willingness to travel for specialist care.
- Consideration for children with complex needs – especially around pre-surgery service.

5.2 Critical care for people who have had a stroke pre-consultation

The following points were consistent in the feedback in terms of what people said mattered to them. The top three strongest themes are highlighted:

- Being seen quickly when get to a hospital.
- Being seen and treated by knowledgeable staff.
- Safety and quality of the service.
  Fast ambulance response times / travel times.
  Good access to rehabilitation services locally.

The following points were also raised:
More education on the prevention of strokes. Involving family and carers (as they know the patient best and can advise while in critical condition).

The detailed verbatim patient and public feedback received in the online survey and during conversations is available on request.

**Patient and public sample quotes when asked what mattered to them when accessing care:**

<table>
<thead>
<tr>
<th>Feedback from patients/public</th>
<th>Service area</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A service of the highest quality ensuring that the wishes and feelings of the child and family come first and professional help and guidance is given in the simplest of terms.”</td>
<td>Children’s surgery and anaesthesia</td>
</tr>
<tr>
<td>“Good outcome and excellent quality care, choice of hospitals”</td>
<td>Children’s surgery and anaesthesia</td>
</tr>
<tr>
<td>“That they’ll have the best possible care, that they wouldn’t be frightened and could have mum, dad or relative with them as much as possible, that they suffered as little discomfort as possible before, during and after surgery.”</td>
<td>Children’s surgery and anaesthesia</td>
</tr>
<tr>
<td>“If my child was havin an op, I’d probably say id want to know the risks, I want to know information about the procedure, is it the best staff possible and the best location”</td>
<td>Children’s surgery and anaesthesia</td>
</tr>
<tr>
<td>“Prompt treatment, good rehabilitation and robust care plans and referrals where appropriate to other services and an overall seamless package of care.”</td>
<td>Hyper acute stroke services</td>
</tr>
<tr>
<td>“Person centred care, support for patient and family”</td>
<td>Hyper acute stroke services</td>
</tr>
</tbody>
</table>
6. Evaluation and next steps for consultations

During this pre-consultation phase, through various qualitative and quantitative communications and engagement methods and activities, we provided multiple opportunities for the communities of South and Mid Yorkshire, Bassetlaw and North Derbyshire to get involved and help shape the future of hyper acute stroke and children’s surgery and anaesthesia services.

All feedback from the pre-consultation communications and engagement activity and conversations will be used to help inform the development of the two business cases for change which are due to be developed and agreed by June 2016 prior to options for consultations being considered. We will clearly state how the views of people have been taken into consideration within the options, appraisal, business case and consultation materials.

The methods and approach of communications and engagement activity will also be built on to produce a full communications and engagement strategy and plans for public consultations which are due to open in September 2016.

In the meantime, we will continue to have an open, honest and accessible approach to communications and engagement and will continue to keep all our stakeholders and those involved so far, up to date with the work and progress of Commissioners Working Together and its’ individual workstreams.
Communications and engagement strategy and plans for public consultation

April 2016

Contents:

• Commissioners Working Together overarching communications and engagement strategy for public consultation

• Communications and engagement plan for public consultation on children’s surgery and anaesthesia services

• Communications and engagement plan for public consultation on hyper acute stroke services

Communications and engagement strategy for public consultation

Introduction

As Commissioners Working Together, we are a collaborative of eight NHS clinical commissioning groups across South and Mid Yorkshire, Bassetlaw and North Derbyshire and NHS England. Some people have better experiences, better outcomes and better access to services than others – and to ensure that everyone experiences the highest quality and safest services possible, we are working with all local hospitals and care providers, staff and patient groups to understand how best to do this for the benefit of our combined population of 2.8 million. Our key partners are:

• NHS Barnsley Clinical Commissioning Group
• NHS Bassetlaw Clinical Commissioning Group
• NHS Doncaster Clinical Commissioning Group
• NHS England
• NHS Hardwick Clinical Commissioning Group
• NHS North Derbyshire Clinical Commissioning Group
• NHS Rotherham Clinical Commissioning Group
• NHS Sheffield Clinical Commissioning Group
• NHS Wakefield Clinical Commissioning Group

We also work with voluntary and community sector partners as well as gaining assurance and input from national and regional clinical advisors and experts.

Between January and April 2016 we held an open pre-consultation for the review of children’s surgery and anaesthesia and hyper acute stroke services. During this phase we gathered the views of our key stakeholders to inform plans for future service configuration and consultation. We are now preparing to enter XX week public consultations on the options for reconfiguring children’s
surgery and anaesthesia and hyper acute stroke services across our commissioning and provider partners in the region.

Effective communication and engagement is a two-way process. Our activity will focus on informing, sharing, listening and responding. Being proactive is central to our communications and engagement strategy of:

- Proactively and effectively communicating our purpose, priorities, messages and values.
- Developing effective, two-way mechanisms where we share news, we listen and respond whilst being open and transparent.
- Identifying relevant and effective methods for audience and stakeholder engagement.

In all communications and engagement activity, we will work with all our local partners and tailor our messages and methods accordingly to each individual group to ensure we maximise all opportunities for connecting with, informing and engaging with our target audiences.

**Aims and Objectives**

- Raise awareness and understanding of the current provision and need for changes to children’s surgery and anaesthesia and hyper acute stroke services in South and Mid Yorkshire, Bassetlaw and North Derbyshire
- Ensure patients, families, carers and the public are involved, are able to share their views on the proposed options and are listened to
- Inform key staff and clinicians in each locality about proposed change options and keep them updated throughout the consultation process
- Ensure existing patients, family and carers have the information they need about any changes to services
- Inform all stakeholders of new proposed models of care and opportunities to have their say in the consultations
- Provide high quality support, advice and updates on consultation activity to the Commissioners Working Together board, partners and staff within each member organisation.

**Key Messages**

Alongside service and consultation specific messages, underpinning all our communications will be the following overarching messages of Commissioners Working Together:

- We know that there's variation in people’s experiences of services across our region, with some people getting better access and outcomes than others.
- We know that many people are treated in hospital when their needs could be better met elsewhere or closer to home.
- If we are to continue providing high quality, safe and sustainable NHS services – we need to change, together.
• Our ambition is to develop excellent healthcare together by reconsidering how services are delivered, redefining how we work together as commissioners, and coming together with all our partners and stakeholders to find the best solutions for our populations.

• Planning and commissioning across a larger area is becoming increasingly urgent as more and more people use NHS services, are living longer and using more advanced technology to improve care.

• For some services, there won’t be enough trained and experienced staff in the future if we continue to provide services the way we do today, with the quality and accessibility of services being reduced.

• At the same time, costs are increasing. If we don’t act now, more people will suffer from unnecessary poor health.

**Target Audiences**

Prior to the pre-consultation phase, a full stakeholder mapping exercise was carried out to identify all stakeholders involved in and affected by any proposed changes to the services reviewed (Appendix 1).

Through various and tailored communications and engagement methods, the following groups have been identified for targeted communications and engagement activity:

• Patients and the public - including seldom heard groups and those identified in the following protected characteristics (Equality Act 2010):
  - Age
  - Disability
  - Gender reassignment
  - Pregnancy and maternity
  - Race (Appendix 2: BME breakdown per population)
  - Religion or belief
  - Sex
  - Sexual orientation

• National and local patient groups

• Local Authorities, MPs and councillors

• Public health

• Governing body members of all CCGs

• Executive board members of all providers
- Clinicians – acute, primary and community care
- Foundation trust and CCG members
- Clinical Senates
- Healthwatch
- Voluntary sector organisations
- Health and Wellbeing boards
- Local, regional and trade media

**Communications Approach**

Overall communications and engagement activity will be pro-actively co-ordinated by the Commissioners Working Together communications team who will work with the programme management team, workstream leads and communications and engagement leads from our commissioner and provider partners to ensure all activity is joined up, timely and appropriate.

After evaluating the communications and engagement activity carried out during the pre-consultation phase, we agreed that our activity for consultations will follow and build on the approach already taken and in place. Our inclusive approach will include:

- Overarching strategic communications and engagement planning and support from the Commissioners Working Together team.
- CCG-led local conversation and awareness raising based on comprehensive, place-based communications and engagement plans.
- Regionally-led clinical and managerial engagement.
- Clinically informed communication materials.
- Clinically led conversations.
- Patient and public involvement in the development of communication materials.

We have established a working group with all communications and engagement leads from our CCG partners, along with communications leads from the region’s acute provider organisations and NHS England, which has been meeting regularly since June 2015. As well as helping to shape and evaluate our communications and engagement approach, the group will meet to discuss and update on consultation feedback and progress.

Our communications and engagement approach for consultation has been further developed from patient and public response during our pre-consultation phase in terms of which methods were most favoured - which we will now use as a focus for our approach eg, website, social media, e-bulletins (Appendix 3).

To further strengthen our communications and engagement working group and activity we will build on our relationships with our public health and also local authority communications colleagues – allowing us to work together to disseminate messages and target existing networks, eg, for seldom heard groups and those included in the protected characteristics.
Communications Principles

All communications and engagement activity carried out by and on behalf of Commissioners Working Together will be:

- **Accessible and inclusive** – to all our audiences
- **Clear and concise** – allowing messages to be easily understood by all
- **Consistent and accountable** – in line with our vision, messages and purpose
- **Flexible** – ensuring communications and engagement activity follows a variety of formats, tailored to and appropriate for each audience
- **Open, honest and transparent** – we will be clear from the start of the consultations what our plans are, what is and what isn’t negotiable, the reasons why and ultimately, how decisions will be made
- **Targeted** – making sure we get messages to the right people and in the right way
- **Timely** – making sure people have enough time to respond and are kept updated on a regular basis
- **Two-way** – we will listen and respond accordingly, letting people know the outcome of all conversations.

Methods

No single communications channel will be effective in reaching and engaging all our audiences, therefore it is important that a variety of different communications and engagement methods are used, presenting relevant information in a timely and proactive way that best meets the needs of our individual stakeholders (as identified during pre-consultation).

Although full details of communications and engagement methods for individual audiences will be included in the communications and engagement planners for each of the consultations, some of our quantitative, qualitative and participatory methods will include the following:

- Stakeholder briefings
- Attendance at partner and stakeholder meetings and events
- Focus groups
- Flyers
- Newsletters and e-bulletins
- Local, regional and trade print and broadcast media
- Internal bulletins
- Public website
- Online surveys
- Deliberative events
• Videos and vox pops

Alongside these methods, a key mechanism for consultation communications and engagement activity will be through the use of social media. We know from the Commissioners Working Together pre-consultations and also by identifying key trends and best practice from similar health and care transformation projects in other regions, that social media is an effective way of communicating and engaging with a variety of audiences.

Social media is a useful way of:

• Disseminating information and signposting
• Raising awareness
• Collecting demographic data
• Demonstrating willingness to engage in dialogue with a target audience
• Speaking to a large number and variety of audiences in real-time.

By developing and creating a number of communications materials and assets, through social media we will listen and respond to and motivate our audience to both share the information we are communicating and also engage with us by taking part in the consultations.

**Branding**

Brand identity is important – particularly when multiple partners are involved. As a partnership we want to be seen as joined up, open and honest, approachable, clinically sound and responsive.

We have developed a Commissioners Working Together logo and identity that will be used on all communications and engagement materials for the two public consultations. Based on feedback from the pre-consultations, a single logo avoids confusion between the eight partners and will be clear to anyone across the region that the consultations are being delivered on behalf of all partners and organisations in the Commissioners Working Together partnership.

**Consultation and engagement legislation**

Throughout our communications and engagement activity for consultations into children’s surgery and anaesthesia and hyper acute stroke services, we as a collaborative of clinical commissioning groups will abide by the following legislation:

**Health and Social Care Act 2012**

The Health and Social Care Act 2012 makes provision for Clinical Commissioning Groups (CCGs) to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners. It also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution.

Health Commissioners must involve and consult patients and the public:

• in their planning of commissioning arrangements
• in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
• In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSCs) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

• In the planning of healthcare services
• The development and consideration of proposals for changes in the way those services are provided, and
• In the decisions to be made affecting the operation of those services.

Commissioners will ensure that the duties required in legislation are met and that patient, the public and stakeholders have the opportunity to have meaningful input in shaping future health services within the scope of the programme.

In undertaking public consultation commissioners we ensure that it is clear to public, patients and stakeholders what they are able to shape or influence and what areas are set due to national policy or safety reasons.

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. The characteristics that are protected by the Act are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Section 149 of the Equality At 2010 states all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘equality of opportunity,’ and c) foster good relations between persons who share a relevant protected characteristics and persons who do not share it.

The Gunning Principals of Consultation

The four ‘Gunning Principals’ are recommended as a framework for all engagement activity but are particularly relevant for consultation and would be used, in the event of a judicial review, to measure whether the process followed was appropriate. The Gunning Principles state that:

Consultation must take place when the proposal is still at a formative stage: Decision-makers cannot consult on a decision that has already been made. If the outcome has been pre-determined, the consultation is not only unfair, but it is also pointless.

This principle does not mean that the decision-maker has to consult on all possible options of achieving a particular objective. A decision-maker can consult on a ‘preferred option’, and even a ‘decision in principle’, so long as its mind is genuinely open - ‘to have an open mind does not mean an empty mind.’
If a decision-maker has formed a provisional view as to the course to be adopted, or is ‘minded’ to take a particular course subject to the outcome of consultations, those being consulted should be informed of this ‘so as to better focus their responses’.

**Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response:** Consultees should be made aware of the basis on which a proposal for consultation has been considered and will thereafter be considered. Those consulted should be aware of the criteria that will be applied when considering proposals and what factors will be considered ‘decisive’ or ‘of substantial importance’ at the end of the process.

**Adequate time must be given for consideration and response:** Unless statutory time requirements are prescribed, there is no necessary time frame within which the consultation must take place. The decision-maker may adopt a policy as to the necessary time-frame (e.g. Cabinet Office guidance, or compact with the voluntary sector), and if it wishes to depart from that policy it should have a good reason for doing so. Otherwise, it may be guilty of a breach of a legitimate expectation that the policy will be adhered to.

**The product of consultation must be conscientiously taken into account:** If the decision-maker does not properly consider the material produced by the consultation, then it can be accused of having made up its mind; or of failing to take into account a relevant consideration.

**Evaluation and Monitoring**

Evaluation will play an important part in our communications and engagement activity, evidencing whether we have achieved our objectives by engaging with our target audiences successfully. We will monitor our activity throughout the consultation period to ensure we are reaching our audiences effectively and providing equal and appropriate opportunities for involvement and feedback.

Through monitoring and evaluation we will be able to learn lessons and gain valuable insight into public and stakeholder sentiment and behaviour, allowing us to tailor our methods appropriately. Examples of how we will monitor our activity include:

- Media and social media monitoring
- Stakeholder meetings for discussions and feedback (particularly Healthwatch and OSC)
- Staff feedback via briefings
- Patient and public feedback via our various methods

Where necessary we will update the strategy to adapt to staff, clinical, patient, public and stakeholder feedback. It is vital that we are able to demonstrate that we listen to comments and suggestions from all our stakeholders, including seeking assurance from independent advisors, in order that they are fully involved and engaged in the reconfiguration of services.
DRAFT Communications and engagement plan for public consultation on children’s surgery and anaesthesia services

Introduction

As Commissioners Working Together, we are a collaborative of eight clinical commissioning groups across South and Mid Yorkshire, Bassetlaw and North Derbyshire and NHS England. Some people have better experiences, better outcomes and better access to services than others – and to ensure that everyone experiences the highest quality and safest services possible, we are working with all local hospitals and care providers, staff and patient groups to understand how best to do this for the benefit of our combined population of 2.8 million.

Between January and April 2016 we held an open pre-consultation for the review of children’s surgery and anaesthesia services. During this phase we gathered the views of our key stakeholders to inform plans for future service configuration and consultation. We are now preparing to enter a XX week public consultation on the options for reconfiguring children’s surgery and anaesthesia services across our commissioning and provider partners in the region:

- NHS Barnsley Clinical Commissioning Group
- NHS Bassetlaw Clinical Commissioning Group
- NHS Doncaster Clinical Commissioning Group
- NHS Hardwick Clinical Commissioning Group
- NHS North Derbyshire Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group
- NHS Wakefield Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Sheffield Children’s Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Mid Yorkshire Hospitals NHS Trust
- The Rotherham NHS Foundation Trust

We will be consulting on the following options: XXX
Aims and objectives

- Raise awareness and understanding of the current provision and need for changes to children’s surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire
- Ensure patients, families, carers and the public are involved, able to have their say on the proposed options, and are listened to
- Inform key staff and clinicians in each locality about proposed change options
- Ensure patients, family and carers have the information they need about any changes to children’s services
- Inform all stakeholders of new proposed models of care and opportunities to be involved

Target audiences

The following audiences will be targeted through tailored communications activity. We will use a variety of methods to connect with each of our key stakeholders, ensuring our messages remain consistent and appropriate for each.

- Patients and the public (including parent and carer forums, seldom heard groups and identified protected characteristics)
- Local Authorities, MPs and councillors
- Governing body members of all CCGs
- Executive board members of all providers
- Clinicians – acute, primary and community care
- Foundation trust and CCG members
- Clinical Senate
- Healthwatch
- Health and Wellbeing boards
- Local, regional and trade media
- Public health

Key messages

As with pre-consultation, our key messages will focus on the reasons why changes are needed to children’s surgery and anaesthesia services whilst highlighting the importance of, and opportunities to get involved in, and take part in the consultation. These messages include:

- We know that across our region some people have better experiences, better outcomes and better access to services than others. We want everyone to experience the highest quality and safest service possible.
• We improving children’s surgery services for everyone across South and Mid Yorkshire, Bassetlaw and North Derbyshire – and we need your help!

Why are we changing services? At the moment:

- Different hospitals refer children in different ways
- Doctors in our smaller hospitals don’t treat as many children as our bigger ones
- Nationally, there aren’t enough health care professionals qualified to treat children, and;
- Some people have better experiences than others – we want this to change.

Note: Key messages will be tailored and confirmed once the business case for change is agreed and there are definite options for consultation.

Communications and engagement methods

To deliver the aims of our communications and engagement plan, we will carry out a range of activity across all geographic areas covered by the Working Together partnership, including both providers and commissioners. The methods and messages used to communicate will be tailored for each audience to maximise every opportunity for public and stakeholder involvement.

A key mechanism for consultation communications and engagement activity will be through the use of social media. We know from the Commissioners Working Together pre-consultations and also by identifying key trends and best practice from similar health and care transformation projects in other regions, that social media is an effective way of communicating and engaging with a variety of audiences.

Social media is a useful way of:

• Disseminating information and signposting
• Raising awareness
• Collecting demographic data
• Demonstrating willingness to engage in dialogue with a target audience
Speaking to a large number and variety of audiences in real-time.

By developing and creating a number of communications materials and assets, through social media we will listen and respond to and motivate our audience to both share the information we are communicating and also engage with us by taking part in the consultations.

Further details of specific qualitative, quantitative and participatory communications and engagement methods for individual audiences are included in the planners below.

**Engagement planner**

<table>
<thead>
<tr>
<th>Type of engagement</th>
<th>Audience</th>
<th>Method examples</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **Qualitative**    | Patients and the public, parent and carer forums, MPs, Local Authorities | • Focus groups  
• Attendance at relevant groups/events  
• Stakeholder briefings  
• Vox pops | CCG and provider partners supported by the Commissioners Working Together team |
|                    | Seldom heard groups and protected characteristics | • Attendance at existing groups eg, parents with children with learning disabilities, Mosques, homeless charities, LGBT forums, sixth form colleges  
• Disseminate information through existing networks for 1:1 and group | |
<table>
<thead>
<tr>
<th><strong>Quantitative</strong></th>
<th>Patients and the public, healthcare staff</th>
<th><strong>Seldom heard groups and protected characteristics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Online survey</strong></td>
<td><strong>Flyers translated into most popular languages (identified through census data in Appendix 2) and disseminated in various locations</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Flyers in various locations: GP practices, outpatient departments, libraries, supermarkets, children’s centres, schools and nurseries</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Participatory</strong></td>
<td>Patients and the public, parent and carer forums, seldom heard groups, healthcare staff and clinicians</td>
<td><strong>Seldom heard groups and protected</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Deliberative events (x8)</strong></td>
<td><strong>Attendance at existing groups and</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Listening events</strong></td>
<td><strong>Commissioners Working Together team supported by CCG and provider partners</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Focus groups</strong></td>
<td></td>
</tr>
<tr>
<td>characteristics</td>
<td>events</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Focus groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social media

<table>
<thead>
<tr>
<th>Audience</th>
<th>Method examples</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>• Twitter and Facebook – blanket and targeted posts to various groups, including health and care organisations, patient groups, Healthwatch organisations, local authorities, press accounts, LGBT networks, youth groups, high profile local/regional businesses, activity centres, schools, parent and carer groups (eg, Mumsnet)</td>
<td>Commissioners Working Together team supported by CCG and provider partners</td>
</tr>
</tbody>
</table>

### Communications planner

<table>
<thead>
<tr>
<th>Communication Type</th>
<th>Audience</th>
<th>Method examples</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Promotion/ Participation | Patients and the public including targeted to parents and carers, voluntary sector organisations and staff | • Newsletters  
  • Social media  
  • Media  
  • Blogs/case studies  
  • Event presence | Commissioners Working Together team supported by CCG and provider partners |
<table>
<thead>
<tr>
<th>Category</th>
<th>Activities</th>
<th>Remarks</th>
</tr>
</thead>
</table>
| Seldom heard groups and protected characteristics | • ‘Market stalls’  
• Attendance at partners AGMs  
• Submissions to targeted publications and newsletters, eg, parent’s assembly, BME community newspapers | Commissioners Working Together team supported by CCG and provider partners as appropriate |
| Updates and briefings                        | Staff from all partners, members of all organisations, GPs, practice staff, Local Authorities, MPs, councillors, board and governing body members, OSC  
• NHS internal comms  
• E-bulletins  
• Briefing papers  
• Verbal briefings/attendance at partner and stakeholder meetings | Commissioners Working Together team supported by CCG and provider partners as appropriate |
| Media                                        | Patients, the public and staff including trade publications  
• Press releases  
• Media interviews  
• Media briefings  
• Submissions to targeted publications and newsletters, eg, parent’s assembly, BME community newspapers | Commissioners Working Together team supported by CCG and provider partners as appropriate |
<table>
<thead>
<tr>
<th>protected characteristics</th>
<th>newsletters, eg, BME community newspapers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social media</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>• Twitter and Facebook – blanket and targeted posts to various groups, including health and care organisations, patient groups, Healthwatch organisations, local authorities, press accounts, LGBT networks, youth groups, high profile local/regional businesses, activity centres, schools, parent and carer groups (eg, Mumsnet)</td>
</tr>
</tbody>
</table>
Introduction

As Commissioners Working Together, we are a collaborative of eight clinical commissioning groups across South Yorkshire and Bassetlaw and North Derbyshire and NHS England. Some people have better experiences, better outcomes and better access to services than others – and to ensure that everyone experiences the highest quality and safest services possible, we are working with all local hospitals and care providers, staff and patient groups to understand how best to do this for the benefit of our combined population of 2.8 million.

Between January and April 2016 we held an open pre-consultation for the review of critical care for people who have had a stroke (hyper acute stroke services). During this phase we gathered the views of our key stakeholders to inform plans for future service configuration and consultation. We are now preparing to enter a XX week public consultation on the options for reconfiguring hyper acute stroke services across our commissioning and provider partners in the region:

- NHS Barnsley Clinical Commissioning Group
- NHS Bassetlaw Clinical Commissioning Group
- NHS Doncaster Clinical Commissioning Group
- NHS Hardwick Clinical Commissioning Group
- NHS North Derbyshire Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Sheffield Children’s Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust

Our consultation has also been informed by the review into hyper acute stroke services by the Yorkshire and the Humber Strategic Clinical Network which made the recommendation, based on current and projected activity, that the number of hyper acute stroke services (HASUs) should be reduced from five to three or four in South Yorkshire and Bassetlaw.

We will be consulting on the following options: XXX
Aims and objectives

- Raise awareness and understanding of the current provision and need for changes to hyper acute stroke services across South Yorkshire, Bassetlaw and North Derbyshire
- Ensure patients, families, carers and the public are involved, able to have their say on the proposed options, and are listened to
- Inform key staff and clinicians in each locality about proposed change options
- Ensure patients, family and carers have the information they need about any changes to hyper acute stroke services
- Inform all stakeholders of new proposed models of care and opportunities to be involved

Target audiences

The following audiences will be targeted through tailored communications activity. We will use a very of methods to connect with each of our key stakeholders, ensuring our messages remain consistent and appropriate for each.

- Patients and the public (including stroke support groups, seldom heard groups and identified protected characteristics)
- Local Authorities, MPs and councillors
- Governing body members of all CCGs
- Executive board members of all providers
- Clinicians – acute, primary and community care
- Foundation trust and CCG members
- Clinical Senate
- Healthwatch
- Health and Wellbeing boards
- Local, regional and trade media
- Public health

Key messages

As with pre-consultation, our key messages will focus on the reasons why changes are needed to hyper acute stroke services whilst highlighting the importance of and opportunities to get involved in and taking part in the consultation. These messages include:

- We know that across our region some people have better experiences, better outcomes and better access to services than others. We want everyone to experience the highest quality and safest service possible.
• We are improving critical care stroke services for everyone across South Yorkshire, Bassetlaw and North Derbyshire – and we need your help!

Why do we need to change services? At the moment:

- We need more stroke doctors and nurses to run our services – but there aren’t enough locally or nationally
- Not all stroke patients are seen by a stroke doctor or admitted onto a stroke unit as quickly as they should be
- There is also a shortage of speech and language and occupational therapists who help rehabilitate people who have had a stroke
- How fast tests are done, which helps to diagnose patients, varies from hospital to hospital

For the above reasons, it is getting harder to provide high quality services and doctors, nurses and healthcare staff all agree that this needs to change.

Note: Key messages will be tailored and confirmed once the business case for change is agreed and there are agreed options for consultation.

Communications and engagement methods

To deliver the aims of our communications and engagement plan, we will carry out a range of activity across all geographic areas covered by the Working Together partnership, including both providers and commissioners. The methods and messages used to communicate will be tailored for each audience to maximise every opportunity for public and stakeholder involvement.

A key mechanism for consultation communications and engagement activity will be through the use of social media. We know from the Commissioners Working Together pre-consultations and also by identifying key trends and best practice from similar health and care transformation projects in other regions, that social media is an effective way of communicating and engaging with a variety of audiences.

Social media is a useful way of:

• Disseminating information and signposting
• Raising awareness
• Collecting demographic data
• Demonstrating willingness to engage in dialogue with a target audience
• Speaking to a large number and variety of audiences in real-time.

By developing and creating a number of communications materials and assets, through social media we will listen and respond to and motivate our audience to both share the information we are communicating and also engage with us by taking part in the consultations.

Further details of specific qualitative, quantitative and participatory communications and engagement methods for individual audiences are included in the planners below.

**Engagement planner**

<table>
<thead>
<tr>
<th>Type of engagement</th>
<th>Audience</th>
<th>Method examples</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualitative</strong></td>
<td>Patients and the public, parent and carer forums, MPs, Local Authorities</td>
<td>• Focus groups</td>
<td>CCG and provider partners supported by the Commissioners Working Together team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Attendance at relevant groups/events</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stakeholder briefings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vox pops</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seldom heard groups and protected characteristics</td>
<td>• Attendance at existing groups eg, Mosques, homeless charities, LGBT forums,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>social network groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Disseminate information through existing networks for 1:1 and group conversations (eg, via public health colleagues to reach rural communities, BME groups, gypsy and traveller communities, asylum seekers,</td>
<td></td>
</tr>
<tr>
<td><strong>Quantitative</strong></td>
<td><strong>Participatory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patients and the public, healthcare staff</strong></td>
<td><strong>Patients and the public, parent and carer forums, seldom heard groups, healthcare staff and clinicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seldom heard groups and protected characteristics</td>
<td>Seldom heard groups and protected characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online survey</td>
<td>Deliberative events (x8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flyers in various locations: GP practices, outpatient departments, libraries, supermarkets, stroke support groups, post offices, social network groups</td>
<td>Listening events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flyers translated into most popular languages (identified through census data in Appendix 2) and disseminated in various locations, eg social network groups, Women’s Institute, Mosques, LGBT groups/events, activity centres (eg for people with learning disabilities).</td>
<td>Focus groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attendance at existing groups and events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioners Working Together team</td>
<td>Commissioners Working Together team supported by CCG and provider partners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Focus groups

**Social media**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Method examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Twitter and Facebook – blanket and targeted posts to various groups, including health and care organisations, patient groups, Healthwatch organisations, local authorities, press accounts, LGBT networks, youth groups, high profile local/regional businesses, activity centres, the Stroke Association, Patient Opinion etc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication planner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication Type</strong></td>
</tr>
</tbody>
</table>
| Promotion/ Participation | Patients and the public including targeted to parents and carers and staff | - Newsletters  
- Social media  
- Media  
- Blogs/case studies  
- Event presence  
- ‘Market stalls’ | Commissioners Working Together team supported by CCG and provider partners |
<table>
<thead>
<tr>
<th>Seldom heard groups and protected characteristics</th>
<th>Attendance at partners AGMs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submissions to targeted publications and newsletters, eg, parent’s assembly, BME community newspapers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Updates and briefings</strong></th>
<th><strong>Media</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff from all partners, members of all organisations, GPs, practice staff, Local Authorities, MPs, councillors, board and governing body members, OSC</td>
<td>Patients, the public and staff including trade publications</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Commissioners Working Together team supported by CCG and provider partners as appropriate
<table>
<thead>
<tr>
<th>Social media</th>
<th>All</th>
<th>community newspapers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Twitter and Facebook – blanket and targeted posts to various groups, including health and care organisations, patient groups, Healthwatch organisations, local authorities, press accounts, LGBT networks, youth groups, high profile local/ regional businesses, activity centres, the Stroke Association, Patient Opinion etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commissioners Working Together team supported by CCG and provider partners</td>
</tr>
</tbody>
</table>
List of appendices:

Appendix 1 – Stakeholder map
Appendix 2 – Population demographics per area
Appendix 3 – Favoured methods of communication as outlined in pre-consultation feedback
### Commissioners Working Together Stakeholder map: Power/influence and interest level

<table>
<thead>
<tr>
<th>Little or no interest</th>
<th>Moderate interest</th>
<th>High interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Power/Influence</strong></td>
<td>- All media: (currently at low interest, high power but some titles will shift right as the programme progresses and will require watching brief): BBC online, BBC Look North, BBC East Midlands, ITV Calendar, ITV Central East BBC Radio Leeds, BBC Radio Sheffield, BBC Radio Derby, Dearne FM, Hallam FM, Trax FM, Sine FM, Rother FM, Capital FM, Derbyshire Times, Worksop Guardian, Gainsborough Standard, The Star, Sheffield Telegraph, Barnsley Chronicle, Doncaster Star, Doncaster Free Press, Wakefield Express, Pontefract and Castleford Express, Yorkshire Evening Post, Rotherham Advertiser</td>
<td>- Regulators (Monitor, CQC). Monitor is currently working with Rotherham Hospital trust on an action plan and may also be involved in discussions with other hospitals. All of the hospitals will be subject to CQC inspections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clinical Senates: (East Midlands, Yorkshire and the Humber)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Health and Wellbeing Boards: Barnsley, Derbyshire, Doncaster, Nottinghamshire, Rotherham, Sheffield, Wakefield</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moderate

Power/Influence

• Local Authority commissioners
  • Voluntary organisations working with people who may be affected by changes (will move up the grid if they become organised)
  • Patient groups related to any potential service changes (will move up the grid if become organised)
  • Working Together Provider Partnership
  • All foundation trust governors (via membership offices in trusts): Barnsley, Sheffield Teaching, Sheffield Children’s, Rotherham, Doncaster and Bassetlaw, Chesterfield.

Little or no power/influence

• Staff at NHS Greater East Midlands Commissioning Support unit
  • Staff in CCGs
  • Voluntary groups, and community groups (could move up and right)
  • Ambulance service trust boards (via chairs and chief executives): Barnsley, Sheffield Teaching, Sheffield Children’s, Rotherham, Doncaster and Bassetlaw.
  • Unions representing staff where changes could be made (will move up the grid if become organised)
    • Regional reps for Unite, Royal Colleges, MIP, Union, GMB.
  • Voluntary organisations working with people who may be affected by changes
  • All foundation trust governors (via membership offices in trusts): Barnsley, Sheffield Teaching, Sheffield Children’s, Rotherham, Doncaster and Bassetlaw, Chesterfield.
General stakeholder list for reference:

**NHS Organisations/ Partnerships**
- NHS England – Area Teams
- NHS Rotherham CCG
- NHS Doncaster CCG
- NHS Sheffield CCG
- NHS Barnsley CCG
- NHS Bassetlaw CCG
- NHS North Derbyshire CCG
- NHS Hardwick CCG
- NHS Wakefield CCG
- Yorkshire and Humber Clinical Senate
- East Midlands Clinical Senate
- The Working Together Provider Partnership
- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- The Mid Yorkshire Hospitals NHS Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children’s NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service
- East Midlands Ambulance Service
- Public Health England
- NHS Yorkshire & Humber Commissioning Support Unit
- NHS Greater East Midlands Commissioning Support Unit
- Acute Clinical Care Operational Delivery Network

**Wider Public Sector Organisations/ Partnerships**
- Healthwatch
- Health and Wellbeing Boards
- MPs
- Local Overview and Scrutiny Committees
- Council members and staff

**Public/ Patients and Groups**
- Public
- Patients
- National & local patient/ pressure groups
- Voluntary groups
- Community groups
- BME groups

**Staff and Members**
- Staff at all of the provider and commissioner organisations
- GP Members of the CCGs
- Senior teams and Boards/ Governing Bodies at each of the commissioner organisations
- Unions
Demographic data per area

**Barnsley**

231,221 total population
49.1% male
50.9% female
White: 96.03%
White Irish: 0.24%
White gypsy or Irish traveller: 0.07%
White other: 1.46%
Mixed /multiple ethnic groups – white and black Caribbean – 0.27%
Mixed /multiple ethnic groups – white and black African – 0.07%
Mixed /multiple ethnic groups – white and Asian – 0.18%
Mixed /multiple ethnic groups – other mixed – 0.16%
Asian/Asian British – Indian – 0.19%
Asian/Asian British – Pakistani – 0.09%
Asian/Asian British – Bangladeshi – 0.02%
Asian/Asian British – Chinese – 0.19%
Asian/Asian British – other Asian – 0.21%
Black/African/Caribbean/Black British: African – 0.43%
Black/African/Caribbean/Black British – Caribbean – 0.06%
Black/African/Caribbean/Black British – Other black –0.03%
Other ethnic group – Arab – 0.07%
Other ethnic group – any other ethnic group – 0.11%

**Bassetlaw:**

112,863 total population
56,024 male
56,839 female
White: 94.5%
White Irish: 0.33%
White gypsy or Irish traveller: 0.08%
White other: 2.44%
Mixed /multiple ethnic groups – white and black Caribbean – 0.4%
Mixed /multiple ethnic groups – white and black African – 0.07%
Mixed /multiple ethnic groups – white and Asian – 0.2%
Mixed /multiple ethnic groups – other mixed – 0.2%
Asian/Asian British – Indian – 0.38%
Asian/Asian British – Pakistani – 0.25%
Asian/Asian British – Bangladeshi – 0.06%
Asian/Asian British – Chinese – 0.16%
Asian/Asian British – other Asian – 0.24%
Black/African/Caribbean/Black British: African – 0.19%
Black/African/Caribbean/Black British – Caribbean – 0.21%
Black/African/Caribbean/Black British – Other black – 0.05%
Other ethnic group – Arab – 0.04%
Other ethnic group – any other ethnic group – 0.13%

**Doncaster:**

302,402 population
149,230 male
153,172 female
White: 91.8%
White Irish: 0.39%
White gypsy or Irish traveller: 0.19%
White other: 2.82%
Mixed /multiple ethnic groups – white and black Caribbean – 0.46%
Mixed /multiple ethnic groups – white and black African – 0.15%
Mixed /multiple ethnic groups – white and Asian – 0.29%
Mixed /multiple ethnic groups – other mixed – 0.2%
Asian/Asian British – Indian – 0.6%
Asian/Asian British – Pakistani – 0.9%
Asian/Asian British- Bangladeshi – 0.04%
Asian/Asian British – Chinese – 0.37%
Asian/Asian British – other Asian – 0.58%
Black/African/Caribbean/Black British: African – 0.43%
Black/African/Caribbean/Black British – Caribbean – 0.25%
Black/African/Caribbean/Black British – Other black – 0.08%
Other ethnic group – Arab – 0.07%
Other ethnic group – any other ethnic group – 0.27%

**NE Derbyshire:**

99,023 total population
48,564 male
50,459 female
White: 96.9%
White Irish: 0.26%
White gypsy or Irish traveller: 0.07%
White other: 0.79%
Mixed /multiple ethnic groups – white and black Caribbean – 0.32%
Mixed /multiple ethnic groups – white and black African – 0.1%
Mixed /multiple ethnic groups – white and Asian – 0.25%
Mixed /multiple ethnic groups – other mixed – 0.11%
Asian/Asian British – Indian – 0.35%
Asian/Asian British – Pakistani – 0.08%
Asian/Asian British- Bangladeshi – 0.03%
Asian/Asian British – Chinese – 0.18%
Asian/Asian British – other Asian – 0.15%
Black/African/Caribbean/Black British: African – 0.15%
Black/African/Caribbean/Black British – Caribbean – 0.06%
Black/African/Caribbean/Black British – Other black – 0.02
Other ethnic group – Arab – 0.04%
Other ethnic group – any other ethnic group – 0.08%

Chesterfield

103,788 total population
50,900 male
52,888 female
White: 94.8%
White Irish: 0.37%
White gypsy or Irish traveller: 0.004%
White other: 1.2%
Mixed /multiple ethnic groups – white and black Caribbean – 0.5%
Mixed /multiple ethnic groups – white and black African – 0.09%
Mixed /multiple ethnic groups – white and Asian – 0.27%
Mixed /multiple ethnic groups – other mixed – 0.17%
Asian/Asian British – Indian – 0.47%
Asian/Asian British – Pakistani – 0.32%
Asian/Asian British – Bangladeshi – 0.13%
Asian/Asian British – Chinese – 0.35%
Asian/Asian British – other Asian – 0.25
Black/African/Caribbean/Black British: African – 0.41%
Black/African/Caribbean/Black British – Caribbean – 0.26%
Black/African/Caribbean/Black British – Other black – 0.07%
Other ethnic group – Arab – 0.06%
Other ethnic group – any other ethnic group – 0.08%
**Rotherham**

257,280 total population

126,247 male

131,033

White: 91.9%

White Irish: 0.3%

White gypsy or Irish traveller: 0.05%

White other: 1.3%

Mixed /multiple ethnic groups – white and black Caribbean – 0.3%

Mixed /multiple ethnic groups – white and black African – 0.11%

Mixed /multiple ethnic groups – white and Asian – 0.33%

Mixed /multiple ethnic groups – other mixed – 0.23%

Asian/Asian British – Indian – 0.37%

Asian/Asian British – Pakistani – 2.96%

Asian/Asian British - Bangladeshi – 0.04%

Asian/Asian British – Chinese – 0.23%

Asian/Asian British – other Asian – 0.5%

Black/African/Caribbean/Black British: African – 0.65%

Black/African/Caribbean/Black British – Caribbean – 0.11%

Black/African/Caribbean/Black British – Other black – 0.06%

Other ethnic group – Arab – 0.22%

Other ethnic group – any other ethnic group – 0.28%

**Sheffield**

552,698 population

272,661 male

280,037 female

White: 80.84%

White Irish: 0.5%
White gypsy or Irish traveller: 0.06%
White other: 2.25%
Mixed /multiple ethnic groups – white and black Caribbean – 0.98%
Mixed /multiple ethnic groups – white and black African – 0.23%
Mixed /multiple ethnic groups – white and Asian – 0.63%
Mixed /multiple ethnic groups – other mixed – 0.55%
Asian/Asian British – Indian – 1.06%
Asian/Asian British – Pakistani – 3.97%
Asian/Asian British- Bangladeshi – 0.6%
Asian/Asian British – Chinese – 1.33%
Asian/Asian British – other Asian – 1.04%
Black/African/Caribbean/Black British: African – 2.0%
Black/African/Caribbean/Black British – Caribbean – 0.99%
Black/African/Caribbean/Black British – Other black – 0.54%
Other ethnic group – Arab – 1.52%
Other ethnic group – any other ethnic group – 0.7%

Wakefield
325,832 total population
159,913 male
165,924 female
White: 92.76%
White Irish – 0.27%
White gypsy or Irish traveller: 0.09%
White other: 2.27%
Mixed /multiple ethnic groups – white and black Caribbean – 0.33%
Mixed /multiple ethnic groups – white and black African – 0.11%
Mixed /multiple ethnic groups – white and Asian – 0.27%
Mixed /multiple ethnic groups – other mixed – 0.17%
Asian/Asian British – Indian – 0.47%
Asian/Asian British – Pakistani – 1.5%
Asian/Asian British- Bangladeshi – 0.009%
Asian/Asian British – Chinese – 0.26%
Asian/Asian British – other Asian – 0.36%
Black/African/Caribbean/Black British: African – 0.6%
Black/African/Caribbean/Black British – Caribbean – 0.1%
Black/African/Caribbean/Black British – Other black – 0.07%
Other ethnic group – Arab – 0.11%
Other ethnic group – any other ethnic group – 0.17%
Appendix 3

During the pre-consultation phase we asked people, “How would you want to see/read/hear about the formal consultation?”

Summary of responses:

By email: 42.7% (82 out of 192 responses)

Online (social and digital media): 34.9% (67 out of 192 responses)

Local media (print and broadcast): 12.5% (24 out of 192 responses)

Face to face meetings and events: 9.9% (19 out of 192 responses)
Finance Report
| Executive / Clinical Lead(s) | Hayley Tingle  
Chief Finance Officer |
|-----------------------------|---------------------|
| Author(s)                   | Tracy Wyatt  
Deputy Chief Finance Officer |

**Purpose of Paper – Executive Summary**

This report sets out the financial position as at the end of March 2016. The CCG has achieved all of its financial targets for 2015/16. The report also outlines:

- A summary of the CCG Efficiency Savings for 2015/16 (Appendix 2)
- A summary of the CCG’s Resource Allocation (Appendix 3)
- A summary of the CCG’s Reserve position (Appendix 4)

**Recommendation(s)**

Members are asked to receive the report and note the financial position.
Impact analysis

<table>
<thead>
<tr>
<th>Assurance Framework</th>
<th>1.2, 1.4, 2.4, 3.1, 3.2, 6.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk analysis</td>
<td>The CCG identified a number of risks as part of the Financial planning for 2015/16. These included:</td>
</tr>
<tr>
<td></td>
<td>• Over performance against the main acute contracts including referral growth and growth in Non PbR Drugs spend</td>
</tr>
<tr>
<td></td>
<td>• Individual Placements</td>
</tr>
<tr>
<td></td>
<td>• Unforeseen prescribing costs</td>
</tr>
<tr>
<td></td>
<td>• Under delivery of parts of the Efficiency Savings programme</td>
</tr>
<tr>
<td></td>
<td>The CCG utilised the flexibility within the overall allocation to meet these challenges and still achieve the target surplus. The 0.5% contingency was also used to mitigate against the in-year financial risks together with the flexing of investment reserves.</td>
</tr>
<tr>
<td>Equality impact</td>
<td>None Identified</td>
</tr>
<tr>
<td>Sustainability impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Financial implications</td>
<td>Highlighted within the Report</td>
</tr>
<tr>
<td>Legal implications</td>
<td>None identified</td>
</tr>
<tr>
<td>Consultation / Engagement</td>
<td>N/A</td>
</tr>
</tbody>
</table>
1. Introduction

This report provides the financial position for NHS Doncaster CCG for 2015/16 as at the end of March (Month 12). Overall, the CCG achieved all of its financial targets for the financial year 2015/16.

2. Current Position

The year end position reflected a surplus of £9,722k which exceeded the annual target of £7,620k by £2,102k. The main variance is due to an additional surplus of £2,000k which was agreed in year with NHS England and £65k for Quarter 4 provider penalties which were retained in line with guidance. The additional surplus will be returned to the CCG but this may not be in 16.17. The outturn position is summarised in the Operating Cost Statement included at Appendix 1.

3. Key Messages and Risks

The largest financial risks identified as part of the Financial Planning process were Individual Placement Costs and the performance against acute contracts. Other risks identified included prescribing and efficiency under performance.

These risks were managed effectively in year by utilising the contingency fund of £2,222k which equated to 0.5% of the CCG’s allocation and by flexing funding ring fenced for investments.

The action plans around CHC have been successful in year and the CCG has seen a reduction in costs resulting in an under spend this year. However, the CCG has seen an increase in S117 placements which has caused a pressure in year.

The main acute contract with DBH over spent by £3.7m which was mainly caused by increased GP referrals, RTT activity and Non PbR drugs costs. Non- NHS acute provider contracts overspent by £1.2m as activity was seen in the private sector to aid RTT pressures.

Prescribing costs overspent by £2.7m due to increased volume and prices. This is a key area for efficiency plans for 2016/17.

4. Efficiency Savings Programme

All contract values negotiated with providers were net of efficiency saving targets where appropriate.
A summary of the overall QIPP schemes and achievement is shown in Appendix 2. £2.7m has been achieved out of the £4m target for the year. Information for some schemes has been very difficult to obtain and therefore it has not been possible to quantify achievement in some areas. The CCG will ensure that any identified schemes for next year are robust and measurable. The main area of under-performance is prescribing as it has not been possible to quantify any savings in this area and as a result this budget overspent by £2.7m. The under performance against the efficiency target has been mitigated by the contingency reserve and slippage on investment reserves.

5. **1% Non Recurrent Headroom**

The CCG set aside £4.4m (1% of the CCG’s recurrent allocation) and this has been fully utilised with the exception of £143k. Funding has been released in Month 12 for Bluebell Wood EOL Suites refurbishment, Nursing Support into Positive Steps and Urgent Care capital Support for DBH.

6. **Further Allocations**

Further allocation changes were made in Month 12 for the following items; a transfer of funding from NHSE for environmental controls equipment; £10k, a transfer back to NHSE for PMS premiums for practices that had not signed their new contracts; £55k and a reduction to the Vanguard Funding for Sheffield Teaching Hospitals; £100k.

7. **Capital Resource**

The CCG has not received any capital funding in 2015/16. The funding for Bluebell Wood will be classified as a capital grant rather than capital funding which is in line with NHSE Guidance.

8. **Other Key Financial Targets**

Below is a summary table outlining the other key financial targets for the CCG, all of the targets were achieved for the financial year.

<table>
<thead>
<tr>
<th>Key Duty</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPPC</td>
<td>95% + invoices paid within 30 days (NHS)</td>
<td>98.37%</td>
</tr>
<tr>
<td></td>
<td>95% + invoices paid within 30 days (non NHS)</td>
<td>99.11%</td>
</tr>
<tr>
<td></td>
<td>95% + invoices paid within 30 days (Total)</td>
<td>98.99%</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>Maximum 1.25% of monthly drawdown remaining at period end</td>
<td>0.28%</td>
</tr>
<tr>
<td>Running Costs</td>
<td>Maintain spend within annual target of £6,842k.</td>
<td>£6,464k</td>
</tr>
</tbody>
</table>

9. **Better Care Fund**
The final year end position is not yet available due to timing differences with Local Authority Accounts, however the CCG element has been utilised in full and it is anticipated that the Local Authority element will also have been fully utilised. The plans for 16/17 are being refined ready for the final submission in May. There are no issues of concern to be highlighted to the Governing Body.

10. Conclusion and Recommendations

Members are asked to:

Receive and note the Finance Report for March 2016 (Month 12).
## Operating Cost Statement

<table>
<thead>
<tr>
<th></th>
<th>Recurrent Budget £000s</th>
<th>Non Rec Budget £000s</th>
<th>Total Budget £000s</th>
<th>Recurrent Budget £000s</th>
<th>Non Rec Budget £000s</th>
<th>Total Budget £000s</th>
<th>Forecast Outturn £000s</th>
<th>Variance (Upper)/ (Under) £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Running Cost Allowance</strong></td>
<td>8,942</td>
<td>8,942</td>
<td>8,942</td>
<td>8,942</td>
<td>8,942</td>
<td>8,942</td>
<td>0</td>
<td>8,942</td>
</tr>
<tr>
<td><strong>In year changes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pa Vaccines Funding Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting list validation and improving operational processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial alloc for eating disorders and planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 Neurology Commissioning Responsibility Transfer - NHS England</td>
<td>-104</td>
<td>0</td>
<td>-104</td>
<td>0</td>
<td>104</td>
<td>-104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 Specialist Wheelchairs Commissioning Responsibility Transfer - NHS England</td>
<td>-1</td>
<td>0</td>
<td>-1</td>
<td>-1</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathside Assistive Technology Contract</td>
<td>-91</td>
<td>-91</td>
<td>-182</td>
<td>-91</td>
<td>-91</td>
<td>-182</td>
<td>0</td>
<td>-182</td>
</tr>
<tr>
<td>Environmental Controls Equipment</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>105</td>
<td>0</td>
<td>105</td>
</tr>
<tr>
<td>Liaison Psychiatry - Mental Health</td>
<td>-76</td>
<td>-76</td>
<td>-76</td>
<td>-76</td>
<td>-76</td>
<td>-76</td>
<td>0</td>
<td>-76</td>
</tr>
<tr>
<td>CAMHS Transformational Funding</td>
<td>-446</td>
<td>-446</td>
<td>-446</td>
<td>-446</td>
<td>-446</td>
<td>-446</td>
<td>0</td>
<td>-446</td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-16 Quality Premium &amp; Award</td>
<td>-342</td>
<td>-342</td>
<td>-342</td>
<td>-342</td>
<td>-342</td>
<td>-342</td>
<td>0</td>
<td>-342</td>
</tr>
<tr>
<td>Vanguards: ACC - Working Together Partnership</td>
<td>-1000</td>
<td>-1000</td>
<td>-1000</td>
<td>-1000</td>
<td>-1000</td>
<td>-1000</td>
<td>0</td>
<td>-1000</td>
</tr>
<tr>
<td><strong>Total Allocations</strong></td>
<td>-435,209</td>
<td>-9,112</td>
<td>-444,321</td>
<td>-434,774</td>
<td>-11,882</td>
<td>-446,656</td>
<td>0</td>
<td>-446,656</td>
</tr>
<tr>
<td><strong>Acute Contracts</strong></td>
<td>181,218</td>
<td>565</td>
<td>181,783</td>
<td>177,061</td>
<td>5,290</td>
<td>182,351</td>
<td>186,124</td>
<td>3,772</td>
</tr>
<tr>
<td>Acute Contracts - DBHFT</td>
<td>221,915</td>
<td>2,791</td>
<td>224,706</td>
<td>223,493</td>
<td>4,235</td>
<td>227,729</td>
<td>230,082</td>
<td>2,354</td>
</tr>
<tr>
<td>Acute Contracts - Other NHS</td>
<td>35,238</td>
<td>545</td>
<td>35,783</td>
<td>35,160</td>
<td>1,311</td>
<td>36,471</td>
<td>36,536</td>
<td>2,385</td>
</tr>
<tr>
<td>Acute Contracts - Other Providers Non NHS</td>
<td>35,238</td>
<td>545</td>
<td>35,783</td>
<td>35,160</td>
<td>1,311</td>
<td>36,471</td>
<td>36,536</td>
<td>2,385</td>
</tr>
<tr>
<td>Acute Contracts - Urgent Care</td>
<td>3,970</td>
<td>10</td>
<td>3,980</td>
<td>4,052</td>
<td>7,262</td>
<td>11,314</td>
<td>10,891</td>
<td>423</td>
</tr>
<tr>
<td>Acute - Non Contract Activity</td>
<td>32,632</td>
<td>10</td>
<td>32,642</td>
<td>32,718</td>
<td>7,448</td>
<td>40,167</td>
<td>39,754</td>
<td>-413</td>
</tr>
<tr>
<td><strong>Total Mental Health Services</strong></td>
<td>47,995</td>
<td>545</td>
<td>48,540</td>
<td>47,976</td>
<td>1,421</td>
<td>49,397</td>
<td>51,782</td>
<td>2,385</td>
</tr>
<tr>
<td>Community Contracts - RDaSH FT</td>
<td>28,301</td>
<td>0</td>
<td>28,301</td>
<td>28,301</td>
<td>0</td>
<td>28,301</td>
<td>28,479</td>
<td>-170</td>
</tr>
<tr>
<td>Community Contracts - Other NHS</td>
<td>361</td>
<td>0</td>
<td>361</td>
<td>361</td>
<td>0</td>
<td>361</td>
<td>379</td>
<td>19</td>
</tr>
<tr>
<td>Community Contracts - Other Providers</td>
<td>3,970</td>
<td>10</td>
<td>3,980</td>
<td>4,052</td>
<td>7,262</td>
<td>11,314</td>
<td>10,891</td>
<td>423</td>
</tr>
<tr>
<td><strong>Total Community Services</strong></td>
<td>32,632</td>
<td>10</td>
<td>32,642</td>
<td>32,718</td>
<td>7,448</td>
<td>40,167</td>
<td>39,754</td>
<td>-413</td>
</tr>
<tr>
<td>Prescribing</td>
<td>60,389</td>
<td>0</td>
<td>60,389</td>
<td>60,004</td>
<td>0</td>
<td>60,004</td>
<td>62,802</td>
<td>2,595</td>
</tr>
<tr>
<td>Oxygen Services</td>
<td>578</td>
<td>0</td>
<td>578</td>
<td>578</td>
<td>0</td>
<td>578</td>
<td>549</td>
<td>-29</td>
</tr>
<tr>
<td><strong>Other Primary Care Services</strong></td>
<td>2,527</td>
<td>1,559</td>
<td>4,086</td>
<td>2,099</td>
<td>1,768</td>
<td>3,867</td>
<td>3,775</td>
<td>-92</td>
</tr>
<tr>
<td><strong>Primary Care Services</strong></td>
<td>33,826</td>
<td>33,826</td>
<td>67,652</td>
<td>34,959</td>
<td>2,791</td>
<td>37,750</td>
<td>35,681</td>
<td>1,070</td>
</tr>
<tr>
<td><strong>Non Recurrent Programmes</strong></td>
<td>12,046</td>
<td>0</td>
<td>12,046</td>
<td>11,148</td>
<td>-7,547</td>
<td>3,601</td>
<td>0</td>
<td>-3,601</td>
</tr>
<tr>
<td><strong>Total Corporate Costs</strong></td>
<td>42,872</td>
<td>0</td>
<td>42,872</td>
<td>42,624</td>
<td>0</td>
<td>42,624</td>
<td>43,934</td>
<td>3,310</td>
</tr>
<tr>
<td><strong>System Resilience</strong></td>
<td>12,046</td>
<td>0</td>
<td>12,046</td>
<td>11,148</td>
<td>-7,547</td>
<td>3,601</td>
<td>0</td>
<td>-3,601</td>
</tr>
<tr>
<td><strong>Contingency Reserve</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>** Investments**</td>
<td>12,046</td>
<td>0</td>
<td>12,046</td>
<td>11,148</td>
<td>-7,547</td>
<td>3,601</td>
<td>0</td>
<td>-3,601</td>
</tr>
<tr>
<td><strong>Total Application of Funds</strong></td>
<td>425,334</td>
<td>11,366</td>
<td>436,701</td>
<td>424,900</td>
<td>14,136</td>
<td>439,036</td>
<td>436,934</td>
<td>-2,102</td>
</tr>
</tbody>
</table>

### Notes

- The operating cost statement covers the fiscal year 2015/16.
- All figures are in £000s (thousands of pounds).
### Savings / Efficiency Programme 2015/16

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Project</th>
<th>Transformational / Transactional</th>
<th>Lead</th>
<th>Clinical Lead</th>
<th>2015/16 Target</th>
<th>Achieved to Month 12</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Urology Pathway</td>
<td>Transactional</td>
<td>Richard Metcalfe</td>
<td>Dr. Marco Pieri</td>
<td>20</td>
<td>20</td>
<td>Medium</td>
</tr>
<tr>
<td>Total Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned Care</td>
<td>Reduction in Emergency admissions - Care of the frailty, ECP, care home admissions</td>
<td>Transformational</td>
<td>TBD</td>
<td>TBD</td>
<td>950</td>
<td>0</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Urology Admissions (Acute Retention)</td>
<td>Transformational</td>
<td>TBD</td>
<td>TBD</td>
<td>0</td>
<td>174</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Earlier treatment - shift in staging (cancer patients)</td>
<td>Transformational</td>
<td>Richard Metcalfe</td>
<td>Dr. Marco Pieri</td>
<td>150</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shift from death in acute to community care</td>
<td>Transformational</td>
<td>Richard Metcalfe</td>
<td>Dr. Lindsey Britten</td>
<td>75</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>All Prescribing schemes including :</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td>1,310</td>
<td>0</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Waste reduction</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repeat Prescribing</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td></td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Cost Saving alternative drug switches</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td></td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Dose Optimisation</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specials review</td>
<td>Transactional</td>
<td>Mark Randerson</td>
<td>Dr. Jeremy Bradley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerable People</td>
<td>Implementation of CHC commissioning criteria &amp; Fast Tracks</td>
<td>Transformational</td>
<td>Claire Hudson</td>
<td>Dr. Lindsey Britten</td>
<td>1,720</td>
<td>2,068</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Total Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Schemes</td>
<td>Property Utilisation</td>
<td>Transactional</td>
<td>Hayley Tingle</td>
<td></td>
<td>260</td>
<td>260</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Woundcare products services</td>
<td>Transactional</td>
<td>Hayley Tingle</td>
<td></td>
<td>285</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Total Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015/16 TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,800</td>
<td>2,652</td>
<td></td>
</tr>
</tbody>
</table>

Note: Risk assessed on the basis of management experience

Unplanned care (Reduction in emergency admissions)
Some of the data is incomplete and due to changes in recording of Paediatric activity it has not been possible to determine the true position in relation to changes in emergency admissions, some further work is required to rebase the activity for Paediatrics.

Admissions and readmissions from care homes have increased and therefore no savings have materialised YTD

Earlier Treatment - Staging for cancer patients - additional information is required to quantify this however an estimate has been made

Shift from Death in Acute to Community Care - additional information is required to quantify this however an estimate has been made.

Prescribing
At present it has not been possible to identify any savings from Prescribing budgets and this budget is forecast to overspend.
## Summary of Resource Allocations as at Month 12 March 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Recurrent £000's</th>
<th>Non Recurrent £000's</th>
<th>Total £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Baseline</td>
<td>-419,200</td>
<td>-419,200</td>
<td></td>
</tr>
<tr>
<td>System Resilience Funding</td>
<td>-2,247</td>
<td></td>
<td>-2,247</td>
</tr>
<tr>
<td>BCF Allocation</td>
<td>-6,920</td>
<td></td>
<td>-6,920</td>
</tr>
<tr>
<td>Non Recurrent Surplus from prior years</td>
<td>0</td>
<td>-7,625</td>
<td>-7,625</td>
</tr>
<tr>
<td>Running Cost Allowance</td>
<td>-6,842</td>
<td></td>
<td>-6,842</td>
</tr>
<tr>
<td>Funding for Tariff options ETO/DTR</td>
<td></td>
<td></td>
<td>-1,487</td>
</tr>
<tr>
<td><strong>Total Resources Available at Plan Stage</strong></td>
<td><strong>-435,209</strong></td>
<td><strong>-9,112</strong></td>
<td><strong>-444,321</strong></td>
</tr>
</tbody>
</table>

### Adjustments to the Resource Limit:

**Month 01 April**
- No adjustments
- Total: 0 0 0

**Month 02 May**
- No adjustments
- Total: 0 0 0

**Month 03 June**
- GPIT Allocation: -800
- Stroke Allocation from NHSE re Nottingham University Contract: -2
- Total: -2 -800 -802

**Month 04 July**
- Waiting list validation and improving operational processes: -11
- Flu Vaccines Funding Transfer to NHS England: 385
- Total: 385 -11 374

**Month 05 August**
- Initial allocation for eating disorders and planning: -178
- Total: 0 -178 -178

**Month 06 September**
- No adjustments
- Total: 0 0 0

**Month 07 October**
- Tier 3 Neurology Commissioning Responsibility Transfer - NHS England: -104
- Tier 3 Specialist Wheelchairs Commissioning Responsibility Transfer - NHS: -1
- PMS Premium Oct-Mar: -91
- Barnsley Assistive Technology Contract: 62
- Environmental Controls Equipment: 105
- Liaison Psychiatry - Mental Health: -76
- Total: 62 -167 -105

**Month 08 November**
- Pass through - Vanguard Funding for Sheffield Teaching Hospitals: 0
- CAMHs Transformational Funding: -446
- Total: 0 -746 -746

**Month 09 December**
- Liaison Psychiatry - Mental Health: -76
- 14-15 Quality Premium award: -348
- Total: 0 -424 -424

**Month 10 January**
- Pass through - Vanguard Funding for Sheffield Teaching Hospitals: -1,000
- Charge Exempt Overseas Visitors Allocation Adjustment: 413
- Total: 0 -587 -587

**Month 11 February**
- Capital Allocation for Bluebell Wood Hospice EOL Suites: 0
- Total: 0 -12 -12

**Month 12 March**
- Environmental controls: -10
- PMS Premium: 55
- Vanguards ACC: Working together partnership, Year end adj.: 100
- Total: -10 155 145

**Revised Resources available as at Month 12 March 2016**
-434,774 -11,882 -446,656
### RESERVES

<table>
<thead>
<tr>
<th></th>
<th>Recurrent</th>
<th>Non Recurrent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
</tr>
<tr>
<td><strong>INVESTMENT RESERVES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Plan</td>
<td>12,046</td>
<td>0</td>
<td>12,046</td>
</tr>
<tr>
<td><strong>Budget Transfers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better Care Fund DMBC transfer</td>
<td>-6,920</td>
<td>-6,920</td>
<td>-6,920</td>
</tr>
<tr>
<td>Additional Complex Assessment Beds</td>
<td>-95</td>
<td>-95</td>
<td>-163</td>
</tr>
<tr>
<td>PTS services to Weston Park</td>
<td>-100</td>
<td>-100</td>
<td>-100</td>
</tr>
<tr>
<td>Unplanned Care Set up costs</td>
<td>-600</td>
<td>-600</td>
<td>-600</td>
</tr>
<tr>
<td>DRFC Awareness Campaigns</td>
<td></td>
<td>-90</td>
<td>-90</td>
</tr>
<tr>
<td>Unplanned Care Development</td>
<td>-687</td>
<td>267</td>
<td>-420</td>
</tr>
<tr>
<td>Sleep Charity</td>
<td>-4</td>
<td>-4</td>
<td>-4</td>
</tr>
<tr>
<td>Gynaecology Prescribing Admin support DBH</td>
<td>-12</td>
<td>6</td>
<td>-6</td>
</tr>
<tr>
<td>RDASH CV Woodfield House</td>
<td></td>
<td>-22</td>
<td>-22</td>
</tr>
<tr>
<td>Section 256 - DMBC for Domiciliary Care</td>
<td>-120</td>
<td>-120</td>
<td>-120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11,148</td>
<td>-7,547</td>
<td>3,601</td>
</tr>
</tbody>
</table>

| **RISK RESERVES AND CONTINGENCIES** |           |               |         |
| 1% Non Recurrent Headroom |           |               |         |
| Initial Plan             | 0         | 4,214         | 4,214   |
| **Budget Transfers**     |           |               |         |
| CHC Risk Pool            | -2,791    | -2,791        | -2,791  |
| Cruse Bereavement Contract | -7        | -7            | -7      |
| Working Together Programme 15.16 (including transport reviews) | -101      | -101          | -101    |
| End of Life Facilitator (RDASH) | -18       | -18          | -18     |
| Gp Support into Positive Steps (RDASH) | -50       | -50          | -50     |
| Treatment Room (RDASH)   | -74       | -74          | -74     |
| Street Triage (RDASH)    | -50       | -50          | -50     |
| Primary Care Liaison (RDASH) | -29       | -29          | -29     |
| Non Recurrent Cancer programme | -72       | -72          | -72     |
| Unplanned Care           | -49       | -49          | -49     |
| S117 and LD Review (RDASH) | -71       | -71          | -71     |
| CAMHS                   | -61       | -61          | -61     |
| End of Life Development  | -16       | -16          | -16     |
| Crisis Hub (Oct - Dec)   | -52       | -52          | -52     |
| Perinatal Service Specification (DBH) | -38       | -38          | -38     |
| Acute Oncology Pilot (DBH) | -18       | -18          | -18     |
| Rheumatology Audit (DBH) | -4        | -4           | -4      |
| EOL Stocktake            | -50       | -50          | -50     |
| Crisis Hub (Jan - Mar)   | -57       | -57          | -57     |
| Wheelchair stock (RDASH) | -65       | -65          | -65     |
| EOL Gold Standard Framework (DBH) | -66       | -66          | -66     |
| Devonshire House Refurb Costs | -50       | -50          | -50     |
| Bluebell Wood Hospice Capital Grant for Refurbishment of EOL Suites | -12       | -12          | -12     |
| Nursing Support into Positive Steps (RDASH) | -9        | -9           | -9      |
| Dietetic Support RDASH   | -60       | -60          | -60     |
| Urgent Care Capital Support (DBH) | -250      | -250         | -250    |
| Final reconciliation of RDASH Contract | 47        | 47           | 47      |
| **Total**                | 0         | 143           | 143     |

| 0.5% Contingency         |           |               |         |
| Initial Plan             | 2,222     | 0             | 2,222   |
| **Budget Transfers**     |           |               |         |
| No transfers as at Month 12 |         |               |         |

| **Total**                | 2,222     | 0             | 2,222   |

| **Cross Check to Operating Cost Statement** |         |               |         |
| 13,370                    | -7,404   | 5,966         |         |

**Note**

1. The £5,966k underspend shown in the Operating Cost Statement has been used to offset the overspends on Acute Contracts, Section 117 Packages of Care and Prescribing.
Corporate Assurance Report – Quarter 4
# Purpose of Paper - Executive Summary

The key points from this report to which the organisation’s attention is particularly drawn are:

- **Risk**: Two Assurance Framework risks were removed at year end; risk 1.5 regarding continuing healthcare quality was de-escalated to the Risk Register, and risk 2.5 regarding the transition of Commissioning Support Services to the CCG was mitigated and closed. A number of new Risk Register risks have been identified, reflecting risk discussions at Governing Body and the fast-moving nature of the register.

- **Incident reporting**: There have been six incidents reported in the last Quarter, and four out of six of the incidents were information governance issues relating to in-housed or hosted clinical Continuing Healthcare services. All incidents were reported in a timely manner, and learning from the incidents was rapidly identified through root cause analysis and remedial action was taken. Due to the significant volume of clinical data held within the in-housed or hosted clinical Continuing Healthcare services from December 2016, we do have an increased data protection risk. This is being addressed through training and support to the team, and by standardising team operating protocols.

- **External Assessments**: The draft Head of Internal Audit Opinion for 2015/16 has been received and no risks were identified from the draft report. A balanced Internal Audit workplan for 2016/17 has been agreed. From 2017/18 onwards, all CCGs will appoint their own External Auditors and directly manage the resulting contract and the relationship. The Audit Committee will develop a sub-group as required to act as an Auditor Panel.

- **Governance Structure**: A review of our governance meeting structures has resulted in a refresh of terms of reference which are due to be consulted upon with our Membership.

- **Emergency resilience**: The Local Health Resilience Partnership (LHRP) has focussed in the last Quarter on the NHS response to terrorism in response to learning from recent international incidents of terrorism, and on assurance against NHS England’s Emergency Preparedness, Resilience & Response (EPRR) standards. An operational sub-group supporting the LHRP has been opened up to CCGs and to Public Health, and we are represented on the group.
by the Head of Health, Safety & Security. The next quarter’s activity will focus on preparedness for Junior Doctor industrial action. We have also responded to collated NHS learning from the Boxing Day floods.

- **Information Governance**: The Section 251 exemptions under which we operate have been extended to 31 March 2017, and we have renewed our Accredited Safe Haven status. Our Information Governance Toolkit was submitted by the deadline of 31 March 2016 following an internal audit of the toolkit, and resulted in a satisfactory score of 76%.

- **Counter Fraud**: A 30-day Counter Fraud Work Plan for 2016/17 focussing on bribery, anti-fraud and corruption arrangements has been approved by the Audit Committee in the last Quarter. The plan was fed by cumulative Counter Fraud Specialist knowledge, CCG incidents, and a counter fraud risk assessment.

- **Organisational Development**: A full review of the uptake of Personal Development Reviews (PDRs) has been undertaken and in order to improve how the CCG plans its training and development of staff, the timings of PDRs are being aligned across the whole organisation with full annual reviews being undertaken in April/May/June. Mid-year reviews will still take place to ensure all staff are on schedule for achieving their objectives and have the relevant support in place to do so. We have seen a drop in compliance rate for mandatory & statutory training, and so for 2016/17 face to face training will be available to support compliance.

**Recommendation(s)**

It is recommended that the meeting considers and notes the information provided.

<table>
<thead>
<tr>
<th>Impact analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assurance Framework</strong></td>
<td>4.1, 5.1, 5.2, 5.3, 5.4, 5.5, 6.1</td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>Risks are highlighted throughout the report.</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>Neutral</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Sustainability impacts are listed in the report</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
CORPORATE ASSURANCE REPORT

Quarter 4
2015/16
(1st January – 31st March 2016)
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Sub-Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Summary</strong></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Section 1</strong></td>
<td>Risk Management</td>
<td>4</td>
</tr>
<tr>
<td>1.1.</td>
<td>Assurance Framework</td>
<td>4</td>
</tr>
<tr>
<td>1.2.</td>
<td>Risk Register</td>
<td>5</td>
</tr>
<tr>
<td>1.3.</td>
<td>Internal Incident Reporting</td>
<td>7</td>
</tr>
<tr>
<td>1.4.</td>
<td>Claims &amp; Legal Issues</td>
<td>8</td>
</tr>
<tr>
<td><strong>Section 2</strong></td>
<td>External Assessments</td>
<td>9</td>
</tr>
<tr>
<td><strong>Section 3</strong></td>
<td>Committee Activity</td>
<td>10</td>
</tr>
<tr>
<td>3.1.</td>
<td>Audit Committee</td>
<td>10</td>
</tr>
<tr>
<td>3.2.</td>
<td>Remuneration Committee</td>
<td>10</td>
</tr>
<tr>
<td>3.3.</td>
<td>Quality &amp; Safety Committee</td>
<td>10</td>
</tr>
<tr>
<td>3.4.</td>
<td>Engagement &amp; Experience Committee</td>
<td>11</td>
</tr>
<tr>
<td>3.5.</td>
<td>Delivery &amp; Performance Committee</td>
<td>11</td>
</tr>
<tr>
<td><strong>Section 4</strong></td>
<td>Corporate Governance</td>
<td>12</td>
</tr>
<tr>
<td>4.1.</td>
<td>Constitution &amp; Establishment</td>
<td>12</td>
</tr>
<tr>
<td>4.2.</td>
<td>Governance Structure</td>
<td>12</td>
</tr>
<tr>
<td>4.3.</td>
<td>Procedural Document Management</td>
<td>14</td>
</tr>
<tr>
<td>4.4.</td>
<td>Health &amp; Safety, Fire Safety &amp; Security</td>
<td>14</td>
</tr>
<tr>
<td>4.5.</td>
<td>Emergency Resilience &amp; Business Continuity</td>
<td>15</td>
</tr>
<tr>
<td>4.6.</td>
<td>Sustainability</td>
<td>15</td>
</tr>
<tr>
<td>4.7.</td>
<td>Complaints Management</td>
<td>17</td>
</tr>
<tr>
<td>4.8.</td>
<td>Whistleblowing</td>
<td>18</td>
</tr>
<tr>
<td><strong>Section 5</strong></td>
<td>Information Governance</td>
<td>19</td>
</tr>
<tr>
<td>5.1.</td>
<td>The protection and use of personal confidential data</td>
<td>19</td>
</tr>
<tr>
<td>5.2.</td>
<td>Information Governance Toolkit</td>
<td>19</td>
</tr>
<tr>
<td>5.3.</td>
<td>Freedom of Information Act Requests</td>
<td>20</td>
</tr>
<tr>
<td>5.4.</td>
<td>Data Protection Subject Access Requests</td>
<td>20</td>
</tr>
<tr>
<td>5.5.</td>
<td>Information Management &amp; Technology</td>
<td>20</td>
</tr>
<tr>
<td><strong>Section 6</strong></td>
<td>Financial Governance</td>
<td>22</td>
</tr>
<tr>
<td>6.1.</td>
<td>Financial procedures &amp; systems</td>
<td>22</td>
</tr>
<tr>
<td>6.2.</td>
<td>Financial governance reporting arrangements</td>
<td>22</td>
</tr>
<tr>
<td><strong>Section 7</strong></td>
<td>Organisational Development &amp; Staffing Governance</td>
<td>22</td>
</tr>
<tr>
<td>7.1.</td>
<td>Organisational Development</td>
<td>23</td>
</tr>
<tr>
<td>7.2.</td>
<td>Staffing Governance</td>
<td>25</td>
</tr>
</tbody>
</table>
Executive Summary

The key points from this report to which the organisation’s attention is particularly drawn are:

- **Risk:** Two Assurance Framework risks were removed at year end; risk 1.5 regarding continuing healthcare quality was de-escalated to the Risk Register, and risk 2.5 regarding the transition of Commissioning Support Services to the CCG was mitigated and closed. A number of new Risk Register risks have been identified, reflecting risk discussions at Governing Body and the fast-moving nature of the register.

- **Incident reporting:** There have been six incidents reported in the last Quarter, and four out of six of the incidents were information governance issues relating to in-housed or hosted clinical Continuing Healthcare services. All incidents were reported in a timely manner, and learning from the incidents was rapidly identified through root cause analysis and remedial action was taken. Due to the significant volume of clinical data held within the in-housed or hosted clinical Continuing Healthcare services from December 2016, we do have an increased data protection risk. This is being addressed through training and support to the team, and by standardising team operating protocols.

- **External Assessments:** The draft Head of Internal Audit Opinion for 2015/16 has been received and no risks were identified from the draft report. A balanced Internal Audit workplan for 2016/17 has been agreed. From 2017/18 onwards, all CCGs will appoint their own External Auditors and directly manage the resulting contract and the relationship. The Audit Committee will develop a sub-group as required to act as an Auditor Panel.

- **Governance Structure:** A review of our governance meeting structures has resulted in a refresh of terms of reference which are due to be consulted upon with our Membership.

- **Emergency resilience:** The Local Health Resilience Partnership (LHRP) has focussed in the last Quarter on the NHS response to terrorism in response to learning from recent international incidents of terrorism, and on assurance against NHS England’s Emergency Preparedness, Resilience & Response (EPRR) standards. An operational sub-group supporting the LHRP has been opened up to CCGs and to Public Health, and we are represented on the group by the Head of Health, Safety & Security. The next quarter’s activity will focus on preparedness for Junior Doctor industrial action. We have also responded to collated NHS learning from the Boxing Day floods.

- **Information Governance:** The Section 251 exemptions under which we operate have been extended to 31 March 2017, and we have renewed our Accredited Safe Haven status. Our Information Governance Toolkit was submitted by the deadline of 31 March 2016 following an internal audit of the toolkit, and resulted in a satisfactory score of 76%.

- **Counter Fraud:** A 30-day Counter Fraud Work Plan for 2016/17 focussing on bribery, anti-fraud and corruption arrangements has been approved by the Audit Committee in the last Quarter. The plan was fed by cumulative Counter Fraud Specialist knowledge, CCG incidents, and a counter fraud risk assessment.

- **Organisational Development:** A full review of the uptake of Personal Development Reviews (PDRs) has been undertaken and in order to improve how the CCG plans its training and development of staff, the timings of PDRs are being aligned across the whole organisation with full annual reviews being undertaken in April/May/June. Mid-year reviews will still take place to ensure all staff are on schedule for achieving their objectives and have the relevant support in place to do so. We have seen a drop in compliance rate for mandatory & statutory training, and so for 2016/17 face to face training will be available to support compliance.
Section 1 – Risk Management

1.1. Assurance Framework

Our Assurance Framework captures risks to the achievement of our strategic objectives. It has been refreshed during the last Quarter and the position is presented as at quarter-end. Two risks were removed from the framework at year end; risk 1.5 regarding continuing healthcare quality was de-escalated to the Risk Register, and risk 2.5 regarding the transition of Commissioning Support Services to the CCG was mitigated and closed.

<table>
<thead>
<tr>
<th>Risks</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risks in excess of the toleration threshold</td>
<td>2 3 2 3</td>
<td>3 3 3 2</td>
</tr>
<tr>
<td>Risks in excess of toleration threshold being treated</td>
<td>2 3 2 3</td>
<td>3 3 3 2</td>
</tr>
<tr>
<td>Risks below the toleration threshold being treated</td>
<td>4 3 3 4</td>
<td>3 1 1 1</td>
</tr>
<tr>
<td>New risks added during the Quarter</td>
<td>0 0 0 1</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Risks removed during the Quarter</td>
<td>0 0 0 0</td>
<td>0 0 0 2</td>
</tr>
</tbody>
</table>

The risks being treated as at Quarter-end are:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description</th>
<th>Updates</th>
<th>Rating</th>
</tr>
</thead>
</table>
| 1.3 | Failure to effectively commission services to reduce health inequalities, potentially resulting in a widening of the inequalities gap. | • This risk remains at a score of 8 (below the risk toleration threshold) but is being treated to strengthen controls and assurances with an action to “further consider the CCG’s role in reducing health inequalities and develop any actions required as a result”.  
  • Work has been ongoing in the last Quarter in partnership with the Public Health Team in the Local Authority to develop a workshop session for Governing Body members on health inequalities. This workshop is planned to be run in Quarter 1 of 2016/17 and should result in the development of a health inequalities plan. | Medium |

| 1.4 | A change to the national business rules for CCG allocations has resulted in an extremely challenging financial position for CCGs in 2016/17 which in Doncaster could affect our local achievement of financial targets and our system transformation plans. The descriptor for Risk 1.4 which focusses on achievement of efficiency savings has therefore been refreshed to capture the current position. The financial position requires a significant efficiency programme as reported to Governing Body in March 2016. The risk identified is the impact which this significant efficiency programme could potentially have upon our local achievement of financial targets and our system transformation plans.  
  • New controls have been added to the risk comprising | | High |
<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description</th>
<th>Updates</th>
<th>Rating</th>
</tr>
</thead>
</table>
|     | programme, could affect our local achievement of financial targets and our system transformation plans | Right Care analysis, prescribing analysis and our financial monitoring regime.  
- The likelihood of the risk has increased from a score of 2 “unlikely” where we do not expect it to happen/recur but it is possible it may do so to a score of 3 “possible” where the risk might happen or recur occasionally or a percentage likelihood of 21-50%. The likelihood risk score will be under regular review throughout the year in line with the reported financial position.  
- The risk treatment has been changed from “tolerate” to “treat” and an action plan has been developed to “develop and implement an efficiency programme aligned to the Right Care analysis, impact assess this against our transformation plan, and monitor progress throughout the year”. This action was opened on 17 March 2016 after the financial position was reported to the March Governing Body meeting. Since this point, the Right Care analysis received from NHS England has been reviewed by CCG team members and an efficiency programme will be developed aligned to this analysis. Prescribing has been identified as a key priority and initial meetings have taken place to begin planning. | High |
| 2.4 | Failure to performance manage contracts to ensure that Providers deliver against local and national performance targets, potentially resulting in organisational non-achievement of required targets. | • This risk remains at a score of 12 (above the risk toleration threshold) and it is being treated with an action to continue to take all contractual and partnership measures available to the CCG to ensure provider performance is brought back on track for key performance targets.  
• The Governing Body receives monthly Quality & Performance reports which identify performance areas which are off trajectory. Year-end performance reports have focussed on positive performance in A&E, Referral to Treatment times, Diagnostic waiting times, Improving Access to Psychological Therapies and the Care Programme Approach (CPA). Performance issues at year-end have been particularly identified in Cancer Waiting Times and Ambulance Response Times. Remedial action on these areas has been reported to Governing Body.  
• Given the likely pressures on the NHS system during the period of Junior Doctor industrial action and ongoing performance issues nationally in urgent care systems and Ambulance Services, the risk will be retained at its existing level and progress on performance will continue to be reported to Governing Body through the Quality & Performance Report. | High |

### 1.2. Risk Register

NHS Doncaster CCG’s Risk Register captures operational team-level risks. Risks scoring 16 or more can be escalated to the Assurance Framework where they could affect achievement of the CCG’s strategic objectives, and risks can also be de-escalated from the Assurance Framework to the Risk Register should risks be
mitigated to a lower level or no longer threaten achievement of the CCG’s strategic objectives. The Risk Register is received annually in its entirety by the Audit Committee, and the latest review took place in March 2016.

As at the end of the Quarter, the actions plans associated with “treated” risks were running to schedule and Risk Leads continued to work with the Corporate Governance Manager to ensure effective management and updating of risks. The key changes to the Risk Register in the last Quarter comprise:

- A risk has been amended on the Quality & Safety Risk Register regarding Safeguarding Adults systems and processes across the Doncaster to put particular emphasis on the implementation of the Care Act.

- New risks have been added regarding:
  - CCG responsibility for a CCG Practice Agreement with each GP practice within their area linked to the GP System of Choice.
  - Safe and timely access to gender reassignment drugs.
  - Potential for disruption to the provision of the Continuing Healthcare service given pending changes during an IT provider transition period.

### RISK REGISTER

<table>
<thead>
<tr>
<th>Risk Type</th>
<th>2014/15</th>
<th></th>
<th>2015/16</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Commissioning</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Employment</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Financial</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Governance</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Performance</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Quality</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Reputational</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>28</td>
<td>29</td>
<td>31</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk rating</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Very High</td>
<td>24</td>
<td>24</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>High</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Low</td>
<td>16</td>
<td>16</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>28</td>
<td>29</td>
<td>31</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terminate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>28</td>
<td>29</td>
<td>31</td>
<td>29</td>
</tr>
</tbody>
</table>
1.3. Internal Incident Reporting

The following table shows the number and category of internal incidents reported during the last quarter, and the severity.

There have been six incidents reported in the last Quarter. Four out of six of the incidents were information governance issues relating to in-housed or hosted clinical Continuing Healthcare services. All incidents were reported in a timely manner, and learning from the incidents was rapidly identified through root cause analysis and remedial action was taken. Due to the significant volume of clinical data held within the in-housed or hosted clinical Continuing Healthcare services from December 2016, we do have an increased data protection risk. This is being addressed through training and support to the team, and by standardising team operating protocols. A further information governance incident relates to a letter received by the CCG from an external body containing inappropriate patient details; the sender was contacted and the letter returned.

The remaining incident relates to an attempted break in at Devonshire House for which the CCG holds a lease. No loss resulted from the attempted break in and the security of Devonshire House was reviewed by the Local Security Management Specialist (LSMS), with minimal further actions required to improve building security.

<table>
<thead>
<tr>
<th>Category</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Accident / Injury</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Confidentiality / Information Governance</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disruptive or Violent behaviour / Assault</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Estates/Facilities/Security/Health &amp; Safety</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Financial loss</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Low (No Harm)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2 - Medium (Minor treatment only)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3 - High (Significant, not permanent harm)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4 - Very High (Permanent harm / damage)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5 - Extreme (death)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Patient Safety Agency (NPSA)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Counter Fraud and Security Management Service SIRS Reporting</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Information Commissioners Office</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
1.4. Claims & Legal issues

Insurance to the CCG is commissioned from the NHS Litigation Authority (NHSLA). The limitation period during which claims can be made is 3 years from the affected individual becoming aware of the issue. No new claims were received in the last quarter and there are no claims outstanding for the CCG.

The CCG has sought legal advice on three matters in the last quarter – Section 256 commissioning arrangements, partnership safeguarding advice, and tenancy arrangements at Devonshire House.
Section 2 – External Assessments

NHS Doncaster CCG is subject to a number of external assessments / inspections in order to provide assurance on the quality of services commissioned and our systems of internal control. The following reports have been received in the last Quarter.

| Internal Audit | Draft Head of Internal Audit Opinion 2015/16: The draft Head of Internal Audit Opinion for 2015/16 was received and noted. No risks were identified from the draft report. |
| Internal Audit | Internal Audit Plan 2016/17: The Internal Audit workplan for 2016/17 was received and accepted. Work between CCG team members and Internal Audit has aimed to create a balanced plan with indicative timings of audits and a 15 month plan to allow planning into 2017/18. |
| Internal Audit | Internal Audit Reports received: |
| Internal Audit | • Quality & Safety Committee Review Report – 2 medium risk and 5 low risk recommendations. |
| Internal Audit | • Continuing Healthcare Payments Certification Report - The audit provided significant assurance of controls. One low risk recommendation. |
| Internal Audit | • Mental Health Payment by Results Report - The audit provided significant assurance of controls. 4 medium risk recommendations. |
| Internal Audit | • Budgetary Control & Key Financial Systems Report – The report provided significant assurance of controls. 1 medium risk recommendation and one low risk recommendation. |
| Internal Audit | • Information Governance Report: The audit provided significant assurance of controls. One medium risk recommendation and four low risk recommendations. |
| Internal Audit | • Data Quality Report: The report provided significant assurance of controls. Three low risk recommendations. |
| Internal Audit | • Benchmarking Report – Conflicts of Interest. |

| External Audit | Audit Plan: The outline audit strategy and planned approach alongside areas of audit focus was received by the Audit Committee in January 2016. |
| External Audit | Appointment of External Auditors: From 2017/18 onwards, all CCGs will appoint their own External Auditors and directly manage the resulting contract and the relationship. Auditor Panels must be established to fulfil the advisory responsibilities associated with the selection, appointment, maintenance of an independent relationship with and removal of external auditors. We are exploring the joint procurement with other South Yorkshire & Bassetlaw CCGs. A Sub Group of the Audit Committee will support this approach. |

| Other inspections | External inspections of the CCG’s arrangements for Health & Safety, Fire Safety, or Information Governance can take place on an ad hoc basis. No inspections have taken place and no reports are expected. |
Section 3 – Committee Activity

3.1. Audit Committee

The Audit Committee reports directly to the Governing Body and meets approximately bi-monthly (up to 7 times a year). Two meetings were held in the last Quarter. The Committee considered and noted assurance on:

- External Audit reports and planning for the 2015/16 year-end audit, and a planning paper on the future appointment of external auditors.
- A range of Internal Audit reports as detailed in Section 2 of this report, including the 2016/17 internal audit workplan.
- Counter Fraud reports, including an update on the Self Reporting Tool (SRT).
- Financial exception reports and agreement of the final accounts timetable.
- Corporate Governance assurance including a review of the Assurance Framework Quarter 3, the Corporate Assurance Report Quarter 3, the year-end review of the full Risk Register, the year-end review of the Probity Register, and reports on the implementation of audit recommendations.
- Minutes from the Corporate Assurance Management Group.

3.2. Remuneration Committee

The Remuneration Committee reports directly to the Governing Body and meets as required. One meeting was held in the last Quarter to consider Chief Officer remuneration following the appointment of a new Chief Officer. The Committee also approved a new policy on Domestic Violence and Abuse.

3.3. Quality & Safety Committee

The Quality & Safety Committee reports directly to the Governing Body and meets bi-monthly. Two meetings have been held in the last Quarter. Full outcomes from quality activity are also reported through a separate monthly Quality & Performance Report to the Governing Body. The Committee focuses on 3 main areas: Quality, Safety, and Experience.

- Quality: The Committee received quality overviews and Commissioning for Quality & Innovation (CQUIN) reports for our two largest local Provider Trusts and received oversight reports of quality and safety in the areas of Care Homes, Individual Placements, Transforming Care (Learning Disabilities), and Primary Care including GP Out of Hours care.
- Safety: The Committee received assurance on Infection Prevention & Control and pressure ulcers, Medicines Management, Safeguarding Adults, Safeguarding Children, Serious Incidents, and considered the Quality & Safety Risk Register.
- Experience: The Committee received the CCG’s Caldicott update.
- The Committee also approved a Clinical Supervision Policy, a refreshed Incident Management Policy, and reviewed its Terms of Reference in accordance with internal audit recommendations.
3.4. **Engagement & Experience Committee**

The Engagement & Experience Committee reports directly to the Governing Body and meets quarterly. One meeting has been held in the last Quarter. The Committee:

- Commenced planning for communication and engagement associated with planned changes to Care Out of Hospital.
- Received assurance reports on the key strategy action plan areas:
  - Better Information and Engaged Communities: focussing on an increase in website traffic, social media and engagements, on the Health Ambassador pilot to engage some of our most isolated communities, and on the Patient Participation Group Network to engage patients through our Member Practices. The annual Statement of Involvement was also approved.
  - Experience of Accessible and Responsive Care: focussing on the Patient Experience Dashboard of qualitative feedback, analysis of the local results from the recent national GP Survey, and analysis of complaints received.
  - Equality: focussing on updated information comprising our Equality Delivery System assessment, general equality information on how we meet our public sector equality duties, and our Equality Objectives. This was published on our website during the Quarter in compliance with our statutory public sector equality duties.
- Received minutes from the Engagement & Experience Management Group.

3.5. **Delivery & Performance Committee**

The Delivery & Performance Committee reports directly to the Governing Body and meets monthly. Only one meeting has been held in the last Quarter. The Committee:

- Considered and approved Continuing Healthcare / Jointly Funded /Section 117 commissioning principles.
- Received an update on the Mental Health Crisis care pathway – a one-year review of our response to the Crisis Care Concordat. A Service Specification and Business Case for a new model will be developed in early 2016/16 and then piloted for 12 to 18 months.
- Considered an evaluation of a jointly commissioned Social Prescribing service in Doncaster through the Better Care Fund, noted the positive evaluation, and confirmed the need to continue and roll out the pilot.
- Received minutes from Strategic Contracting meetings.
Section 4 – Corporate Governance

4.1. Constitution and Establishment

As a Membership organisation comprising 43 Member Practices, NHS Doncaster CCG remains fully authorised by NHS England.

Scheduled elections for North West, Central, and South East Locality Lead positions took place in January 2016 and resulted in the re-election of the existing North West and South East Locality Leads. The Central election did not attract any applicants and was scheduled to be re-advertised after the Chair position election concluded in late March 2016. The Chair election resulted in the appointment of a new Chair for a 3-year term – Dr David Crichton. The Lay Member positions which ended in March 2016 were also recruited to (except for the Patient & Public Involvement Lay Member), including an additional Lay Member to support primary medical care commissioning.

Delegated responsibility from NHS England for commissioning primary medical care commences from 1st April 2016. The new Primary Care Commissioning Committee met once in Shadow in March 2016 and meets formally on a monthly basis from 1 April 2016.

4.2. Governance Structure

Our meeting governance structure is detailed overleaf. Activity flowing through each formal Committee of the Governing Body is captured in Section 3 of this report.

A Governing Body Timeout in November 2015 has resulted in agreement of “design rules” for refresh and realignment of our internal governance structure in order to support our organisational effectiveness and resilience in a changing local/national environment and support effective clinical engagement. Our aim is robust and yet proportionate and dynamic governance through our internal meeting structures. Future governance structure changes are therefore expected and will be consulted upon with Governing Body and our Membership prior to submission to NHS England.
The Officers fulfilling the key statutory roles required of a CCG are noted below:

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Officer</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Accountable Emergency Officer</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Accounting Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>Caldicott Guardian</td>
<td>2 deputies: Deputy Chief Nurse, and Quality &amp; Patient Safety Manager</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Designated Nurse for Safeguarding Children</td>
</tr>
<tr>
<td></td>
<td>Designated Professional for Safeguarding Adults</td>
</tr>
<tr>
<td>Research Governance</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>Equality and Diversity Executive Lead</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Whistleblowing Lead</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Senior Information Risk Owner</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Health &amp; Safety “Competent Person”</td>
<td>Head of Health, Safety &amp; Security</td>
</tr>
<tr>
<td>Fire Safety “Responsible Person”</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Fire Safety “Competent Person”</td>
<td>Head of Health, Safety &amp; Security</td>
</tr>
<tr>
<td>Security Management Director</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Local Security Management Specialist</td>
<td>Head of Health, Safety &amp; Security</td>
</tr>
<tr>
<td>Claims Officer</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>Local Counter Fraud Specialist</td>
<td>360 Assurance</td>
</tr>
<tr>
<td>Registration Authority</td>
<td>HR Team (via Lead Provider Framework)</td>
</tr>
<tr>
<td>Accountable Officer</td>
<td>Director of Nursing in the local NHS England Area Team (delegated operationally to the CCG Head of Medicines Management)</td>
</tr>
<tr>
<td>Controlled Drugs</td>
<td></td>
</tr>
</tbody>
</table>

4.3. Procedural Document Management

Procedural documents due for review in 2016 are on track.

4.4. Health & Safety, Fire Safety & Security

Health & Safety:
- The Competent Person for Health & Safety has confirmed to the Corporate Governance Management Group that the CCG remains compliant with health & safety legislation.
- Premises inspections are continuing and ongoing.
- The annual organisational health & safety risk assessment is in date and is next due for review in September 2016.
- The annual First Aid risk assessment is in date, has been received by the Corporate Governance Management Group, and is next due for review in January 2017.
Fire:
- The annual fire risk assessment for Sovereign House is in date, and is next due for review in September 2016.
- Fire Marshalls are running weekly fire alarm tests.

Security:
- Our existing self-assessment against the NHS Protect Security Standards remains in place with all standards remaining green.
- The Standards for Providers and Commissioners 2016-17: security management have been published in draft, and once the finalised standards are available our self-assessment will be updated.

4.5. Emergency Resilience and Business Continuity

The Local Health Resilience Partnership (LHRP) has focussed on the NHS response to terrorism in response to learning from recent international incidents of terrorism, and on assurance against NHS England’s Emergency Preparedness, Resilience & Response (EPRR) standards. The three Yorkshire and Humber LHRPs have undertaken a check and challenge process and no issues have been raised with the self-assessment returns from our providers or from ourselves as a CCG. An operational sub-group supporting the LHRP has been opened up to CCGs and to Public Health, and we are represented on the group by the Head of Health, Safety & Security. The next quarter’s activity will focus on preparedness for Junior Doctor industrial action.

In terms of learning from the Boxing Day floods, some provider telephone systems and backups were knocked out when the telecommunication companies in Leeds flooded. The local CCG in the affected area was asked to coordinate a list of vulnerable people who may need support from the emergency services. The CCG team is working through local assurances in response to these learning points.

Directorate Business Continuity plans are being refreshed on an ongoing basis. We are planning for further CCG awareness raising during Business Continuity Week in Quarter 1 of 2016/17.

4.6. Sustainability

Our refreshed sustainability commitments are detailed below, many of which have already been embedded into complimentary areas of our commissioning activities such, and therefore reported within the sub-sections of this report.

<table>
<thead>
<tr>
<th>Area of focus</th>
<th>Development Plan</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership, engagement</td>
<td>Regularly review our Sustainable Development Management Plan for approval by our</td>
<td>• The Sustainable Development Management Plan was refreshed during 2015/16.</td>
</tr>
<tr>
<td>and workforce development</td>
<td>Governing Body at least every 3 years.</td>
<td>• Our Engagement &amp; Experience Committee has received assurance in the last quarter on</td>
</tr>
<tr>
<td></td>
<td>Continue to engage with and</td>
<td></td>
</tr>
<tr>
<td>Area of focus</td>
<td>Development Plan</td>
<td>Progress update</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>empower communities through enacting our Communication, Engagement &amp; Experience Strategy, reporting progress to our Engagement &amp; Experience Committee.</td>
<td>the strategy areas of Better Information &amp; Engaged Communities, Patient Experience, and Equality Objectives. These are detailed further in Section 3 of this report.</td>
</tr>
<tr>
<td></td>
<td>• Continue to support our team members through enacting our Organisational Development Strategy, reporting progress through our Corporate Assurance Reports.</td>
<td>• Our Organisational Development Strategy was refreshed in 2015 and the action plan continues to be implemented and updates are reflected in Section 7 of this report.</td>
</tr>
<tr>
<td>Carbon hotspots</td>
<td>• Continue to engage with and empower our team members to save carbon through initiatives such as recycling, saving energy and reducing unnecessary travel.</td>
<td></td>
</tr>
<tr>
<td>Commissioning and procurement</td>
<td>• Regularly review procurement documentation to ensure that economic, environmental and social sustainability remain intrinsic to the process.</td>
<td>• The Procurement Strategy has sustainability principles embedded within it and sustainability requirements are included in tender documentation.</td>
</tr>
<tr>
<td>Sustainable clinical and care models</td>
<td>• Continue to focus on system transformation within our Strategic Plan, reporting progress to our Governing Body.</td>
<td>• Our Strategic Plan was refreshed and reaffirmed in late 2015, and the focus is very much on system transformation.</td>
</tr>
<tr>
<td>Healthy, sustainable and resilient</td>
<td>• Work in partnership to support delivery of the Health &amp; Wellbeing Board Strategy, monitoring progress through the Health &amp; Wellbeing Board.</td>
<td>• The refreshed Health &amp; Wellbeing Strategy was published in December 2015.</td>
</tr>
<tr>
<td>communities</td>
<td></td>
<td>• We have been working in Quarter 4 in partnership with Public Health colleagues to develop our organisational approach to identifying and tackling health inequalities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We are part of the <em>Well Doncaster</em> pilot in Denaby to explore community empowerment interventions to improve health inequalities.</td>
</tr>
<tr>
<td>Metrics</td>
<td>• Use core indicators to assess our own and our providers’ sustainability performance,</td>
<td>• The core indicators have been set by the NHS Sustainable Development Unit and will be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>would be refreshed and reaffirmed in late 2015, and the focus is very much on system transformation.</td>
</tr>
</tbody>
</table>
### Area of focus | Development Plan | Progress update
--- | --- | ---
| **Innovation, Technology and Research & Development** | • Implement our Information Technology Strategy, reporting progress annually to the Governing Body. | • Our Information Technology (IT) Strategy was refreshed in 2015 and implementation is progressing as reported in Section 5.5 of this report.

| **Creating social value** | • Continue to consider all aspects of sustainability when reviewing business cases and taking commissioning decisions. | • Our Delivery and Performance Committee considers a range of indicators when assessing business cases, and sustainability is embedded into the Business Case template.

- Our ambition of Care Outside of Hospital (our main priority) very much aligns to creating social value by embedding care in local communities and reducing unnecessary travel.

#### 4.7. Complaints Management

Below is a summary of complaints data for NHS Doncaster CCG for the last quarter which has been reported to the Health & Social Care Information Centre.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Upheld</th>
<th>Partially upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15 Annual Return</strong></td>
<td>46</td>
<td>6</td>
<td>Not reported</td>
<td>40</td>
</tr>
<tr>
<td><strong>2015/16 Quarter 1</strong></td>
<td>11</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>2015-16 Quarter 2</strong></td>
<td>13</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>2015/16 Quarter 3</strong></td>
<td>18</td>
<td>1</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td><strong>2015/16 Quarter 4</strong></td>
<td>14</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td><strong>2015/16 Annual Total</strong></td>
<td>56</td>
<td>6</td>
<td>16</td>
<td>30</td>
</tr>
</tbody>
</table>

3 complaints opened in Quarter 4 are unresolved and therefore carried forward to Quarter 1 of 2016/17. 1 complaint (currently closed) is awaiting the outcome of a Parliamentary & Health Service Ombudsman (PHSO) investigation.

Of the 14 complaints received and investigated (5 were received as MP letters), 4 complaints related to the Continuing Health Care (CHC) Previously Unassessed Periods of Care (PUPoC) relating to the time taken to assess and the process, 3 complaints related to current CHC relating to the decision-making process and subsequent funding decisions, 1 complaint related to CHC and the time taken for the Appeal process, 1 complaint related to the care received prior to assessment for CHC, 1 complaint related to the lack of a specialised health and social care placement in Doncaster, 1 complaint related to a Personal Health Budget, 2 complaints related to specialised service provision, and 1 complaint related to Children’s Services and the delays in the Autism Spectrum Disorder (ASD) pathway. 12 additional complaints received were signposted to relevant providers for investigation.
The complaint which was upheld related to the delays in ASD diagnosis and pathway. The complaints which were partially upheld related to delays in the current CHC process, care prior to CHC assessment, and the lack of a specialised health and social care placement in Doncaster. 1 complaint remains with the Parliamentary and Health Service Ombudsman (PHSO) for investigation. It relates a retrospective CHC claim and an appeal against non-eligibility for CHC.

The clear theme emerging is around Continuing Healthcare - delays in processing applications or the process/outcome. We have previously confirmed that during implementation of the national CHC guidance and making decisions on funding packages, these themes are to be expected. We have benchmarked with other CCGs, and the level of CHC related complaints is slightly above the regional average but we continue to monitor progress closely.

Whilst as a commissioner of care we do not answer all complaints directly, we do however signpost, listen and learn from people who use the services we commission, and work with our providers to improve the care they provide. The information they have shared with us is recorded anonymously in our patient experience themes and trends reporting so that it can influence future commissioning decisions.

4.8. Whistleblowing

Whistleblowing may relate to financial, employment or clinical care. The CCG has not received any whistleblowing disclosures.

<table>
<thead>
<tr>
<th>Category</th>
<th>2014/15</th>
<th></th>
<th></th>
<th></th>
<th>2015/16</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Whistleblowing disclosures</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Section 5 – Information Governance

5.1. The protection and use of Personal Confidential Data

NHS Doncaster CCG continues to operate within the Section 251 exemptions agreed by the national Confidentiality Advisory Group. NHS England has received confirmation of approval from the Secretary of State for Health, through the Confidentiality Advisory Group (CAG), for an extension of commissioning Section 251s until 31 March 2017. This will support the transition from existing temporary arrangements, to a sustainable future model that meets commissioners’ needs and complies with legal and security requirements.

- CAG 2-03(a)/2013 Application for transfer of data from the Health and Social Care Information Centre (HSCIC) to commissioning organisation Accredited Safe Havens (ASH).
- CAG 7-04(a)/2013 Disclosure of commissioning data sets and GP data for risk stratification purposes to data processors working on behalf of GPs.
- CAG 7-07(a)(b)(c)/2013 Application for transfer of data from the HSCIC to commissioning organisation accredited safe havens: inclusion of invoice validation as a purpose within CAG 2-03 (a)/2013.

We have a Data Sharing Contract with the Health & Social Care Information Centre which takes us through to 2017, and Data Sharing Agreements which underpin this contract have been refreshed in the last Quarter.

5.2. Information Governance Toolkit

The Information Governance Toolkit is a national toolkit administered by the Health & Social Care Information Centre (HSCIC) which enables us to measure our information governance compliance. Level 2 is the required standard and we achieved this across all standards. The last published CCG assessment is available online via https://www.igt.hscic.gov.uk/reportsnew.aspx. Version 13 of the Toolkit was completed and published by the required deadline of 31st March 2016 with a score of 76% (satisfactory). Internal Audit undertook an audit of the Information Governance Toolkit in Quarter 4 which resulted in significant assurance.

Information Governance activity in the last quarter has included:

- The Information Security Action Plan progress report was reported to the Corporate Governance Management Group and the four actions within the plan were confirmed as complete.
- Internal Audit of the Information Governance Toolkit - all actions from the recommendations were completed prior to submission.
- Developing a Caldicott Management Statement.
- Staff training on Information Governance.
- Reviewing Information Governance incidents.
- Developing Information Sharing Agreements where necessary to support safe and appropriate sharing of confidential data.
• Refresh of the Incident Policy.
• Updating the evidence log for the Information Governance Toolkit.

5.3. Freedom of Information Act Requests

The following table shows the number of Freedom of Information Act requests received and the number responded to within the 20 working day timeframe.

<table>
<thead>
<tr>
<th>Enquirer type</th>
<th>2014/15</th>
<th></th>
<th></th>
<th></th>
<th>2015/16</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Commercial</td>
<td>19</td>
<td>27</td>
<td>16</td>
<td>27</td>
<td>23</td>
<td>26</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Education Establishment</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td></td>
<td>1</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td>15</td>
<td>13</td>
<td>15</td>
<td>9</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Member of Public</td>
<td>21</td>
<td>16</td>
<td>20</td>
<td>25</td>
<td>25</td>
<td>26</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>MP</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td></td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other NHS</td>
<td>5</td>
<td>13</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Public Authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solicitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary / Charitable</td>
<td>5</td>
<td>11</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>86</strong></td>
<td><strong>65</strong></td>
<td><strong>74</strong></td>
<td><strong>70</strong></td>
<td><strong>80</strong></td>
<td><strong>65</strong></td>
<td><strong>62</strong></td>
</tr>
<tr>
<td>% responded to within 20 working days</td>
<td>98.6%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Seven Section 21 exemptions were quoted for information accessible by other means. This is an increase in this type of exemption, and serves to demonstrate our ongoing approach to place more information into the public domain on our website to support transparency.

Trends in request topics relate to commissioning arrangements and budgets/spend in specialist clinical areas of interest, and staffing roles with associated contact details.

5.4. Data Protection Subject Access Requests

The CCG is required to meet statutory timeframes for responding to Subject Access Requests under the Data Protection Act. The statutory timeframe is 40 days. One subject access request was received within the last Quarter and was responded to within the statutory timeframe.

5.5. Information Management & Technology

NHS Doncaster CCG has had our proposal to develop a Local Digital Roadmap based on the CCG’s footprint approved by NHS England. The submission date for the Digital Roadmap is the end of June 2016 in line with the draft guidance that was
published on 21st March 2016. Any work required around combining CCG footprints into a wider footprint aligned to the Sustainability & Transformation Plan is being reviewed.

A CCG-Practice agreement relating to IT services has been developed based on the NHS England template.

Action is ongoing to take forward the process of replacing laptops, desktops and monitors for staff based in White Rose House, Sovereign House and also for our staff based at 722 Prince of Wales Road in Sheffield. The old equipment will be recycled under the IT contract.
Section 6 – Financial Governance

6.1. Financial procedures and systems

The Standing Financial Instructions, Standing Orders and Scheme of Delegation are in date, having been updated in March 2016 to mirror our Constitutional changes.

6.2. Financial Governance

Losses and Special Payments: No losses or special payments have been reported during the Quarter.

Waivers for SFIs: One new application to waive the tenders and quotes procedures has been approved for Blueteq as a sole supplier for monitoring and controlling the use of high cost drugs.

Debtors/Creditors: There were no outstanding Debtor balances over six months old and over £5,000 at quarter-end.

Declarations of Interest: The NHS Doncaster CCG Declarations of Interests Register was updated throughout the period and includes declarations from all employees. A full Probity Register report was received by the Audit Committee in March 2016.

Disclosure of Gifts and Hospitalities: There have been no gifts or hospitality accepted by the organisation in line with the Standards of Business Conduct & Conflicts of Interest Policy during the Quarter. One offer of corporate hospitality from our External Auditors, KPMG, was declined.

6.3. Counter Fraud

The CCG’s Counter Fraud Specialist (CFS) is commissioned via 360 Assurance. The Audit Committee receives assurance via Counter Fraud reports which cover the areas of contract performance, strategic governance, inform and involve, and prevent and deter.

A 30-day Counter Fraud Work Plan for 2016/17 focussing on bribery, anti-fraud and corruption arrangements was approved by the Audit Committee in the last Quarter. The plan was fed by cumulative Counter Fraud Specialist knowledge, CCG incidents, and a counter fraud risk assessment. The highest counter fraud risk areas in the risk assessment are the potential for commissioned service providers to charge for work not completed (particularly in Continuing Healthcare), and risks associated with extending the provision of Personal Health Budgets for patients to commission their own healthcare.
7.1. Organisational Development

Organisational Development is our systematic approach to improving organisational effectiveness – one that aligns our strategy, our people and our processes to drive forward our vision and effectively enact our Strategic Plan. Our Organisational Development Strategy is underpinned by an action plan, and in 2015/16 we agreed to focus on the areas detailed below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a shared narrative of our vision and strategy</td>
<td>Our Strategic Plan has been refreshed and re-affirmed, approved by Governing Body, and the key areas of focus are reiterated across the breadth of our corporate communications and documentation.</td>
</tr>
<tr>
<td>Exploring the opportunities afforded by delegation for primary care commissioning from NHS England, and developing appropriate governance arrangements in response to any delegation</td>
<td>We will receive formal delegation from NHS England for primary medical care commissioning from 1 April 2016. We held a shadow meeting of our new Primary Care Commissioning Committee in March, and it becomes a formal Committee held in public from 1 April 2016. We have appointed a Lay Member for primary care commissioning during Quarter 4, who commenced in post on 1 March 2016. We have included in our forward Internal Audit Workplan an audit around our new primary care commissioning arrangements.</td>
</tr>
</tbody>
</table>
| Reviewing the breadth of our organisational meeting structure to ensure that the structure supports effective communication and maximises clinical added value. | We have already included the Primary Care Commissioning Committee in our governance structure. During Quarter 4 we undertook a full review of each of the Committees reporting to Governing Body. This has resulted in a recommendation from the Governing Body for the following changes. These will be consulted upon with Members in Quarter 1 of 2016/17:  
  • Ensuring that the terms of reference follow the same formatting convention for consistency.  
  • Adding a section on Counter Fraud, Bribery & Corruption to the Audit Committee terms of reference.  
  • Re-naming the Quality & Safety Committee the “Quality & Patient Safety Committee”, refreshing the membership and removing reference to obsolete Sub Groups and a function relating to publishing an explanation of how the Group spent any payment in respect of quality – this function will instead be delegated to the Chief Finance Officer.  
  • Moving the Engagement & Experience Committee from quarterly to monthly to respond to the direction set by the Governing Body on health inequalities and patient engagement. Refreshing the membership. Recognising 2 external patient engagement forums.  
  • Re-naming the Delivery & Performance Committee the |
| Ensuring our continued cultural competence as an employer, working to identify any potential barriers to employment for equality groups and exploring ways in which we could overcome them. | “Executive Committee” and merging the existing terms of reference for the Delivery & Performance Committee with the existing terms of reference for the informal Senior Management Team meeting.  
- Completing the schedules appended to the nationally-set Primary Care Commissioning Committee terms of reference.  
- Amending corresponding cross-references throughout the Constitution to these terms of reference changes. |
| --- | --- |
| In May 2016 CCGs will be required to publish a report which outlines how the Workforce Race Equality Scheme (WRES) is being implemented. We already report our workforce profile to Governing Body and publish it in the Annual Report. Data is available which shows the breakdown of the workforce by ethnicity and pay band. A report has been produced at year end which provides an analysis of recruitment activity by protected characteristic and shows numbers of applications, numbers shortlisted and the profile of the appointed candidate.  
Wider work is being undertaken in relation to the broader aspects of WRES. Specific training was commissioned in 2015/16 on ‘Cultural Awareness’ and ‘Understanding Unconscious Bias’. Consideration is being given to make these modules mandatory for all staff. In house training is delivered on bullying and harassment at intervals throughout the year and is aimed at managers and staff. Following receipt of the staff survey results, mini in house surveys are being planned to pick out key points from the results. The purpose of this is to ensure that the whole workforce, including those who transferred to the CCG in December 2015 (after the annual staff survey closed) is captured. It is hoped that the results from these mini surveys will provide a more fluid and accurate staff perspective.  
Equality opportunities monitoring has been refreshed, and we have more accurate disability declarations and will be looking at appropriate support to team members. |
| Developing a more “personalised” or individualised approach to development activities. | A full review of the uptake of Personal Development Reviews (PDRs) has been undertaken and in order to improve how the CCG plans its training and development of staff the timings of PDRs are being aligned across the whole organisation with full annual reviews being undertaken in April/May/June. Mid-year reviews will still take place to ensure all staff are on schedule for achieving their objectives and have the relevant support in place to do so.  
The Head of HR has negotiated access to an NHS Learning & Development programme, and a brochure of all available courses is being developed. We continue to respond on a more personalised basis to individual development needs. |
The Colleague Engagement Group continues to meet bi-monthly and has been focusing on developing an action plan from the results of the 2015/16 annual NHS staff survey results and looking at staff wellbeing support options. The group has also recommended and will be working on a supervision model for non-clinical staff who are involved in clinical issues.

7.2. Staffing Governance

7.2.1. Staffing structure

Our Governing Body comprises:

- Chair
- Locality Leads x10 as elected representatives of Member Practices (two in each of the five Localities)
- Three Lay Members – one to lead on audit, remuneration and conflict of interest matters (and also act as Deputy Chair of the Governing Body), one to lead on patient and public participation matters, and one to lead on primary care commissioning
- Registered Nurse (also the Chief Nurse)
- Secondary Care Specialist Doctor
- Accountable Officer (the Chief Officer)
- Chief Finance Officer

The Lay Members and Secondary Care Doctor each hold a Lay leadership portfolio:

<table>
<thead>
<tr>
<th>Member</th>
<th>Lead corporate areas</th>
</tr>
</thead>
</table>
| Mr Albert Schofield (From 1 April 2016 this will be Miss Anthea Morris) | • Chair of Audit Committee  
                        • Chair of Remuneration Committee  
                        • Lay lead for Audit and Governance |
| Miss Anthea Morris (From 1 April 2016 this will be Mrs Linda Tully undertaking a dual role) | • Chair of Engagement & Experience Committee  
                        • Lay Public and Patient Involvement Champion |
| Mrs Linda Tully (From 1 March 2016) | • Chair of Primary Care Commissioning Committee  
                        • Lay lead for primary care commissioning |
| Dr Emyr Wyn Jones | • Chair of Quality & Safety Committee  
                        • Lead for Secondary Care, bringing an understanding of patient care in the secondary care setting |
Each Locality Lead has a portfolio role comprising a) joint leadership of one of the five Localities as detailed in Section 4.2 of this report, b) clinical leadership of clinical commissioning priority areas such as Dementia or Cancer, and c) clinical input to corporate areas such as Audit or Quality:

<table>
<thead>
<tr>
<th>Locality Lead</th>
<th>Lead clinical areas</th>
<th>Lead corporate areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andy Oakford</td>
<td>• Unplanned Care</td>
<td>• Audit Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Delivery &amp; Performance Committee</td>
</tr>
<tr>
<td>Dr Jeremy Bradley</td>
<td>• Prescribing</td>
<td>• Remuneration Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality &amp; Safety Committee</td>
</tr>
<tr>
<td>Dr Marco Pieri</td>
<td>• Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Surgical Specialities</td>
<td></td>
</tr>
<tr>
<td>Dr Niki Seddon</td>
<td>• Mental Health</td>
<td>• Primary Care Commissioning Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Delivery &amp; Performance Committee</td>
</tr>
<tr>
<td>Dr Sam Feeney</td>
<td>• Community Services</td>
<td>• Engagement &amp; Experience Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remuneration Committee</td>
</tr>
<tr>
<td>Dr Pat Barbour</td>
<td>• Children’s Services including CAMHS</td>
<td>• Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>Dr Khaimraj Singh</td>
<td>• Neurology</td>
<td>• Engagement &amp; Experience Committee</td>
</tr>
<tr>
<td></td>
<td>• Information Technology &amp; Premises</td>
<td></td>
</tr>
<tr>
<td>Dr Lindsey Britten</td>
<td>• Continuing Healthcare / Individual Placements / End of Life Care / Long Term Conditions</td>
<td>• Quality &amp; Safety Committee</td>
</tr>
<tr>
<td>Dr Karen Wagstaff</td>
<td>• Dementia</td>
<td>• Audit Committee</td>
</tr>
<tr>
<td></td>
<td>• Care outside of Hospital</td>
<td></td>
</tr>
</tbody>
</table>

Our team staffing structure consists of a Chief Officer with five directly-reporting Chiefs of Service. Each Chief leads a team working to deliver the agendas as detailed overleaf.
7.2.2. Staffing breakdown

<table>
<thead>
<tr>
<th>Area</th>
<th>Staffing breakdown</th>
<th>Count / %</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Headcount</td>
<td>188</td>
<td>133 are direct CCG employees, and 55 are in hosted services</td>
</tr>
<tr>
<td></td>
<td>Whole Time Equivalent</td>
<td>166.84</td>
<td>This is a significant increase and is largely attributable to the new hosted Continuing Healthcare Teams</td>
</tr>
<tr>
<td>Turnover</td>
<td></td>
<td>9.7%</td>
<td>During this quarter there have been 5 cases of long term sickness absence due to significant health issues</td>
</tr>
<tr>
<td>Cumulative sickness rate</td>
<td></td>
<td>3.67%</td>
<td></td>
</tr>
<tr>
<td>Formal cases of discipline, grievance, poor performance or bullying and harassment</td>
<td>2</td>
<td>3 informal cases</td>
<td></td>
</tr>
</tbody>
</table>

7.2.3. Mandatory & Statutory Training

A compliance dashboard is produced each month and this is monitored to ensure that employees who are non-compliant, or who will become non-compliant in the next three months, are encouraged to complete their training. Any significant issues are reported to the Senior Management Team. The target compliance rate is 100% of eligible staff. The Quarter end position is detailed below alongside a comparison with the previous Quarter.
We have seen a drop in compliance rate, and so for 2016/17 face to face training will be available which will group together the following modules:

Module 1:  
- Fire Safety  
- Health & Safety incorporating Risk Management  
- Moving and Handling

Module 2:  
- Safeguarding Adults  
- Safeguarding Children

Face to face training will be offered as an option for all other modules.

<table>
<thead>
<tr>
<th>Name of Training</th>
<th>Compliance rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3 2015/16</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>91%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>86%</td>
</tr>
<tr>
<td>Fraud</td>
<td>54%</td>
</tr>
<tr>
<td>Health &amp; Safety incorporating Risk Management</td>
<td>92%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>87%</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>89%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>93%</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People</td>
<td>92%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>92%</td>
</tr>
<tr>
<td>Induction</td>
<td>100%</td>
</tr>
</tbody>
</table>
Chair and Chief Officer Report
Meeting name | Governing Body
---|---
Meeting date | 19 May 2016
Title of paper | Chair and Chief Officer Report

**Executive / Clinical Lead(s)**
- Dr David Crichton, Clinical Chair
- Mrs Jackie Pederson, Chief Officer

**Author(s)**
- Mrs Sarah Atkins Whatley, Chief of Corporate Services

**Purpose of Paper - Executive Summary**

The purpose of this report is to update the Governing Body on issues relating to the activity of the CCG of which the Governing Body needs to be aware, but which do not themselves warrant a full Governing Body paper.

This month the paper includes updates on the following areas:

- Planning update
- Guidance on managing conflicts of interest in CCGs
- Constitutional changes
- Central Locality Election outcome
- Transfer of commissioning responsibility for adult obesity services in 2016/17
- Information Sharing with the Health & Social Care Information Centre
- 360 Stakeholder Survey

**Recommendation(s)**

The Governing Body is asked to:

- Note the report.

**Impact analysis**

<table>
<thead>
<tr>
<th>Assurance Framework</th>
<th>3.2, 5.1, 6.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk analysis</td>
<td>None</td>
</tr>
<tr>
<td>Equality impact</td>
<td>Neutral</td>
</tr>
<tr>
<td>Sustainability impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Financial implications</td>
<td>Nil</td>
</tr>
<tr>
<td>Legal implications</td>
<td>Nil</td>
</tr>
<tr>
<td>Consultation / Engagement</td>
<td>360 Stakeholder Survey</td>
</tr>
</tbody>
</table>
1. Planning update

_Sustainability & Transformation Plan:_ Partnership work across South Yorkshire & Bassetlaw continues on the production of the local Sustainability & Transformation Plan (STP).

_Doncaster place-based plan:_ Visioning events are being held with partners to support the development of a Doncaster place-based plan. Discussions already held with Governing Body will feed directly into these events.

**General Practice Forward View:** NHS England has launched the General Practice Forward View which commits to an extra £2.4 billion a year to support general practice services by 2020/21. The View details that spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2021 - a 14% real terms increase. As part of this package, NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups. The plan also contains specific, practical and funded steps to grow and develop the workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern primary care is offered to patients. [https://www.england.nhs.uk/ourwork/gpfv/](https://www.england.nhs.uk/ourwork/gpfv/)

**GP IT:** As part of the General Practice IT (GPIT) Operating Framework refresh, assessment criteria have been developed to give a clear indication of digital maturity across general practices in England. This aims to provide CCGs with insight to support the effective commissioning of GPIT services, local investment decisions and the development of local digital roadmaps. Where possible, data is sourced from existing data collection routes, including the Health and Social Care Information Centre tracking database and the annual e-Declaration submission. In addition, CCGs have been required to complete a GPIT digital maturity questionnaire in April 2016.

2. Draft guidance on managing conflicts of interest in CCGs

NHS England has published revised draft statutory guidance to bring a stronger, more consistent approach to conflicts of interest management across the NHS. The key changes set out are:

- A recommendation for CCGs to have a minimum of three lay members on the Governing Body in order to support with conflicts of interest management;
- The introduction of a conflicts of interest guardian in CCGs;
- A requirement for CCGs to include a robust process for managing any breaches within their conflict of interest policy and for any breaches to be published on the CCG’s website;
• Strengthened provisions around decision-making when a member of the governing body, or committee or sub-committee is conflicted;
• Strengthened provisions around the management of gifts and hospitality, including the need for prompt declarations and a publicly accessible register of gifts and hospitality;
• A requirement for CCGs to include an annual audit of conflicts of interest management within their internal audit plans and to include the findings of this audit within their annual end-of-year governance statement;
• A requirement for all CCG staff, governing body and committee members, and GP members to complete mandatory online conflicts of interest training, which will be provided by NHS England. The online training will be supplemented by a series of face-to-face training sessions for CCG leads in key decision-making roles.

Once the guidance is in its final format, we will be seeking to rapidly enact it into our Standards of Business Conduct & Conflicts of Interest Policy.

3. Constitutional changes

The recommended Constitutional changes to the terms of reference of our main Committees, which were agreed by the Governing Body at our April meeting for consultation with our Members, are with our members until the end of May for their views. If approved by 75% of Members, the changes will be submitted to NHS England in early June and we will move to the new governance structure.

As agreed at the April Governing Body meeting, the CCG will now commence discussions with the Membership in relation to the locality commissioner footprint and opportunities to optimise the model moving forwards

4. Central Locality Election outcome

A vacancy remains in the Central Locality for a Locality Lead. This position was originally put out to the Central membership for applications in January 2016, but no applications were received. Following the completion of the Chair election process, the vacancy was re-advertised as planned in April 2016.

During the application stage of the process, requests were received from six out of eight of our Central Member Practices to suspend the election for the vacant position on the basis that further discussions about the future Central Locality footprint were pending imminently.

The CCG senior team discussed the request in line with the guidance in our Constitution and confirmed that the request had reached the guideline thresholds in our Constitution both in terms of response rate (66%) and decision-making (75%). As per the Membership request, the Central Election was therefore suspended.
At the next Central Locality meeting, the Locality will aim to discuss whether they wish to consider any interim arrangements to provide additional Central Locality support and representation within the CCG.

There are forthcoming scheduled routine elections for the North East and South West Localities in July 2016. In advance of these elections, the Localities will be consulted to understand whether they wish to proceed with these elections as scheduled or defer them pending their own discussions on future Locality footprints.

The forward election schedule is detailed below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Locality</th>
<th>Lead</th>
<th>Locality</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016</td>
<td>North East</td>
<td>Dr Oakford (Lead A)</td>
<td>South West</td>
<td>Dr Wagstaff (Lead A)</td>
</tr>
<tr>
<td>January 2017</td>
<td>Central</td>
<td>Vacancy (Lead A)</td>
<td>North West</td>
<td>Dr Pieri (Lead A)</td>
</tr>
<tr>
<td>July 2017</td>
<td>South East</td>
<td>Dr Singh (Lead A)</td>
<td>North East</td>
<td>Dr Bradley (Lead B)</td>
</tr>
<tr>
<td>January 2018</td>
<td>South West</td>
<td>Dr Britten (Lead B)</td>
<td>Central</td>
<td>Dr Feeney (Lead B)</td>
</tr>
<tr>
<td>July 2018</td>
<td>North West</td>
<td>Dr Seddon (Lead B)</td>
<td>South East</td>
<td>Dr Barbour (Lead B)</td>
</tr>
<tr>
<td>January 2019</td>
<td>North East</td>
<td>Lead A</td>
<td>South West</td>
<td>Lead A</td>
</tr>
<tr>
<td>July 2019</td>
<td>Central</td>
<td>Lead A</td>
<td>North West</td>
<td>Lead A</td>
</tr>
<tr>
<td>January 2020</td>
<td>South East</td>
<td>Lead A</td>
<td>North East</td>
<td>Lead B</td>
</tr>
<tr>
<td>July 2020</td>
<td>South West</td>
<td>Lead B</td>
<td>Central</td>
<td>Lead B</td>
</tr>
</tbody>
</table>

5. **Transfer of commissioning responsibility for adult obesity services in 2016/17**

NHS England is working through local collaborative commissioning forums to support the transfer of adult obesity services to clinical commissioning groups, which began on 1 April 2016. NHS England, supported by the Obesity Surgery Clinical Reference Group, has prepared guidance for CCGs, including a template service specification and best practice guidance, for commissioning in 2017/18. [https://www.england.nhs.uk/resources/resources-for-ccgs/](https://www.england.nhs.uk/resources/resources-for-ccgs/)
6. Information Sharing with the Health & Social Care Information Centre

NHS Doncaster CCG has renewed our Data Sharing Agreement with the Health & Social Care Information Centre (HSCIC) as an Accredited Safe Haven to receive data from the HSCIC to support our effective commissioning of services. The approval is to October 2016.

7. 360 Stakeholder Survey

NHS England undertook to conduct the CCG 360° stakeholder survey for the fourth year on behalf of all CCGs. The survey aimed to assess whether relationships with stakeholders continue to be central to the effective commissioning of services by CCGs, and in doing so improve quality and outcomes for patients. As before, the survey was conducted by Ipsos MORI. We have received the results of the survey in recent weeks.

Doncaster’s overall response rate was 47%; the average response rate across the 210 CCGs within the survey was 61%. Generally, we had a higher response rate from our Health & Wellbeing Board, our NHS providers, other patient groups and our Local Authority than our peer CCGs. However we had a lower response rate from our Member Practices, and a nil response from our local Healthwatch. Not all Member Practices completed all questions.

<table>
<thead>
<tr>
<th>Overall response rate</th>
<th>GP member practices</th>
<th>Health and Wellbeing Board</th>
<th>Local Health Watch</th>
<th>Other patient groups</th>
<th>NHS providers</th>
<th>Other CCGs</th>
<th>Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster</td>
<td>47%</td>
<td>36%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>National average</td>
<td>61%</td>
<td>59%</td>
<td>60%</td>
<td>76%</td>
<td>72%</td>
<td>57%</td>
<td>75%</td>
</tr>
</tbody>
</table>

The following themes have emerged from the analysis of the report.

- Our generally positive working relationships and engagement with our stakeholders.
- A need to focus on more sustained stakeholder involvement in determining and explaining our commissioning priorities.
- A need to re-look at how we engage with and listen to our Members – a theme that has already been picked up and which is at the core of the pending review of the Locality engagement structure.
- A focus on visible leadership.

The Stakeholder Survey is one element of the feedback which we receive as an organisation to support us in evaluating and improving our relationships with stakeholders to ensure that our stakeholders’ views continue to be central to the effective commissioning of healthcare services.
There were no surprises to us as an organisation in the analysis of the survey; we were already aware of the emerging themes and trends as an organisation and in many areas were already taking action to address the issues.

We would like to take this opportunity to thank our stakeholders for the time and thought which they put into their responses. Only with an open relationship in which we can tell each other what is going well and what could be better, can we improve our partnership effectiveness as an organisation.

A summary of the report is appended to this paper and the full report can be found at www.doncasterccg.nhs.uk
NHS Doncaster CCG Stakeholder Survey Report 2016 – Analysis

1. Introduction

NHS England undertook to conduct the CCG 360° stakeholder survey for the fourth year on behalf of all CCGs. The survey aimed to assess whether relationships with stakeholders continue to be central to the effective commissioning of services by CCGs, and in doing so improve quality and outcomes for patients. As before, the survey was conducted by Ipsos MORI.

To ensure consistency and comparability of results, we used the same stakeholder list which we used in 2014/15, which is in line with the nationally mandated stakeholder types:

- Member Practices
- Providers: Acute Trust, Mental Health / Community Trust
- Local Council
- Health & Wellbeing Board
- Patient representative organisations
- Other CCGs

The Stakeholder Survey ran from 29 February 2016 to 1 April 2016. The output report was received in early May 2016.

2. Response rate

Doncaster’s overall response rate was 47%; the average response rate across the 210 CCGs within the survey was 61%.

Generally, we had a higher response rate from our Health & Wellbeing Board, our NHS providers, other patient groups and our Local Authority than our peer CCGs. However we had a lower response rate from our Member Practices, and a nil response from our local Healthwatch. Not all Member Practices completed all questions.

<table>
<thead>
<tr>
<th></th>
<th>Overall response rate</th>
<th>GP member practices</th>
<th>Health and Wellbeing Board</th>
<th>Local Health Watch</th>
<th>Other patient groups</th>
<th>NHS providers</th>
<th>Other CCGs</th>
<th>Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doncaster</strong></td>
<td>47%</td>
<td>36%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>National average</strong></td>
<td>61%</td>
<td>59%</td>
<td>60%</td>
<td>76%</td>
<td>72%</td>
<td>57%</td>
<td>75%</td>
<td>56%</td>
</tr>
</tbody>
</table>
3. Outcome report

The full nationally-produced outcome report from the survey is available on our website [www.doncasterccg.nhs.uk](http://www.doncasterccg.nhs.uk). The report covers the authorisation domains:

- Well-led organisations
- Performance
- Finance
- Planning
- Delegated functions

4. Analysis

The following themes have emerged from the analysis of the report.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Result</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working relationships and engagement</td>
<td>The majority of respondents rate their overall working relationship with us as very good or fairly good, and are very or fairly satisfied with the way that the CCG has engaged with them over the last 12 months.</td>
<td>This is a positive outcome and reflects the open, transparent and engaging CCG leadership culture which we are trying to foster.</td>
</tr>
<tr>
<td>Our commissioning priorities</td>
<td>Some respondents do not feel that we fully take their views on board and may not understand the reasons when we make commissioning decisions, and may not feel that we effectively communicate our commissioning decisions to them.</td>
<td>We recognise that not all our stakeholders feel fully involved in all aspects of commissioning. We have set out our key transformational programme areas for 2016/17+ and our primary focus for engagement in 2016/17 is on Primary Care and Intermediate Care. We hope that this sustained focus on care outside of hospital will help us to engage more fully with and involve all our stakeholders on the commissioning decisions which we need to make and explain the reasons for any areas where we cannot take all views on board.</td>
</tr>
<tr>
<td>Theme</td>
<td>Result</td>
<td>Analysis</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Member engagement</td>
<td>The survey is not representative of the views of our full Membership; 15 Member Practices took part (36%). At least half of responding Member Practices reflected that they feel they may lack:  • influence on CCG decision-making;  • systematic two-way accountability;  • involvement in the CCG’s finances;  • an understanding of the implications of service improvement plans;  • an understanding of plans to address health inequalities;  • what is required of them as Member Practices to achieve these plans.</td>
<td>Despite local encouragement and reminders from Ipsos Mori, Member Practices have tended not to engage with the survey. We therefore do not have a representative sample of views. Discussions are already taking place locally with our Member Practices to understand their preferred clinical commissioning involvement and communication mechanisms, alongside discussions on how we engage with general practice as Providers. A review of the Locality engagement structure is planned for early 2016/17. We hope that the planned full stakeholder engagement on Primary Care and Intermediate Care (see above) will support our more effective engagement with Member Practices as clinical commissioners moving forwards.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Compared to the surveys in 2014 and 2015, there is a generally deteriorating position on respondents who positively agree with the statements on leadership.</td>
<td>During the period in which the survey was running, NHS Doncaster CCG was facing some challenges including a change of leadership in Chair and Chief Officer, and other personnel changes in the senior leadership team. We now have a stable senior leadership team and are commencing a period of engagement with our Membership on how they wish to be engaged in their role as clinical commissioners. Clinical leadership visibility is to be improved through direct engagement with Member Practices through our new Chair attending monthly TARGET education events which all GPs attend.</td>
</tr>
<tr>
<td>Theme</td>
<td>Result</td>
<td>Analysis</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>Engagement with other CCGs</td>
<td>Other CCGs do not feel fully engaged with the work of our CCG.</td>
<td>We have described a place-based model of commissioning for Doncaster, which naturally limits the wider engagement. We are now engaging across a wider footprint on collaborative commissioning programmes including 999/111 and Working Together. We are engaged in the new local Sustainability &amp; Transformation Plan development across a South Yorkshire &amp; Bassetlaw footprint.</td>
</tr>
<tr>
<td>Deteriorating position</td>
<td>Compared to the surveys in 2014 and 2015, there is a generally deteriorating position on respondents who positively agree with the given statements.</td>
<td>During the period in which the survey was running, NHS Doncaster CCG was facing some challenges including a change of leadership in Chair and Chief Officer, other personnel changes in the senior leadership team, a significant financial deficit in our main Acute Foundation Trust, and contract negotiations with providers. The deteriorating position is generally expressed most clearly through the views of our Membership – see analysis above regarding Member engagement.</td>
</tr>
<tr>
<td>Feedback from organisations representing patients</td>
<td>We received generally positive feedback from organisations representing patients. There was no response to the survey from Healthwatch Doncaster.</td>
<td>Generally positive feedback from organisations representing patients is a positive outcome and reflects the partnership we are trying to develop with our patients, both in geographical communities and communities of interest. We were disappointed not to receive feedback from our partner, Healthwatch Doncaster. We hope to meet with the senior team from the new Community Interest Company of Healthwatch Doncaster which was founded on 1 April 2016 to discuss engagement moving forwards. We have now moved our Engagement</td>
</tr>
<tr>
<td>Theme</td>
<td>Result</td>
<td>Analysis</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>&amp; Experience Committee, on which Healthwatch Doncaster and Doncaster CVS are key members, from quarterly to monthly to increase engagement and involvement of our patient group representative partners in the CCG.</td>
<td>Feedback from our Providers</td>
<td>Our Providers have given generally positive feedback on our relationships. This is a positive outcome and reflects the partnership working culture which we are trying to foster alongside our more contractual relationship.</td>
</tr>
<tr>
<td>Feedback from our Providers</td>
<td>Our Providers have given generally positive feedback on our relationships.</td>
<td>Feedback from our Providers</td>
</tr>
<tr>
<td>Integrated Commissioning</td>
<td>There are different views from Local Authority colleagues on our working together on integrated commissioning.</td>
<td>Integration of Commissioning</td>
</tr>
</tbody>
</table>

5. Conclusion

The Stakeholder Survey is one element of the feedback which we receive as an organisation to support us in evaluating and improving our relationships with stakeholders to ensure that our stakeholders’ views continue to be central to the effective commissioning of healthcare services.

There were no surprises to us as an organisation in the analysis of the survey; we were already aware of the emerging themes and trends as an organisation and in many areas were already taking action to address the issues.

We would like to take this opportunity to thank our stakeholders for the time and thought which they put into their responses. Only with an open relationship in which we can tell each other what is going well and what could be better, can we improve our partnership effectiveness as an organisation.
Items to Note
Purpose of Paper - Executive Summary

This report sets out the key quality and performance issues to be noted by the NHS Doncaster Clinical Commissioning Group (NHS Doncaster CCG) Governing Body. The report covers 3 main sections this month:

- Provider Performance - main local healthcare providers
- Other services commissioned by NHS Doncaster CCG
- Items for escalation regarding Local Delivery Plan in year delivery

The performance rating, indicated by Red, Amber or Green status, denotes the current month performance and does not reflect the historic trends. This is supported by a detailed appendix (Appendix 1) which highlights performance for NHS Doncaster CCG and all local providers with regards to the main performance indicators.

The key areas of change, both positive and negative, to note since the last report are:

**Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBHFT)**
- Cancer 62 day measures – all measures were met by the Trust in February 2016.
- A&E – Performance met in April 2016 at 95.2%.
- Diagnostics – failed to meet the standard in March 2016 at 98.3%.

**Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH)**
- IAPT Recovery Rate failed to meet target at 46.4% though reliable improvement remains above 60%

**Other Commissioned Services**
- YAS – change to reporting measures

**Local Delivery Plans**
- Cancer – Breach allocation
Recommendation(s)

The NHS Doncaster CCG Governing Body is asked to:

- Note the key quality performance areas for attention

<table>
<thead>
<tr>
<th>Impact analysis</th>
<th>2.1, 2.2, 2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance Framework</td>
<td>Risks are captured in the Executive Summary</td>
</tr>
<tr>
<td>Risk analysis</td>
<td>Neutral</td>
</tr>
<tr>
<td>Equality impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Sustainability impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Financial implications</td>
<td>As identified in the report</td>
</tr>
<tr>
<td>Legal implications</td>
<td>Nil</td>
</tr>
<tr>
<td>Consultation / Engagement</td>
<td>N/A</td>
</tr>
</tbody>
</table>
INTRODUCTION

This report sets out the key quality and performance issues to be noted by the NHS Doncaster Clinical Commissioning Group (NHS Doncaster CCG) Governing Body using March data unless noted. The report covers 3 main sections this month:

- Provider Performance - main local healthcare providers
- Other services commissioned by NHS Doncaster CCG
- Items for escalation regarding Local Delivery Plan in year delivery

The report is supported by a detailed appendix (Appendix 1) which highlights performance for NHS Doncaster CCG and all local providers with regards to the main performance indicators.

SECTION 1: PROVIDER PERFORMANCE REPORT

The following section of the report details performance for each main local provider, namely DBHFT and RDASH. Performance is across a range of quality and more traditional “performance” measures. As such the report includes performance as a whole for DBHFT and Doncaster sites for RDASH, and does not simply relate to the service provided to NHS Doncaster CCG.

**Doncaster & Bassetlaw Hospitals NHS Foundation Trust**

**Governance**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>February 2016</th>
<th>March 2016</th>
<th>April 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes to the board</strong></td>
<td>A Director of People and Organisational Development was appointed subject to references and pre-employment checks in February 2016 and due to start date of 2nd May 2016.</td>
<td>None Applicable</td>
<td>None Applicable</td>
</tr>
<tr>
<td><strong>Monitor Governance Rating</strong></td>
<td>Under Review</td>
<td>Red – Subject to enforcement action</td>
<td>Red – Subject to enforcement action</td>
</tr>
<tr>
<td></td>
<td>On 1st March Monitor announced the outcome of its investigation into the potential breach of license relating to finance and governance matters, reaching the conclusion that there had been a breach of license and therefore enforcement action to remedy the breach was in order.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor will now hold regular, initially bi monthly, Enforcement Progress meetings with the Trust.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Trust have agreed main trajectories with Monitor and Doncaster CCG for the national targets for A&amp;E, RTT, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial sustainability risk rating</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Mortality

The Trust's rolling 12 month Hospital Standardised Mortality Rate (HSMR) improved for the 7th month in a row standing at 95.34 at the end of December 2015.

The Trust's Standardised Hospital Mortality Indicator (SHMI), which also includes deaths following discharge from hospital, was 1.0573 for the 12 month period ending 30th Sept 2015 which is within the expected range. Improvements in HSMR and SHMI are due to:

- A gradual reduction in crude mortality (number of patients who die in the hospital compared to the number of patients who attend for treatment).
- Improved depth of coding due to better clinical documentation.
- The provision of seven day services for end of life and palliative care.
- The enhancement of the Trust's seven day programme
- The mortality outcomes of stroke services being amongst the best in Yorkshire and Humber.
- Improved mortality rates for fractured neck of femur services.

Contractual actions 2016/17

Contract Queries: no queries issued during April 2016.
Performance Notices: zero.

Number of serious incidents reported (CCG)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Q3 2015/16 - 23</th>
<th>Q4 2015/16 - 30</th>
<th>April 2016 - 8</th>
</tr>
</thead>
</table>

Please note that the above figures include delogs.

There has been a reduction in the number of SIs reported in March. DBHFT have achieved an overall reduction in the number of SIs reported in 2015/2016 based on the number reported in 2014/2015.

Patient Experience

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Q3 2015/16</th>
<th>Q4 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints/concerns Opened</td>
<td>361</td>
<td>368</td>
</tr>
</tbody>
</table>

The annual rate of complaints is 11% less than in 2014/15 and the amount of complaints categorised as high risk reducing during the year from 7 in Quarter 1 to 2 in Quarter 4.

Clearing historical cases at a greater rate than the rate of new complaints is a key aim of improving the handling and management of complaints. Weekly monitoring and performance reporting arrangements are provided to Care Group leads, so that they can ensure that they have effective systems in place. Supportive interventions from the Patient Experience Team to help improve processes are being taken forward with each Care Group Head of Nursing or Midwifery and the Clinical Governance Lead in Diagnostic and Pharmacy Care Group. Where this is happening, improving performance is evident, with Surgical, MSK & Frailty Care Groups, while Specialties Care Group have made the greatest progress, although having a smaller number of complaints.

Actions implemented to improve the management of complaints include:

- All complaints to come through the Head of Nursing who will nominate a lead person to investigate.
- Maintain Good performance in quality of reply letters which have achieved the quality checking standard for Chief Executive approval.
- In addition to questions detailed by the complainant, further information related to practice/procedures is included in responses in order to provide a full and informative response.
• Discuss learning from complaints with individual Ward/Department Managers and
• Continue to develop action plans with evidence of completion

Friends & Family Test

Inpatients

![Graph showing Inpatient response rates over time](image)

A&E

![Graph showing A&E response rates over time](image)

Outpatients

![Graph showing Outpatients response rates over time](image)

A&E response rates nationally are lower than the rates for inpatient areas however DBHFT’s response rate has been disappointing despite exploring a number of initiatives to increase response rates, specifically, including a text messaging service. Response rates have consistently been below other Trusts across Yorkshire & the Humber (13.6%) and nationally across England, with best performance.
reaching 6.7% and the worst at 1.9%.

The Emergency department have recently reviewed their systems and processes for increasing the response rate for FFT and are also installing new boards which will include information relating to FFT for patients in the department.

The percentage of Antenatal patients recommending services was maintained at 96% with England’s average figure falling to 95%. Postnatal community recommendations fell below the national average to 96%.
Workforce

In 2015/16 DBHFT remained focused on safe staffing levels and investments were made in line with national recommendations from evidence based tools including Association of UK University Hospitals (AUKUH), e-panda, best and Birth Rate plus. Over the year more than 98% of shifts identified were filled with the nursing workforce required to meet the needs of the patients in accordance with the assessments.

The Trust have also continued work to reduce the reliance on temporary staff which was helped by the successful recruitment of 44 student nurses during the year and remain committed to developing staff and the internal management skills programme (with more than 460 participants attending one of the four developed modules). The participants range from band 1 to band 8d ensuring that all levels of staff have access to leadership development.

There has been a vast improvement in staff appraisals and the staff survey results revealed 88% of staff state they have had an appraisal in the last 12 months, compared to 65% in 2014/15. Ensuring the quality of appraisals remains high is a priority as it is recognised that staff engagement and leadership development are at the heart of quality, innovations and service improvement.

The Trust’s focus on excellence in education and training has resulted in high scores for student satisfaction and a host of other indicators including multidisciplinary learning, building the platform for future recognition in this area. The Trust is also becoming a recognised medical examinations centre due to the successful delivery of several important examinations in year.

Safety

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Never Events (cumulative)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>A further Never Event was reported during February relating to a retained swab which was removed with no harm to the patient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An investigation has been completed which has identified that there were deficits in the accuracy of record keeping and therefore the expected standard of checking was not achieved. Following this incident the accuracy of record keeping has been closely monitored and the Trust are now able to demonstrate improved compliance against the expected standards. DBHFT will continue to monitor compliance for maternity service swab counts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA (cum.)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The previously reported MRSA bacteraemia has now been attributed to March 2016 which means there have been two cases in 2015/16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Post Infection Review meeting has been held and the agreed outcome of the meeting was that the case was unavoidable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-diff Actual Trajectory (NHSE cum.)</td>
<td>13</td>
<td>16</td>
<td>22</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>20</td>
<td>24</td>
<td>28</td>
<td>32</td>
<td>36</td>
<td>40</td>
<td>44</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>
| The Trust has achieved a 27% reduction in the number of Trust attributable C-Difficile cases from 2014/15 and achieved the 2015/16 target which is a strong performance in light of a slight
increase in the number of cases reported nationally (forecast at 5247 nationally in comparison to 5233 in 2014/15).

<table>
<thead>
<tr>
<th>Hospital Acquired Pressure Ulcers (category 3, 4 and ungradeable) (target of less than 82 during 2015/16)</th>
<th>Q3 2015/16 - 11</th>
<th>Q4 2015/16 - 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust has achieved a 49.5% in year reduction of Hospital Acquired Pressure Ulcers in comparison to the previous year at 52 in total for 2015/16 against the annual target of less than 82, and also the stretch target of less than 62.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The reported figure of pressure ulcers is subject to the Root Cause Analysis (RCA) overview panel so the figures for prior months are subject to change. The governance process allows for the delogging of serious incidents if they are deemed to be unavoidable. The final decision about Hospital/ Non Hospital Acquired is confirmed following the RCA meeting which is attended by the CCG who are party to the decisions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Serious Falls (target of less than 20 during 2015/16)</th>
<th>Q3 2015/16 - 3</th>
<th>Q4 2015/16 - 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance for 2015/16 achieved target at 12 for the year against a target of 20. This is the same number of serious falls as in 2014/15. During 2015/16 the Trust has also seen a significant reduction in repeated falls; 160 in comparison to 224 in 2014/15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust invested in the Sign Up to Safety Campaign and as part of this work, the Trust has received funding to invest in a Falls Prevention Practitioner through the Fred and Ann Green Legacy. The Falls Prevention Practitioner supports the improvement of falls prevention, through Falls Champions, training and delivering the strategic steps to support reliable care processes.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Operational Effectiveness

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 week Referral to Treatment Times Incomplete Waits (target 92%)</td>
<td>93.5%</td>
<td>93.2%</td>
<td>92.7%</td>
<td>92.6%</td>
<td>92.1%</td>
<td>92.3%</td>
<td>92.1%</td>
<td>92.1%</td>
</tr>
</tbody>
</table>

Incomplete pathways in March ended at 92.1%, meeting the standard, however with 5 specialties failing to meet the 92% target of patients waiting under 18 weeks.

- Trauma and Orthopaedics 90.0%
- General Surgery 89.9%
- ENT 90.0%
- Urology 90.0%
- General Medicine 91.8%

Trajectories have been set for all the 5 specialties to be compliant by April 2016.

Current issues surrounding service performance relate to validation issues following the implementation of CaMIS, including issues with deviation from Patient Tracking Lists (PTL) process, incomplete review lists preventing patients being booked in, some clinics incorrectly set up meaning slots are not all filled, and validation taking twice as long in CaMIS compared to the previous PAS.

The impact of validation issues on the reported performance may be masking improvement that was expected to be seen in these specialties, from actions taken to reduce long waiting patients as previously reported. Following improvement in validation issues, performance will be reviewed per specialty to understand if further action needs to be taken for improvement.
Diagnostic test times (target 99%)

<table>
<thead>
<tr>
<th></th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>97.6%</td>
<td>99.5%</td>
<td>99.6%</td>
<td>98.8%</td>
<td>96.5%</td>
<td>99.5%</td>
<td>99.7%</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

Diagnostic waits failed to meet target in March, with 121 patients waiting over 6 weeks.

A number of issues have been identified in March which contributed to the reduction in performance. These are:

- Un-appointed DEXA patients (who had all been waiting less than 6 weeks) were not being included in the total waiters reported.
- Un-appointed radiology patients with an exam status of “Approved” were not being included in the total waiters. These are un-appointed patients who have been electronically vetted, and were mostly waiters under 6 weeks. There was 1 additional 6+ week waiter in MRI included in this update.
- DBHFT internal Patient Tracking List was not including patients waiting for dexa-scans who had not been allocated an appointment and therefore were not tracking them appropriately.

Compounding this, clinic lists were reduced due to clinician sickness in March, which further contributed to the breaches. The identified patients have been appointed and the reporting has been corrected. Performance is expected to be back on track and remain on track from April 2016 in line with the agreed improvement trajectory, linked to Sustainability and Transformation funding.

52 Week Waits – Incomplete Pathway

<table>
<thead>
<tr>
<th></th>
<th>DCCG</th>
<th>Other</th>
<th>NHSE</th>
<th>DBHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aug 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sept 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nov 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dec 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jan 16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feb 16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar 16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

No patients were waiting over 52 weeks at DBHFT at the end of March 2016. Work continues with the local prisons and NHS England to ensure compliance with access targets.

4 Hour access - total time in the A&E department (target 95%)

<table>
<thead>
<tr>
<th></th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
<th>Apr 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>94.5%</td>
<td>94.4%</td>
<td>95.4%</td>
<td>94.2%</td>
<td>95.5%</td>
<td>92.1%</td>
<td>92.5%</td>
<td>92.5%</td>
<td>95.2%</td>
</tr>
</tbody>
</table>
**FCMS – Urgent Care Centre Performance contributing to Total A&E Performance above**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBHFT’s April position improved, and achieved target, with 95.2% of patients being discharged or transferred within 4 hours. This is also an increase on last year’s April performance which was 94.1%.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing remains a challenge following the February reduction to agency caps. The department has had staff leave to surrounding Trusts as a result of the cap not being enforced at all Trusts which is being addressed through Working Together for a unified approach. A number of initiatives are underway to improve staffing levels including offering permanent contracts and flexible contracts where possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Handover times have deteriorated following the increases in acuity. This was compounded by East Midlands Ambulance Service stopping using Radio Frequency Identification to measure waiting times, now being dependent on a manual process which the Trust is unable to fully validate. Electronic handover screens are now in place. As performance has improved through April and acuity has reduced, an improvement is expected to be seen in handover times from April onwards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cancelled Operations (target <0.8%)**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>2.0%</td>
<td>2.9%</td>
<td>2.1%</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>

Cancelled operations performance improved in March to 1.1%.

**Outpatient DNA rate of total appointments**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.0%</td>
<td>9.1%</td>
<td>8.6%</td>
<td>9.4%</td>
<td>10.3%</td>
<td>9.5%</td>
<td>7.9%</td>
<td>7.6%</td>
<td>8.2%</td>
<td></td>
</tr>
</tbody>
</table>

DBHFT’s total DNA rate increased by 0.6% to 8.2% in March.

**Two week wait from referral to date first seen: symptomatic breast patients (target 93%)**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>93.1%</td>
<td>94.9%</td>
<td>87.7%</td>
<td>97.4%</td>
<td>94.6%</td>
<td>93.3%</td>
<td>94.9%</td>
<td>97.4%</td>
<td></td>
</tr>
</tbody>
</table>

**Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected) (target 93%)**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>93.2%</td>
<td>93.1%</td>
<td>90.8%</td>
<td>96.4%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>93.5%</td>
<td>96.6%</td>
<td></td>
</tr>
</tbody>
</table>

**31 day wait from diagnosis to first definitive treatment (target 96%)**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>98.6%</td>
<td>99.3%</td>
<td>99.4%</td>
<td>98.8%</td>
<td>98.2%</td>
<td>99.4%</td>
<td>97.6%</td>
<td>97.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**31 day wait for subsequent treatment – surgery (target 94%)**

<table>
<thead>
<tr>
<th></th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.7%</td>
<td>100%</td>
<td>87.5%</td>
<td>100%</td>
<td>90.0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>31 day wait for subsequent treatment – anti cancer drug regimen (target 98%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>31 day wait for subsequent treatment – Radiotherapy (target 94%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>62 day wait for first treatment from urgent GP referral to treatment (target 85%)</td>
<td>84.0%</td>
<td>82.6%</td>
<td>86.2%</td>
<td>81.5%</td>
<td>81.5%</td>
<td>89.3%</td>
<td>76.3%</td>
<td>85.2%</td>
<td></td>
</tr>
<tr>
<td>62 day wait for first treatment from NHS cancer screening service referral (target 90%)</td>
<td>100%</td>
<td>90.9%</td>
<td>79.4%</td>
<td>93.3%</td>
<td>91.5%</td>
<td>95.8%</td>
<td>82.4%</td>
<td>91.9%</td>
<td></td>
</tr>
</tbody>
</table>

Cancer Summary

All cancer measures met the respective standards in February 2016.

Improvement work continues across South Yorkshire and Bassetlaw as previously reported. National Cancer Breach Allocation Guidance has been produced by NHS England to provide a more refined system of cancer breach allocation between referring and treating trusts. The local network is collaboratively working and developing a local breach allocation policy and reviewing pathways. The impact of this guidance on DBHFT’s performance has been analysed, resulting in a potential risk for DBHFT where in certain scenarios, more patients may be allocated against the treating provider (often STHFT) than currently, which reduces the amount of patients in the denominator, making it more difficult to achieve the standard. For example if a patient is referred to the tertiary centre after 38 days but is treated by the tertiary centre within time, the full patient is allocated to the treating provider, instead of 0.5 to both the referring and treating provider. In conjunction with this is the potential to standardise systems (Info-flex) to streamline inter-trust referrals to make it easier to refer by day 38.

The local network group have confirmed the timescales around the policy (live from 1st April and in place by October 2016), and reporting dates and transition points. DBHFT have agreed with the CCG and NHS Improvement to meet the 62 day standard in every month of 2016/17.

<table>
<thead>
<tr>
<th>Outliers (Daily averages)</th>
<th>February 2016</th>
<th>March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most Outliers</td>
<td>Least Outliers</td>
</tr>
<tr>
<td>Medicine to Orthopaedics</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Medicine to S12</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Medicine to surgery</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Medicine to gynaecology</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>
CQUINs

2015/16

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The Quarter 4 evidence from the Trust was due at the end of February 2016. At the time of writing this report, this was not received.</td>
</tr>
</tbody>
</table>

2016/17

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The quarter 1 evidence is due from the Trust at the end of July 2016.</td>
</tr>
<tr>
<td>2</td>
<td>The quarter 2 evidence is due from the Trust at the end of October 2016.</td>
</tr>
<tr>
<td>3</td>
<td>The quarter 3 evidence is due from the Trust at the end of January 2017.</td>
</tr>
<tr>
<td>4</td>
<td>The quarter 4 evidence is due from the Trust at the end of February 2017.</td>
</tr>
</tbody>
</table>

Local Intelligence Issues

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke: direct admission within 4 hours (target 90%)</td>
<td>65.0%</td>
<td>66.7%</td>
<td>58.2%</td>
<td>60.0%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Stroke: Proportion of patients scanned within 1 hour of arrival at hospital (target 50%)</td>
<td>42.5%</td>
<td>54.8%</td>
<td>50.9%</td>
<td>51.1%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Stroke: Proportion of patients scanned within 24 hours of arrival at hospital (target 100%)</td>
<td>97.5%</td>
<td>95.2%</td>
<td>98.2%</td>
<td>93.3%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Stroke – Proportion of high risk TIA patients investigated and treated within 24 hours of first contact with a health professional (target 60%)</td>
<td>75.9%</td>
<td>80.6%</td>
<td>71.0%</td>
<td>72.2%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**Stroke Summary**

Performance has improved during January by 7.3% for direct admissions in 4 hours and by 2.9% for the proportion of patients scanned within 24 hours of arrival hospital though both remain below target. Performance for the other measures deteriorated but remained above target.

The key pathway, which has improved this month, is direct admission. Seventeen out of a total of 52 patients failed to be admitted within 4 hours. Issues remain around initial presentation as the majority of patients, who were not directly admitted, waited over 10 hours as their presenting symptoms were not suggestive of a stroke.

The Stroke Network is due to make their final decisions on the future of hyper acute stroke units (HASU) in the next few months. The Trust is assessing the current service both for quality and performance metrics to perform as a HASU, as well as the potential additional requirements in terms of beds and staffing.
In addition to RDASH performance reports the CCG has developed Mental Health Service and Community Nursing Service Performance, Quality and Outcome Framework which are used to review and monitor service delivery and service trends. The reporting framework and the governance structure are documented within the 2016/17 contract.

The same process is being developed for specialist community services and the Trust has started work on producing a dashboard for the Continence Service and a Children’s Community Nursing Service. The reporting framework and governance has been included within the 2016/17 contract.

### Governance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of serious incidents reported</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Monitor Governance Rating</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Monitor Financial sustainability risk rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

No evident concerns.

Contractual Actions

No contractual actions were undertaken during March 2016.

### Patient Experience

**Friends and Family Test**

**Mental Health**

Performance has improved in February to 83% though is still below the national average. Detailed comments for all FFT areas are shared with DCCG’s Patient Experience Manager and the Trust share learning across their service teams.
The percentage of people recommending community services in Doncaster improved during February and the response rate remains lower than the England average at 0.21% (national 3.6%).

Workforce

<table>
<thead>
<tr>
<th>Time Period</th>
<th>March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview by exception</strong></td>
<td>Skelbrooke – On 2 red shifts the qualified staff nurse called in sick at short notice therefore the ward were unable to cover the absence. The late staff nurse stayed until midnight. On the following shift the same qualified staff had been booked in for overtime which left the later shift rated red also. On another 2 red shifts a Nursing Assistant rang in sick and the ward were unable to cover with bank staff or overtime. Other wards and the bleep holder were notified. Coral - Rated low for qualified staff due to working on the minimum staffing level of 1 Qualified (Q) and 3 Non Professionally Qualified (NPQ) staff per day shift as opposed to the optimum staffing level of 2Q and 2 NPQ staff per day shift. The ward never fell below its minimum safe staffing levels during this period. Factors which influenced staffing ratios : • Qualified nurse remained on long term sick leave and the shortfall was made up by NPQ staff • A second Qualified nurse commenced a period of sick leave. • The new recruit to the Qualified nurse establishment has been awarded their registration. During weekdays the ward also have up to 4 AHPs on duty between 9/5 as well as the Qualified Ward Manager. Hawthorne – A total of 14 shifts were rated amber-red following additional patient need and staff sickness. These shifts were supported by additional NPQs and staff from Hazel ward. No incidents occurred and the ward remained safe.</td>
</tr>
</tbody>
</table>

Safety

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Never Events</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

After initial fact finding an incident that had previously been reported as a Never Event, was found not to have met the criteria. Following discussion with DCCG, it was agreed that the incident should be delogged. The Incident will continue to be
Operational Effectiveness

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Sept 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
<th>Feb 16</th>
<th>Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access to psychological services - the proportion of people who complete treatment who are moving to recovery (Target – 50%)</td>
<td>49.8%</td>
<td>53.4%</td>
<td>51.0%</td>
<td>50.9%</td>
<td>61.6%</td>
<td>57.2%</td>
<td>46.4%</td>
</tr>
</tbody>
</table>
| The Recovery rate fell again to 46.4% in March 2016 which is below the 50% target for people moving to recovery. Performance for the year did achieve target at 50.8%. The Trust are currently investigating the drop in performance and a meeting is scheduled with Commissioners to discuss recent changes to the data warehouse supporting this dataset.

Despite under performance for the recovery rate measure the percentage of people showing reliable improvement but not moving to recovery is at 66.1% for March, and 63.4% for the year as a whole.

| Improving Access to Psychological Therapies (IAPT), cumulative – Access (Target 3.75% per quarter, 15% annually) | 8.8% | 10.4% | 11.9% | 13.3% | 14.7% | 16.3% | 17.4% |
| IAPT – Reliable Improvement (no target) | 64.7% | 62.0% | 63.0% | 64.9% | 66.3% | 68.8% | 66.1% |
| Percentage of referrals | 90.2% | 87.3% | 87.3% | 87.6% | 82.8% | 86.7% | 87.5% |

These cases are attributed to NHS Doncaster CCG and apportioned to RDASH. If RDASH services are involved in the clinical management of the patient the root cause analysis is carried out by the RDASH Infection Prevention and Control Team.

Out of the 6 C-diff cases taken to Post Infection Review Panel only 1 was identified as having a lapse in care.
### Percentage of referrals to IAPT who have received 1st treatment within 6 weeks (target 75%)

|          | 99.2% | 99.6% | 99.4% | 99.1% | 99.4% | 98.9% | 99.4% |

### Percentage of referrals to IAPT who have received 1st treatment within 18 weeks (target 95%)

|          | 92.8% | 90.1% | 90.5% | 91.6% | 91.3% | 92.0% | 91.6% |

The service continues to review the 47 patients with outstanding S117 reviews. Actions to address this include:

- Service Leads are focusing on teams with the most outstanding reviews which include Intensive Community Therapies, Social Inclusion and Recovery.
- Outstanding reviews are monitored on a weekly basis with daily reports available on the RePortal (internal Trust monitoring system).
- Continued emphasis on the importance of getting appointments booked in and monitored in regular team meetings.

### Adults receiving a 12 month S117 review compliance (Target 95%)

|          | 92.8% | 90.1% | 90.5% | 91.6% | 91.3% | 92.0% | 91.6% |

### The percentage of older people patients requiring non urgent treatment (mental health) who receive treatment within 6 weeks of assessment (8 week pathway) (Target 85%)

|          | 92.6% | 66.9% | 68.8% | 81.1% | 78.4% | 78.5% | 86.3% |

### The percentage of new patient waits for podiatry within 18 weeks (target 95%)

|          | 100%  | 100%  | 100%  | 100%  | 100%  | 100%  | 100%  |

### The percentage of patients seen within 18 weeks of referral to Evergreen Falls Prevention Service (target 95%)

|          | 100%  | 100%  | 100%  | 100%  | 88.8% | 100%  | 100%  |

### The percentage of patients seen within 18 weeks of referral to Dietician (target 95%)

|          | 100%  | 100%  | 100%  | 100%  | 98.8% | 99.0% | 100%  |

### Percentage of urgent

<p>|          | 100%  | 100%  | 98.9% | 100%  | 100%  | 100%  | 98.0% |</p>
<table>
<thead>
<tr>
<th>referrals to CAMHS triaged within 24 hours of receipt (target 98%)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of urgent referrals to CAMHS assessed within 24 hours of receipt (target 98%)</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of assessed patients starting their treatment plan within 8 weeks of referral (target 95%)</td>
<td>97.8%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>85.2%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Percentage of patients who have an agreed their Care Pathway and Treatment Plan (target 100%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### CQUINs

**2016/17**

**Quarter 1**
The quarter 1 evidence is due from the Trust at the end of July 2016.

**Quarter 2**
The quarter 2 evidence is due from the Trust at the end of October 2016.

**Quarter 3**
The quarter 3 evidence is due from the Trust at the end of January 2017.

**Quarter 4**
The quarter 4 evidence is due from the Trust at the end of February 2017.

### Local Intelligence Issues

<table>
<thead>
<tr>
<th>Time Period</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services Dataset (MHDS)</td>
<td>Nationally there has been a complete change to the structure of the Mental Health Data Set, with December 2015 being the last reporting month. January 2016 data will be based on the new MHSDS which is a completely new structure. RDaSH has commenced the national submission of the dataset, but it is not yet ready to share with the CCG. Refreshed data back to January 2016 will be shared with the CCG once available. The new MHSDS covers mental health services provided to Adults, Older People, Children and Learning Disability clients. From October 2015 the Children and Young People’s Health Service Dataset commenced national submission. This set contains all community health interventions for children and young people. Again, RDASH has commenced the national submission but is not yet at a point where the data can be shared with the CCG. Once this dataset is fully embedded, it is proposed that it will be extended to include adult community</td>
</tr>
</tbody>
</table>

---

18
Therefore, at this moment in time, the CCG is not receiving any datasets relating to RDASH-provided services. However, going forward, the new datasets will provide a far better picture of the services that RDASH are providing. It is hoped that data will start to be shared with DCCG in July 2016.
SECTION 2: OTHER COMMISSIONED SERVICES

2.1 FCMS

As a new provider in Doncaster FCMS continue to review the quality of their data and are currently migrating to an improved performance reporting tool. As a result figures reported to the CCG may be subject to change. More recent changes in service delivery with regards to the use of NHS Pathways to manage some of the out of hours calls has also resulted in some further work being required to ensure that the total number of calls is captured. As a result the performance data has not been included in this month’s report. FCMS continue, however, to report performance through to the CCG. This includes exception reporting for all patients that are not seen within the allocated timescale, explaining the reasons why and actions being taken. At this point there are no significant issues to raise. FCMS are a core part of the Doncaster urgent care system and regularly attend the System Resilience Group and the weekly Operational Group. Their input and working relationships with partner organisations during the Tour de Yorkshire for example, was clearly evident in those forums.

2.2. Yorkshire Ambulance Service (YAS)

NHS Doncaster CCG YAS Performance:

<table>
<thead>
<tr>
<th></th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1 MTD</td>
<td>72.03%</td>
<td>68.18%</td>
<td>59.13%</td>
<td>68.97%</td>
<td>62.88%</td>
<td>64.47%</td>
</tr>
<tr>
<td>R1 YTD</td>
<td>71.05%</td>
<td>70.66%</td>
<td>69.24%</td>
<td>69.21%</td>
<td>68.50%</td>
<td>68.04%</td>
</tr>
<tr>
<td>R2 MTD</td>
<td>66.96%</td>
<td>65.54%</td>
<td>64.41%</td>
<td>65.79%</td>
<td>64.01%</td>
<td>64.80%</td>
</tr>
<tr>
<td>R2 YTD</td>
<td>67.99%</td>
<td>67.65%</td>
<td>67.22%</td>
<td>67.05%</td>
<td>66.75%</td>
<td>64.48%</td>
</tr>
</tbody>
</table>

NHS England have conducted a clinically led and evidence-based review of the current call coding systems and NHS performance standards to ensure they make sense for patients and are operationally well-designed. There has now been confirmation that the result is a new call coding set which will be trialled in two sites - South Western Ambulance Service NHS Foundation Trust and Yorkshire Ambulance Service - for a minimum of 12 weeks from April 2016.

Academic partners at Sheffield University’s School of Health And Related Research (ScHARR) have overseen and assured the process to date, and the trial will be monitored by an operational group chaired by the Association of Ambulance Chief Executives (AACE), reporting to the ARP Expert Reference Group and Steering Group. This work has also been shared with NHS England’s national stakeholder group, including patient and public representatives.

In order to ensure patients will continue to receive safe and timely care during the trial NHS England are implementing an enhanced system of data collection and monitoring, over and above that which is usually available, including 48 hour review of any potential serious incidents and accelerated clinical outcome reporting. These data will be monitored by the operational and expert reference groups, with independent academic input from Sheffield University. A set of critical review criteria has been agreed, along with a process to stop the trial and revert to the current system if necessary.

An evaluation of this pilot is expected in the summer of 2016.
Performance reporting started from 21\textsuperscript{st} April so full information will be provided for these figures from May 2016.

The new standards have been defined as:
Red – Life-threatening; Time critical life-threatening event needing immediate intervention and/or resuscitation; 8 minute target.

Amber – Emergency; Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport; 19 minute target.

Green – Urgent; Urgent problem (not immediately life-threatening) that needs transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management; 60 minute target.

The details of the proposed Collaborative Commissioning arrangements for YAS are also to be discussed under a separate paper, with the request of all Yorkshire and Humber CCGs to have agreed to an arrangement by the end of May.

2.3 Nursing / Care Homes / Domiciliary Care Providers

The information provided within this section is taken up to 30 April 2016. Since the last Governing body meeting there have been 0 new embargoes against admissions / new care packages placed. There has been 0 embargoes lifted or restrictions put in place.

At present there are 3 providers within Doncaster with embargoes in place and 0 providers with restrictions in place.

2.4 Care Home Strategy

Version 7 of the Care Home Strategy was presented at the Care Home Executive Group in April 2016, where suggestions and comments were received. The Care Home Strategy has now been finalised, taking into account the comments from the group and distributed to all members for review.

Following this last stage of the review it is intended the Strategy will then be ready for consideration and approved by appropriate groups.

2.5 Serious Case Reviews / Lesson Learnt Reviews

No new Serious Case Reviews or Lessons Learnt Reviews have been recommended or commissioned since the last Governing Body Report.

2.6 Industrial Action

Further industrial action was undertaken by junior doctors 6\textsuperscript{th} – 7\textsuperscript{th} April and 26\textsuperscript{th} – 27\textsuperscript{th} April, the second of which encompassed emergency care. Planning and preparation was undertaken to ensure that all Trusts continued to deliver clinically safe services to all patients through integrated planning.

DBHFTs planning required cancellation of elective and non-urgent outpatient appointments and support from consultant colleagues was provided in line with their
overall duty of care and in support of their junior colleagues. Significant support was also required from senior nurses and other practitioners and allied staff.

No serious incidents have been identified from these time periods and patients are being rebooked as soon as possible.

2.7 Childrens Local Priority Scheme – Quarter 4

The report provides an update on Team Doncaster’s (health and social care Commissioners and Providers) local transformation plan at the end of Q4.

<table>
<thead>
<tr>
<th>Local Priority Scheme</th>
<th>Current Stage of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish named mental health and wellbeing leads in schools (internal)</td>
<td>72% positive response from schools/ academies</td>
</tr>
<tr>
<td>Continuous consultation and engagement with children, young people and families</td>
<td>Young Minds awarded the contract and work began on 1st March 2016.</td>
</tr>
<tr>
<td>Appointment of workforce development lead</td>
<td>Consultant began on 14th March and is in the audit stage. Using pilot sites for deeper dive audit.</td>
</tr>
<tr>
<td>Audit and rolling training programme</td>
<td>As above</td>
</tr>
<tr>
<td>Develop an ‘innovation partnership’ approach with a local university to deliver an accredited training programme with nationally recognised modules</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
<tr>
<td>CAMHs worker to be embedded in the Early Help Hub</td>
<td>Currently 1WTE in post developing links and working through the logistics of embedding into the hub.</td>
</tr>
<tr>
<td>Named CAMHs leads in schools &amp; Primary Care</td>
<td>25% of new resource in place. Other 75% out to advert.</td>
</tr>
<tr>
<td>Supporting self care</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
<tr>
<td>Development of single point of access</td>
<td>Proprietary work is underway to integrate CAMHs referrals into Early Help Hub to form a single point of access.</td>
</tr>
<tr>
<td>Further develop evidence base</td>
<td>One CAMHs worker booked onto CBT course.</td>
</tr>
<tr>
<td>Implement all areas of the crisis care concordat</td>
<td>24/7 crisis helpline went live in September 2016, CAMHs liaison and interface function model agreed with eight applicants, expect someone in post in July 2016. Liaison and diversion service is increasing it’s understanding of CYP services. On-going regional work on crisis response based on recent workshops. Police cell not to be used as a place of safety from 1st January 2016 and local system set-up. The mapping of all age psychiatry services has been completed. Exploring local crisis solutions in parallel with regional work.</td>
</tr>
<tr>
<td>Intensive home treatment service to be provided</td>
<td>Service model being explored and posts are out to advert.</td>
</tr>
<tr>
<td>Expansion of peer mentoring service</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
<tr>
<td>Enhance the current assessment process to include sensitive enquiries</td>
<td>Audit of 50 cases files to check current skills and if the questions are routinely being asked.</td>
</tr>
<tr>
<td>Enhance the current do not attend policy</td>
<td>Dip sample audit of policy compliance</td>
</tr>
<tr>
<td>Develop multi-agency teams</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
<tr>
<td>Improved community paediatric services (inc ASD and ADHD)</td>
<td>Reductions in waiting times for both and improved quality of assessments. Both are NICE compliant</td>
</tr>
<tr>
<td>Development of domestic violence multi-agency teams</td>
<td>Multi-agency teams are in place</td>
</tr>
<tr>
<td>Provision of eating disorder community services</td>
<td>Services began on 1st March 2016 and this will be a phased evolution of service. Posts are out to advert and education element is in place ready for delivery from April 2016.</td>
</tr>
<tr>
<td>Redeploy generic staff currently seeing ED cases now seen by community team to improve access to self-harm and crisis and invest underspend from ED funds</td>
<td>Not intended for 2016/17 implementation</td>
</tr>
</tbody>
</table>
2.8 2016/17 DBHFT and RDASH CQUIN Scheme Overview

The National CQUIN scheme for 2016/17 focuses on 5 indicators and has been influenced by the ambitions of the 5 Year Forward View (FYFV). The local scheme has been developed and fits with ambitions of the local area aligned with Sustainability and Transformation Plans.

The table below shows each element and also the providers it is relevant to. Finances (based on 2.5% of the contract value) have been proportioned and agreed by relevant financial and contracting teams. Based on the guidance there is 1% contract value for the local DBHFT CQUIN scheme and 1.5% contract value for the local RDASH CQUIN scheme. The rest is indicated against the National scheme.

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Staff Health and Wellbeing</td>
</tr>
<tr>
<td>2</td>
<td>Identification and early treatment for sepsis</td>
</tr>
<tr>
<td>3</td>
<td>Improving the physical health for patients with severe mental illness (PSMI)</td>
</tr>
<tr>
<td>4</td>
<td>Cancer 62 day waits</td>
</tr>
<tr>
<td>5</td>
<td>Antimicrobial resistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Indicator</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Patient Safety – maintenance of quality based on Financial recovery plans</td>
</tr>
<tr>
<td>7</td>
<td>Discharge of MDTs – continuation of 15/16 scheme</td>
</tr>
<tr>
<td>8</td>
<td>End of Life MDTS – continuation of 15/16 scheme</td>
</tr>
<tr>
<td>9</td>
<td>Pressure Ulcer reduction against sign up to safety pledge to reduce avoidable pressure ulcers by 50% by 2017</td>
</tr>
<tr>
<td>10</td>
<td>Holistic Patient Care</td>
</tr>
</tbody>
</table>

SECTION 3: NHS Doncaster CCG Local Delivery Plans- Items to note

Cancer

The National Cancer Breach Allocation – as reported above in DBHFT section.
### Doncaster CCG 2015/16 Performance Report

#### A&E

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Pass Condition</th>
<th>Fail Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>T</strong> A&amp;E waiting time - Maximum waiting time of 4 hours in the A&amp;E department (DBHFT)</td>
<td>Equal to or greater than 95%</td>
<td>Less than 95%</td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>11663 12632 12129 12499 11278 11515 11304 10236 11211 10405 9976 11545 11365</td>
</tr>
<tr>
<td></td>
<td>Less than baseline</td>
<td>Greater than 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11365 11856 11834 12165 11780 11527 11902 10881 13370 11294 10706 11856 11762</td>
</tr>
</tbody>
</table>

| | Baseline | 14746 15855 15131 15110 14003 14275 13916 12817 14144 13099 12548 14800 14396 |
| | Less than baseline | Greater than 5% |
| | | 14396 15058 14739 15048 14602 14399 13603 13229 13370 12750 12176 14679 12350 |

| | Baseline | 7950 8612 8251 8477 7623 7838 7614 6925 7548 7035 6774 7769 7540 |
| | N/A | 7540 7935 7902 8139 7825 7688 7155 6978 7026 7376 6815 7360 7811 |
| % of patients seen within 4 hours at DRI | Equal to or greater than 95% | Less than 92% |
| | Baseline | 3713 4020 3878 4022 3655 3677 3690 3311 3663 3370 3202 3776 3825 |
| | N/A | 3825 3921 3912 4026 3955 3639 3843 3903 3913 3918 3891 4496 3951 |
| % of patients seen within 4 hours (Bassetlaw) | Equal to or greater than 95% | Less than 95% |
| | Baseline | 72.4% 73.2% 71.4% 70.6% 69.7% 68.9% 68.8% 67.4% 67.2% |
| | N/A | 72.4% 73.2% 71.4% 70.6% 69.7% 68.9% 68.8% 67.4% 67.2% |
| T Trolley waits in A&E | Equal to or less than 12 Hours | Greater than 12 Hours |
| | 0 0 0 0 0 0 0 0 0 0 0 0 0 |

#### Ambulance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Pass Condition</th>
<th>Fail Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C</strong> Ambulance clinical quality – Category A (Red 1) 8 minute response time YAS</td>
<td>Equal to or greater than 75%</td>
<td>Less than 71.25%</td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>74.9% 73.7% 69.4% 70.8% 68.7% 70.3% 74.5% 73.7% 69.0% 69.0% 69.5% 68.5%</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>75.6% 76.7% 74.8% 74.5% 73.6% 72.9% 73.3% 71.9% 72.6%</td>
</tr>
</tbody>
</table>

| | Baseline | 72.7% 73.5% 70.4% 70.1% 70.0% 70.4% 72.6% 73.3% 71.0% 72.5% 72.0% 70.2% |
| | N/A | 72.7% 73.5% 70.4% 70.1% 70.0% 70.4% 72.6% 73.3% 71.0% 72.5% 72.0% 70.2% |

| | Baseline | 96.2% 96.3% 95.3% 95.3% 95.0% 95.3% 95.3% 95.3% 93.9% 94.7% 94.3% 93.7% |
| | N/A | 95.0% 95.3% 94.4% 93.8% 93.5% 93.2% 93.0% 92.6% 92.5% |

| | Baseline | 69.6% 71.4% 69.0% 67.0% 64.7% 66.4% 67.0% 65.5% 64.5% 68.5% 61.0% 64.8% |
| | N/A | 64.4% 75.9% 75.3% 71.6% 67.3% 71.1% 72.0% 68.2% 55.1% 60.0% 62.9% 64.5% |
## Doncaster CCG 2015/16 Performance Report

### Key:
- **CCG**: CCG related Targets
- **DBHFT**: DBHFT
- **RDaSH**: RDaSH
- **Misc**: Misc Delivery Plans
- **TBC**: No Data Available

### Doncaster CCG 2015/16 Performance Report

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Ambulance clinical quality - Category A 19 minute transportation time DONC</td>
<td>Equal to or greater than 95%</td>
<td>Less than 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>All handovers between ambulance and A&amp;E must take place within 15 minutes - those over 30 minutes</td>
<td>0</td>
<td>Greater than 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>All handovers between ambulance and A&amp;E must take place within 15 minutes - those over 60 minutes</td>
<td>0</td>
<td>Greater than 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>All cancer two week wait</td>
<td>Equal to or greater than 93%</td>
<td>Less than 88%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>Equal to or greater than 93%</td>
<td>Less than 88%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis</td>
<td>Equal to or greater than 96%</td>
<td>Less than 91%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The new standards are defined at the bottom of the report. The data provided is prior to signoff via YAS and is subject to change.
## Doncaster CCG 2015/16 Performance Report

### Key:
- **CCG**
- **DBHFT**
- **RDaSH**
- **ND** (No Data Available)
- **T** (Trust Targets)
- **C** (CCG related Targets)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C 11-day standard for subsequent cancer treatment - anti cancer drug regimens</td>
<td>Equal to or greater than 98%</td>
<td>Less than 87%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.3%</td>
<td>100.0%</td>
<td>97.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C 11-day standard for subsequent cancer treatments - radiotherapy</td>
<td>Equal to or greater than 94%</td>
<td>Less than 89%</td>
<td>100.0%</td>
<td>97.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C 11-day standard for subsequent cancer treatments - surgery</td>
<td>Equal to or greater than 94%</td>
<td>Less than 89%</td>
<td>98.5%</td>
<td>100.0%</td>
<td>95.2%</td>
<td>96.9%</td>
<td>96.7%</td>
<td>90.9%</td>
<td>100.0%</td>
<td>95.8%</td>
<td>100.0%</td>
<td>85.0%</td>
<td>81.8%</td>
<td>86.4%</td>
<td></td>
</tr>
<tr>
<td>C Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer</td>
<td>Equal to or greater than 85%</td>
<td>Less than 80%</td>
<td>77.6%</td>
<td>87.5%</td>
<td>86.2%</td>
<td>85.0%</td>
<td>77.4%</td>
<td>81.0%</td>
<td>77.2%</td>
<td>77.2%</td>
<td>83.87%</td>
<td>75.5%</td>
<td>81.1%</td>
<td>83.9%</td>
<td></td>
</tr>
<tr>
<td>C Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service</td>
<td>Equal to or greater than 90%</td>
<td>Less than 85%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>88.2%</td>
<td>100.0%</td>
<td>88.9%</td>
<td>78.6%</td>
<td>100.0%</td>
<td>94.4%</td>
<td>93.75%</td>
<td>75.0%</td>
<td>87.5%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>C Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status</td>
<td>Equal to or greater than 90%</td>
<td>Less than 85%</td>
<td>82.4%</td>
<td>88.9%</td>
<td>88.9%</td>
<td>76.2%</td>
<td>79.0%</td>
<td>86.7%</td>
<td>83.3%</td>
<td>90.9%</td>
<td>82.14%</td>
<td>83.3%</td>
<td>88.9%</td>
<td>89.5%</td>
<td></td>
</tr>
<tr>
<td>T All cancer two week wait.</td>
<td>Equal to or greater than 93%</td>
<td>Less than 88%</td>
<td>93.6%</td>
<td>94.7%</td>
<td>92.5%</td>
<td>93.2%</td>
<td>93.1%</td>
<td>90.8%</td>
<td>96.4%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.5%</td>
<td>96.6%</td>
<td>94.5%</td>
<td></td>
</tr>
<tr>
<td>T Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>Equal to or greater than 93%</td>
<td>Less than 88%</td>
<td>94.4%</td>
<td>94.6%</td>
<td>95.7%</td>
<td>93.1%</td>
<td>94.9%</td>
<td>97.7%</td>
<td>97.4%</td>
<td>94.6%</td>
<td>93.3%</td>
<td>94.9%</td>
<td>97.4%</td>
<td>96.3%</td>
<td></td>
</tr>
<tr>
<td>T Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis</td>
<td>Equal to or greater than 96%</td>
<td>Less than 91%</td>
<td>98.4%</td>
<td>99.3%</td>
<td>98.9%</td>
<td>98.3%</td>
<td>99.3%</td>
<td>99.4%</td>
<td>98.6%</td>
<td>98.2%</td>
<td>99.4%</td>
<td>97.6%</td>
<td>97.6%</td>
<td>97.9%</td>
<td></td>
</tr>
<tr>
<td>T 11-day standard for subsequent cancer treatments - anti cancer drug regimens</td>
<td>Equal to or greater than 98%</td>
<td>Less than 87%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>T 11-day standard for subsequent cancer treatments - surgery</td>
<td>Equal to or greater than 94%</td>
<td>Less than 89%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>95.7%</td>
<td>100.0%</td>
<td>87.5%</td>
<td>100.0%</td>
<td>90.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
### Doncaster CCG 2015/16 Performance Report

### Indicator Pass Condition Fail Condition

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doncaster CCG 2015/16 Performance Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Q1 Q2 Q3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or greater than 85%</td>
<td>Less than 82%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or greater than 90%</td>
<td>Less than 85%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Mental Health Measure – Care Programme Approach (CPA) - The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days (stretch local target)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or greater than 95%</td>
<td>Less than 90.25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Mental Health Measure- Improved access to psychological services - The proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or ‘captured’ by referral routes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or greater than 7.5%</td>
<td>Less than 7.125%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Incidence of healthcare associated infection: MRSA bacteraemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or less than 46</td>
<td>Greater than 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Incidence of healthcare associated infection: C. difficile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to or less than 20</td>
<td>Greater than 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key:
- **T** = Trust Targets
- **C** = CCG related Targets
- **ND** = No Data Available
# Doncaster CCG 2015/16 Performance Report

## Key:
- **CCG**
- **DBHFT**
- **RDaSH**
- **Misc**
- **ND** (No Data Available)

### T = Trust Targets
### C = CCG related Targets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Measure</strong>: Improved access to psychological services - The proportion of people who complete treatment who are moving to recovery (Target)</td>
<td>Equal to or greater than 50%</td>
<td>Less than 47.50%</td>
<td>48.3%</td>
<td>50.8%</td>
<td>51.7%</td>
<td>43.9%</td>
<td>46.5%</td>
<td>49.8%</td>
<td>53.4%</td>
<td>51.0%</td>
<td>50.9%</td>
<td>61.6%</td>
<td>57.2%</td>
<td>46.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Mixed Sex Accommodation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Mixed Sex Accommodation (MSA) Breaches CCG</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>T Mixed Sex Accommodation (MSA) Breaches (DBHFT)</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>T Mixed Sex Accommodation (MSA) Breaches (RDaSH)</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Cancelled Operations - All patients who operations cancelled for non clinical reasons to be offered another binding date within 28 days</td>
<td>0</td>
<td>Greater than 0</td>
<td>11</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Stroke &amp; TIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Stroke: proportion of patients scanned within 4 hours of arrival at hospital</td>
<td>Equal to or greater than 90%</td>
<td>Less than 85.5%</td>
<td>80.8%</td>
<td>83.6%</td>
<td>88.7%</td>
<td>67.3%</td>
<td>68.2%</td>
<td>65.0%</td>
<td>66.7%</td>
<td>58.2%</td>
<td>60.0%</td>
<td>67.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Stroke: proportion of patients scanned within 1 hour of arrival at hospital</td>
<td>Equal to or greater than 50%</td>
<td>Less than 45%</td>
<td>43.4%</td>
<td>43.6%</td>
<td>52.6%</td>
<td>42.5%</td>
<td>54.8%</td>
<td>58.9%</td>
<td>51.1%</td>
<td>50.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Stroke: proportion of patients scanned within 24 hours of arrival at hospital</td>
<td>100%</td>
<td>Less than 95%</td>
<td>98.1%</td>
<td>94.5%</td>
<td>100.0%</td>
<td>97.5%</td>
<td>95.2%</td>
<td>98.2%</td>
<td>93.3%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Stroke: Proportion of patients scanned within 24 hours of first contact with a professional</td>
<td>Equal to or greater than 60%</td>
<td>Less than 57%</td>
<td>59.2%</td>
<td>78.8%</td>
<td>73.9%</td>
<td>79.4%</td>
<td>79.3%</td>
<td>75.9%</td>
<td>80.6%</td>
<td>71.0%</td>
<td>72.2%</td>
<td>66.7%</td>
<td>70.0%</td>
<td>81.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Waiting Times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Number of 52 week Referral to Treatment Pathways - the number of admitted pathways greater than 52 weeks for admitted patients whose clocks stopped during the period on an adjusted basis</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Number of 52 week Referral to Treatment Pathways - the number of non-admitted pathways greater than 52 weeks for non-admitted patients whose clocks stopped during the period</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Number of 52 week Referral to Treatment Pathways - the number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period</td>
<td>0</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>T</td>
<td>Diagnostic test waiting times</td>
<td>Equal to or greater than 99%</td>
<td>Less than 99%</td>
<td>97.4%</td>
<td>98.2%</td>
<td>99.4%</td>
<td>99.6%</td>
<td>97.6%</td>
<td>99.5%</td>
<td>95.6%</td>
<td>98.8%</td>
<td>96.5%</td>
<td>99.5%</td>
<td>99.7%</td>
<td>98.3%</td>
</tr>
<tr>
<td>C</td>
<td>Diagnostic test waiting times</td>
<td>Equal to or greater than 99%</td>
<td>Less than 99%</td>
<td>97.7%</td>
<td>97.8%</td>
<td>99.5%</td>
<td>97.7%</td>
<td>99.4%</td>
<td>99.6%</td>
<td>99.1%</td>
<td>97.5%</td>
<td>99.5%</td>
<td>99.7%</td>
<td>98.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All first outpatient attendances</td>
<td>Equal to or less than 7446</td>
<td>Greater than 7818</td>
<td>7615</td>
<td>7990</td>
<td>7183</td>
<td>7777</td>
<td>6842</td>
<td>8174</td>
<td>7695</td>
<td>7816</td>
<td>7404</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis</td>
<td>N/A</td>
<td>N/A</td>
<td>90.4%</td>
<td>90.4%</td>
<td>91.2%</td>
<td>81.9%</td>
<td>80.9%</td>
<td>80.5%</td>
<td>80.5%</td>
<td>81.2%</td>
<td>82.5%</td>
<td>79.1%</td>
<td>79.4%</td>
<td>77.6%</td>
</tr>
<tr>
<td>T</td>
<td>The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period</td>
<td>N/A</td>
<td>N/A</td>
<td>95.0%</td>
<td>95.7%</td>
<td>95.2%</td>
<td>92.7%</td>
<td>93.7%</td>
<td>93.4%</td>
<td>92.3%</td>
<td>91.7%</td>
<td>90.1%</td>
<td>89.4%</td>
<td>88.8%</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period</td>
<td>Equal to or greater than 92%</td>
<td>Less than 87%</td>
<td>93.7%</td>
<td>93.7%</td>
<td>93.5%</td>
<td>93.4%</td>
<td>93.5%</td>
<td>93.2%</td>
<td>92.7%</td>
<td>92.6%</td>
<td>92.1%</td>
<td>92.3%</td>
<td>92.1%</td>
<td>92.1%</td>
</tr>
<tr>
<td>C</td>
<td>Percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period</td>
<td>N/A</td>
<td>N/A</td>
<td>95.6%</td>
<td>95.8%</td>
<td>95.4%</td>
<td>94.3%</td>
<td>94.1%</td>
<td>94.0%</td>
<td>92.8%</td>
<td>91.7%</td>
<td>91.8%</td>
<td>90.4%</td>
<td>89.6%</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis</td>
<td>N/A</td>
<td>N/A</td>
<td>84.8%</td>
<td>86.2%</td>
<td>86.6%</td>
<td>81.3%</td>
<td>82.5%</td>
<td>80.5%</td>
<td>79.4%</td>
<td>81.2%</td>
<td>82.7%</td>
<td>78.7%</td>
<td>79.8%</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period</td>
<td>Equal to or greater than 92%</td>
<td>Less than 87%</td>
<td>93.6%</td>
<td>93.8%</td>
<td>93.6%</td>
<td>93.5%</td>
<td>93.6%</td>
<td>93.3%</td>
<td>92.4%</td>
<td>92.6%</td>
<td>92.3%</td>
<td>92.3%</td>
<td>92.8%</td>
<td>92.7%</td>
</tr>
</tbody>
</table>
Doncaster CCG 2015/16 Performance Report


* The new standards for YAS are as followed:
Red – Life-threatening; Time critical life-threatening event needing immediate intervention and/or resuscitation; 8 minute target.

Amber – Emergency; Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport; 19 minute target.

Green – Urgent; Urgent problem (not immediately life-threatening) that needs transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management; 60 minute target.

Further Detail on Amber Codes

Amber R – a patient who does not have an immediately life threatening condition but requires an emergency response. Their condition/problem requires assessment/management on scene and it is likely that they will require conveyance to hospital. Example – patients having a heart attack (MI) require on scene management by a clinician AND conveyance to an appropriate facility (PPCI).

Amber T – a patient who does not have an immediate life threatening condition but requires an emergency response. Their condition/problem is time dependant on reaching definitive care and therefore a conveying resource is the most important. Example Stroke (CVA) patients require rapid transport to a hyper-acute stroke unit or other appropriate facility.

Amber F – a patient who does not have an immediate life threatening condition but does require an emergency response. Their condition/problem may well be managed on scene by a clinician and may or may not require onward referral. Example – hypoglycaemia.
Paper A

Commissioners Working Together Board  
Meeting held 2 February 2016, in the Boardroom, Doncaster CCG

Decision Summary for CCG Boards

<table>
<thead>
<tr>
<th></th>
<th>Minutes of the previous meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CWTB 01/16</td>
</tr>
<tr>
<td></td>
<td>(a) that discussions will take place with the Sheffield Test Beds project to determine governance arrangements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialised Commissioning Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CWTB 03/16</td>
</tr>
<tr>
<td></td>
<td>(a) that outcome data available in Specialised Services will be circulated</td>
</tr>
<tr>
<td></td>
<td>(b) that a clinical area be selected and the Specialised Services team and CCGs will bring together the data on outcomes available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>The Working Together Programme Strategic Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CWTB 04/16</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Commissioners Working Together Board Governance and Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) that members further explore governance and organisation of the CWT Board at the meeting of the Clinical Chairs and Accountable Officers (4/2/16)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) that the recommendation from the South Yorkshire Cancer Strategy Group to take the next steps around developing a cancer alliance was supported</td>
</tr>
<tr>
<td></td>
<td>(b) that the governance framework, the membership and terms</td>
</tr>
</tbody>
</table>
of reference of the LWABC Programme Executive Board, and
the membership and terms of reference of the LWaBC
Prioritisation Panel are approved
Minutes of the meeting of Commissioners Working Together Board, held 2 February 2016, 9:30 – 11:30, Doncaster CCG Boardroom

Present:
Dr Nick Tupper, Clinical Chair, NHS Doncaster CCG (Meeting Chair)
John Boyington, Lay Member
Will Cleary-Gray, Programme Director, Working Together Programme
Moira Dumma, Director of Commissioning Operations, NHS England
Michelle Ezro, Associate Director, NHS Wakefield CCG
Chris Edwards, Chief Officer, NHS Rotherham CCG
Steve Hardy, Lay Member
Dr Stephen Kell, Clinical Chair, NHS Bassetlaw CCG
Alison Knowles, Locality Director, NHS England
Phil Mettam, Chief Officer, NHS Bassetlaw CCG
Dr Tim Moorhead, Clinical Chair, NHS Sheffield CCG
Julia Newton, Director of Finance, NHS Sheffield CCG
Maddy Ruff, Chief Officer, NHS Sheffield CCG
Lesley Smith, Chief Officer, NHS Barnsley CCG
Helen Stevens, Associate Director of Communications and Engagement, Working Together Programme
Kate Woods, Programme Office Manager, Working Together Programme

Apologies:
Dr Nick Balac, Clinical Chair, NHS Barnsley CCG
Dr Philip Earnshaw, Clinical Chair, NHS Wakefield CCG
Dr Julie Kitlowski, Clinical Chair, NHS Rotherham CCG
Dr Steven Lloyd, Clinical Chair, Hardwick CCG
Dr Ben Milton, Clinical Chair, NHS North Derbyshire CCG
Mark Smith, Interim Chief Officer, NHS North Derbyshire CCG
Chris Stainforth, Chief Officer, NHS Doncaster CCG
Jo Webster, Chief Officer, NHS Wakefield CCG

In Attendance:
Cherie Cope, Project Support, Working Together Programme
Tracey Bray, Head of Supply Management, NHS England Specialised Services
Matthew Groom, Assistant Director Specialised Commissioning, NHS England Specialised Services

<table>
<thead>
<tr>
<th>Minute reference</th>
<th>Item</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/16</td>
<td>Welcome, Introduction and Apologies</td>
<td>The Chair opened the meeting noting apologies for absence.</td>
</tr>
<tr>
<td>02/16</td>
<td>Minutes of the previous meeting and matters arising</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The minutes were accepted as a true and accurate record.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NLAG/Hull/Sheffield collaboration update</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commissioners Working Together Board (CWT Board) noted that a meeting to discuss the collaboration between Sheffield, NLAG and Hull had been deferred and likely to be rescheduled for March 2016. The proposed footprint for the Strategic Transformation Plan (STP) for South Yorkshire and Bassetlaw had included those areas as associates. There was further work to be done locally and noted that all must remain cited on this due the potential impact particularly on Doncaster provision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sheffield City Region Devolution agreement - update</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CWT Board noted the need to remain cited on the development of the devolution agenda.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Test beds press release</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Members received a copy of the media release on the success of the Sheffield Test Beds bid. This was a significant piece of work, linked to the digital roadmap with many partners engaged. CWT Board noted the need to remain cited on the detail of this programme of work the value in influencing the agenda. Governance arrangements were to be determined. MR and WCG would be part of those discussions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>03/16</th>
<th>Specialised Commissioning Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The CWT Board was presented with an update on Specialised Commissioning.</td>
</tr>
<tr>
<td></td>
<td>Prescribed Specialised Services was made up of 143 services and had a commissioning responsibility for £1.3bn specialised services across Yorkshire and the Humber. A piece of work was taking place around how to tier services and where they were most appropriately commissioned. As part of this strategy, the eight “bundles” were clarified for the CWT Board:</td>
</tr>
<tr>
<td></td>
<td>• Cardio respiratory</td>
</tr>
<tr>
<td></td>
<td>• Cancer</td>
</tr>
<tr>
<td></td>
<td>• Maternity and children</td>
</tr>
<tr>
<td></td>
<td>• MH</td>
</tr>
<tr>
<td></td>
<td>• Trauma</td>
</tr>
<tr>
<td></td>
<td>• Internal medicine</td>
</tr>
<tr>
<td></td>
<td>• Lower GI and pelvis</td>
</tr>
</tbody>
</table>
• Blood and infection.

Work was taking place to build service scenarios.

6 principles of collaboration had been developed nationally:

• Improve pathway integrity for patients
• Enable better allocation of investment decisions
• Move towards population accountability
• Improve financial incentives over the long term
• Ensure providers can effectively be held to account
• To focus NHS England on services that are truly specialised

A query was raised from the CWT Board around how to assess improvements to patient outcome through the principles outlined. The challenges around collection of data were noted. Specialised service specifications had been developed and therefore the standards expected were clear and could be used to work through the STP process and start to measure using the quality outcomes framework. There were opportunities to build on this work and the ambition was to improve outcomes while also improving specialised services.

It was noted that there was agreement with the national team from a Clinical Commissioning Group (CCG) perspective to understand the finance at CCG level before delegating and commissioning, develop a strong narrative from a patient perspective on why things should change, and also quality data around the size and scale of the gap. The STP would need to contain the financial gap, the health gap and the quality gap for specialised services. Members noted the importance of working together with Specialised Services team to identify this within South Yorkshire and Bassetlaw and at an individual CCG level.

The CWT Board were updated on the latest position of segmentation levels, noting 143 services had been stratified and put into the level at which they would be commissioned.

**Tier 1:** NHS England national commissioning  
**Tier 2:** NHS England collaborative commissioning  
**Tier 3:** CCG +LA / delegated commissioning  
**Tier 4:** Devolved and/or could delist

At a local level, the Y&H Specialised Commissioning Oversight Group (SCOG) had discussed the segmentation work and projects highlighted to the group would be carried out in partnership with the CCGs. A discussion would take place with SCOG around how CCGs could collaborate, addressing pooling and financial risk.

The Working Together Programme challenges were outlined to
A further discussion was had by members around patient outcome and the need for data on health outcomes to ensure all were meeting patient need in the right way. In response to work carried out by the Specialised Services team around cardiac device outcomes, which included mapping services through and examining the position, a comment was made around the need for data demonstrating better outcomes, post device and that evidence was required that the service being delivered matched the evidence base to translate into better patient outcomes.

A comment was made that the understanding of clinical networks was becoming less clear and coherent from a commissioning perspective.

It was confirmed that in terms of quality service, there were dashboards mandated within Specialised Services giving outcome indicators and standards. These were increasing year-on-year and providers were mandated to submit this information.

The CWT Board noted that the issues around data on patient outcome was a challenge to all and CCG commissioners required the same level of understanding of services being commissioned.

A request was made for the presentation of outcome data available in Specialised Services to be circulated and this was agreed.

The CWT Board requested that a clinical area be selected and the Specialised Services team as well as CCGs would bring together the data on outcomes available to consider what further was required.

It was agreed that there needed to be a clear understanding of the specialised commissioning over-allocation, noting that this was contracted by provider (50% by needs-based and 50% on historical spend).

The Working Together Programme Strategic Review

A presentation was delivered to the group on the piece of work undertaken to give CCGs a high level collective overview of local health systems from a number of viewpoints. The review pulled together a range of datasets for the whole footprint to allow the development of a baseline and to form the basis of discussions around opportunities to develop the STP. Areas of focus for the review were noted as health and wellbeing, quality and meeting constitutional standards, finance and activity flows and workforce. The group were asked to note that the report was currently an
initial iteration and detailed document would be shared with
the group when ready.

Health and wellbeing
The report demonstrated that all areas shared common
health need challenges, particularly around south Yorkshire
and Bassetlaw in terms of deprivation, child poverty,
smoking and the main preventable causes of premature
mortality; cancer and cardiovascular disease. Local
communities fared worse than the national average in many
areas.

Quality and Performance
It was highlighted that demand for services was growing
year on year and the ability to meet constitutional standards
was challenging. Significant variation in terms of the way
services were delivered across the patch, both in terms of
local access, pathways and cost were noted.

Finance and activity
The group noted the predicted funding gap across the health
community of £750 million over the next five years across all
sectors, with the greatest challenge facing the acute sector.

Workforce
The group were advised on an overall increasing trend for
acute workforce. The known national and regional shortages
in key workforce groups were noted. Some risks were noted
with the expected number of GPs and the workforce to
enable the implementation of out of hospital strategies.

The presentation would be circulated to all post meeting.

The CWT Board noted feedback from the Strategic Planning
Forum (Commissioners and Providers) had been a helpful start in
developing the STP.

It was commented that detail on primary care would be a useful
inclusion in this report. An example was raised that in Sheffield it
was known that activity increases 30% in winter months and this
data reflected in the review would be useful.

After discussion around the gap emerging and concerns raised
around looking at outpatient follow ups in isolation to general
practice and community services. This would be discussed further
outside the meeting.

A comment was noted around the necessity of configuring care
differently in order to address the £850m financial gap.

Members noted shared learning across the country; the changes
implemented needed to be system management as was as
transformational.
The CWT Board were advised that the detail of this work would be shared with Y&H public health colleagues as a next step on 3 February 2016.

A discussion took place on the benefits of establishing a collective commissioner efficiency target as well as starting to change the pace around care in different settings. The work undertaken with the review was noted as a helpful start. Members noted that the financial position varied across the patch and may impact on the pace of change.

The need to broaden the range of the work streams was highlighted, to address community and mental health and primary care need. Consideration would be required as part of the STP, around how to drive the management of complex patients and how to move towards prevention longer term. The CWT Board agreed that each of the local plans would drive this detail.

A discussion took place around the criteria to achieve transformational funding noting that providers must achieve the constitutional targets. Therefore setting accountability was crucial.

It was agreed that consideration was required around programme priorities and this would be discussed further at the forthcoming Clinical Chairs and Accountable Officers meeting on 4 February.

It was noted that there was commitment for each place to reconvene on 14 March and there needed to be significant reframing of local strategies, priorities and ambitions to achieve what was required. This should align to discussions at the Clinical Chairs and Accountable Officers meeting when considering priorities.

05/16

Commissioners Working Together Board Governance and Organisation

Lynne Copp was invited by the CWT Board to discuss governance and organisation. A presentation was delivered highlighting the need for a clear vision and strategic intent of an organisation to be translated into objectives to drive any business operational model. This business model design and organisational design strategies should be underpinned by the culture and values of the organisation. The need to achieve effective patient outcomes and sustainability was noted and methods by which to create this environment noted:

- to begin with an understanding of the current position
- to carry out a diagnosis
- to define what will be required to work alongside one
Members were invited to comment.

CE set context of the collaborative work to date, with an initial formal gateway review taking place in November 2014, and key feedback from this had been around decision making and governance. Work had also taken place with the Kings Fund.

The scale of the challenge ahead was noted.

It was agreed that the STP would require a different way of working and the expectations of the Working Together Programme would be different. Work would be required around understanding the shared values to enable difficult decisions to be made when required.

The current Working Together Programme projects would require a collective decision making structure and it was agreed there was immediate work to address this alongside a longer-term piece of work around developing a strategic approach to collaborating in South Yorkshire, Bassetlaw and North Derbyshire.

It was agreed that the diagnostic presented to the CWT Board would be effective for an organisation to adopt, however a different approach would be required to develop skills around complex adaptive systems and system leadership. A comment was raised that this should also be a concurrent piece of work with providers.

LC confirmed that the group needed to define what readiness capacity looked like to use as a bar to measure all in terms of readiness and capacity and development plans. Next steps would arise from there.

The group agreed to explore this further at the session on 4 February.

06/16  Clinical Workstreams - a summary of progress

Hyper Acute Stroke
The CWT Board noted the resolution to risks that were included in the highlight report with changes to the Strategic Clinical Network, and recruitment within the Working Together Programme team being brought forward to address this. Members were updated on a preconsultation event that had taken place with Providers and Commissioners. This had been a useful session although options could have been further explored. Work was taking place to develop the blueprint in the context of Yorkshire and the Humber. It was noted that this work would go through the assurance
process in April 2016, and Summer 2016 had been identified as the point of a consultation decision point when the options were fully developed.

A query was raised around the pace of change and the content of the STP would be around significant transformation. It was agreed that consideration was required around how to drive this transformation. To do this stronger connections were required with providers to enable the wider transformation discussions.

The CWT Board agreed that there was a need, with some organisations in South Yorkshire that were not sustainable in their current form, to be challenging with providers and each other collectively and to be clear on provider accountability in this process. A framework was required and set this against the integration of local plans, tiering and delivery of key targets.

**UEC**
The CWT Board was updated on activity around the Networks and the Programme. A Network plan was due to be submitted on 8 February. WCG reported that MR (who had left the meeting) had wished to reflect the pace expected of this work and the challenge of this against the current resources. A request was made to consider how collectively this might be resourced in an appropriate and effective way. It was noted that the timetable for Designation had not yet been released. Further guidance was expected. It was noted that by 2017 it was anticipated that 20% of the country would be delivered in this model. MD advised on the West Yorkshire structure which clearly defined the work of the Vanguard and the work of the commissioners. It was agreed that further consideration of this issue was required at the meeting of the Clinical Chairs and Accountable Officers on 4 February.

---

<table>
<thead>
<tr>
<th>07/16</th>
<th>Planning guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The CWT Board noted reflections from the Strategic Planning Forum with Providers that took place 1 February 2016.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>08/16</th>
<th>Cancer</th>
</tr>
</thead>
</table>

**Development of Cancer Alliance for South Yorkshire, Bassetlaw and North Derbyshire**
The CWT Board was asked to support the recommendation from the South Yorkshire Cancer Strategy Group to take the next steps to developing a cancer alliance. A discussion took place, and the need to be clear what the expectation of the members would be; to implement change.
The CWT Board supported the recommendation.

**Living With and Beyond Cancer – Accountability and Governance Framework**

The CWT Board was presented with a report setting out the detail of the Macmillan Living with and Beyond Cancer governance framework. In October 2015, the Project Initiation Document was agreed by the Commissioners Working Together Programme Executive. The presented paper set out the detail of the structures for delivery of the programme.

The CWT Board:

- Approved the governance framework
- Approved the membership and terms of reference of the LWABC programme executive board
- Approved the membership and terms of reference of the LWaBC prioritisation panel

Due to time restrictions, all were asked to feedback comments directly to WCG outside of the meeting.
Receipt of Minutes from Committees
Minutes of the Quality & Patient Safety Committee  
Held on Thursday 5th May 2016 at 9.00am  
Boardroom, Sovereign House

Formal Committee Members present:
Dr Emyr Jones (Chair)  
Mr Ian Boldy  
Mrs Gill Bradley  
Dr. Jeremy Bradley  
Dr Lindsey Britten  
Mrs Suzannah Cookson  
Mrs Wendy Feirn  
Mrs Andrea Ibbeson  
Mr Victor Joseph  
Mrs Jenny Rayner  
Mr Andrew Russell  
Mrs Mary Shepherd  
Mrs Andrea Stothard  

Committee Members Present:
Secondary Care Doctor Member  
Named Nurse Safeguarding Adults  
Deputy Head of Medicines Management Team  
GP Representative  
GP Lead for Quality  
Head of Quality, Designated Nurse for Safeguarding & LAC  
Senior Nurse, Quality & Patient Safety  
Named Nurse for Children’s Safeguarding  
Consultant in Public Health, Doncaster Council  
Senior Officer for Quality  
Head of Quality in Contracts  
Chief Nurse  
Quality in Contracts Manager

Formal Committee Members in Attendance:
None

In attendance:
Lesley Twigg  
Minutes

1. **Welcome and Apologies**

Dr Jones welcomed everyone to the meeting.

Apologies were recorded from:
- Mr Booth, Specialist Placements Lead
- Mrs Quinn, Patient Experience Manager
- Mrs Randerson, Head of Medicines Management

2. **Declarations of Interest**
No new declarations of interest were made.

3. **Minutes and Actions of the Previous Meeting – Enclosures A & B**

   The minutes of the meeting held on Thursday 5th May were agreed as a correct record.

4. **Matters arising not on the agenda**

   The Committee went through the action log for the meeting. All updates will be recorded on the action log.

   There were no other matters arising raised by Committee members.

5. **QUALITY**

5.1 **Primary Care Quality Strategy – Enclosure C**

   Mrs Cookson updated the committee that the strategy was in line with Assurance Framework and that we are working with IT colleagues regarding what indicators can be pulled through. Once we have the data the profile can be developed and this can be RAG rated for each practice. Mrs Cookson added that the strategy had gone to the Primary Care Committee as a consultation paper.

   Dr Bradley asked how practices would be RAG rated and Mrs Cookson responded that this has not been agreed as yet but as the information comes through there were be a scoring mechanism, Mrs Shepherd added that it will be in line with the quality assurance processes in the CCG but acknowledged that this will never be an exact science, she added that the indicators would highlight areas of concern. Dr Bradley said that all the practices need to understand the risk profile and how this works with Dr Jones adding that understanding the risk profile and ensuring that all practices have a collective understanding on how this will work is key. Dr Jones asked what GP input there had been and how resource intensive would this be. Mrs Shepherd responded that it will be resource intensive and she has concerns about this, she asked the committee what medical roles are needed and where do we get them from. Mrs Shepherd added that Mrs Sherburn is having conversations regarding pulling GPs from Sheffield, Rotherham.

   Dr Jones asked if other CCGs were going through the same and Mrs Shepherd confirmed that they were. Mrs Shepherd added that Margaret Kitchen had led on the work to develop the Doncaster and Bassetlaw policy and this has now been rolled out nationally.
Mrs Cookson informed the committee that there is a later version of the strategy which she share with the committee, she clarified that it hasn’t significantly changed but there are small amendments that have been made. Mrs Cookson ended her update by informing the committee that she was interviewing for the Band 7 Primary Care post on 9th and 12th May.

Dr Jones asked the Committee if they were happy to approve the strategy in principle once the final version had been issued by Mrs Cookson. Committee members confirmed approval in principle as operational implementation will be closely monitored.

**Action 001 / 5.5.16:** Mrs Cookson to email the final version of the strategy to Committee members.

### 5.2 Urgent Care Quality – Verbal Update

Mr Russell updated that he had met with FCMS who have looked at pathways, availability of staff, case mix etc for Easter 2016 and compared this to Easter 2015 and performance has improved with no sign of any breaches. Mr Russell said that Mrs Leighton was still working through the data and so far this is in line with expectations of the service.

Work is on-going on the quality metrics with work still being done on narrowing the data down. Mrs Shepherd said that we need to understand if the metrics are right.

Mrs Shepherd updated that she attended the contract meeting and that the CCG need to take a sense check on the data we are asking for, there is a meeting planned to review Key Performance Indicators (KPIs) but this is definitely an improving picture for FCMS. FCMS are doing a lot of work on medical cover and rotas and the CCG will support them with this, the junior doctor strike and the Tour de Yorkshire were last week and the system worked well.

Dr Jones said that he was happy that this is an improving picture and that the key issue is the medical staff, he added that he still had concerns that the quality metrics do not show us how well we are doing compared to the national picture or to providers of the same size. Mrs Shepherd responded that there is not one set of metrics and that these are embedded into the contract. Dr Britten asked if there was a report and Mr Russell responded that we are trying to extract data into a quality report with key indicators. Mrs Bradley informed the committee that the Medicines Management team provide support to FCMS.

Dr Jones asked if there were any further questions on this agenda item and asked that Mr Russell bring an update proposal on this to
the next meeting. Committee members had no further questions regarding this update.

**Action 02 / 5.5.16:** Mrs Twigg to include Urgent Care Quality on the agenda for the next meeting on Thursday 7\(^{th}\) July, and Mr Russell to provide an update proposal.

Mrs Twigg / Mr Russell

## 5.3 Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBHFT) Update – Enclosure D

Mrs Cookson updated that the next Clinical Quality Review Meeting (CQRG) meeting will be held on Tuesday 10\(^{th}\) May and that the agenda is very full for the meeting. Mrs Cookson said that she was attending the Trusts Mortality Monitoring Group meeting tomorrow (6\(^{th}\) May). Mrs Cookson added that the Trust is managing their Care Quality Commission (CQC) Action Plan and their Turnaround Plan. The Trust have a task and finish group that links to the Turnaround Plan and CCG have been invited to be part of this group; we have not yet seen the plan.

Mrs Shepherd said that Dawn Jarvis had presented the draft plan and that there is nervousness that the financial situation may impact on quality; Mr Russell added that the focus internally is on the bottom line and that we had asked to speak about the Quality Improvement Assessment.

Committee members noted the paper and had no further questions regarding this update.

## 5.4 Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH) Update – Enclosure E

Mrs Cookson updated that there was nothing of significance to inform the Committee regarding the RDaSH update. They are continuing to work on their Care Quality Commission (CQC) Action Plan which is now published on the Trust’s website. Revalidation is going well within the Trust with the first cohort having gone through the process; this will be evaluated at the end of May.

The trust has achieved all of their Commissioning for Quality & Innovation (CQUIN) standards for 2015/16, Dr Jones asked what the value was of the CQUINs and Mrs Stothard responded that this is £3.2 million.

Finally Mrs Cookson updated that the Cost Improvement Programme (CIP) will be going to the Trust’s Board meeting this week and will then be shared next week.
Committee members noted the paper and had no further questions regarding this update.

5.5 Care Home Report – Enclosure F

Mr Boldy updated that the Care Home Strategy is now complete and is ready to share once signed off by the relevant Committees. The strategy will be shared with GPs at locality meetings.

Mr Boldy informed the committee that Mrs Rayner has been undertaking a big piece of work to map which GPs work with each care home in the borough; once this work is complete a weekly update will be provided to GPs regarding any concerns with specific care homes.

Work is ongoing to monitor Out of Area (OOA) placements, with conversations with the local authority regarding the feasibility of them undertaking the monitoring of our OOA placements alongside their own is taking place.

Key highlights from the Care Homes update highlighted to the Committee were:

- Mr Boldy informed the Committee that care home concerns are discussed at the weekly meeting with Doncaster Council; Dr Jones responded that this provides assurance and adding that the report is easy to read and highlights the good working relationships with the local authority. Mrs Shepherd added that this is due to Mr Boldy and Mrs Ferron who between them have created these systems. Mr Joseph asked how often the Care Quality Commission visited care homes and Mr Boldy responded that this is dependent on the level of concern.

- Mr Joseph updated the Committee that the Infection Prevention & Control (IPC) service in care homes that had been withdrawn is now being re-commissioned.

Committee members noted the paper and had no further questions regarding this update.

5.6 Individual Placements – Enclosure G

Mrs Shepherd highlighted the following points from the update:

- The Continuing Healthcare (CHC) Team has now TUPED back to the CCG, and Mr Boldy is managing this function. Options to outsource outstanding reviews are being considered. Dr Jones asked if this would impact on finance and patient quality. Mrs Shepherd said that it would as the shift in eligibility has impacted. Dr Jones said that we need to get this right.
• There is a lot of work being done with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) and Doncaster Council on patients who are entitled to Section 117 aftercare.

• Previously Unassessed Periods of Care (PUPOC) – NHS Doncaster CCG hosts this function for 12 CCGs; NHS England have praised us for taking this responsibility. Doncaster has poor performance for our outstanding reviews but this shows that we are not prioritising our own. There will be a Parliamentary review at the end of March 2017 if not cleared. Mrs Shepherd said that she would be spending time with the Lay Members to go through this and consider how to take forward; she will also prepare a brief for the Governing Body. Dr Jones said that we have got to be robust in our processes as we host for 12 other CCGs. Mr Russell added that we have a conversation every two weeks with NHS England about this. Mrs Shepherd said that there were financial implications to commission externally for this work to be done.

Committee members noted the paper and had no further questions regarding this update.

5.7 Primary Care Quality Report – Enclosure H

Mrs Cookson referred the Committee to the report provided for further information on practices where the CCG are supporting on improvements.

Mrs Shepherd updated that NHS England are leading on work with this practice and we are integral to this. Dr Britten said that we need to ensure that patients are cared for. Mrs Shepherd said that we are involved with the practice in regular meetings with NHS England and we are currently waiting for a nursing review to be completed and asked that the committee agree what needs to be brought here and also tease out the governance, this will be escalated to Governing Body as there are concerns regarding Primary Care in this area of Doncaster. Dr Bradley added that we also need to be mindful that neighbouring practices are not impacted by the issues with this practice.

Mr Russell asked if the risk profile had been discussed and would this Committee monitor the action plan for this practice. After discussion the Committee agreed that Mrs Shepherd would discuss with NHS England if the Risk Profile can be shared with this Committee and Mrs Shepherd and Dr Jones will discuss the situation regarding this practice with the chair of the Primary Care Committee.
**Action 03 / 05.05.16:** Mrs Shepherd to discuss with NHS England if the Risk Profile for the practice can be shared with this Committee.

**Action 04 / 05.05.16:** Mrs Shepherd and Dr Jones to discuss this practice with the chair of the Primary Care Commissioning Committee.

Committee members noted the paper and had no further questions regarding this update.

**Case Conference Report May 2016 – Enclosure I**

Mrs Cookson referred to the report and said that the Children’s Trust are very specific regarding what goes out in the letter to GPs, this data will be included in the dashboard going forward.

Committee members noted the paper and had no further questions regarding this update.

**5.8 Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBHFT) Commissioning for Quality & Improvement (CQUIN) Attainment – Verbal Update**

Mrs Stothard updated the Committee that Quarter 4 evidence for the Trust is still outstanding and this has been escalated to the Strategic Contracting meeting.

Committee members had no further questions regarding this update.

**Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) Commissioning for Quality & Improvement (CQUIN) Attainment – Enclosure J**

Mrs Stothard updated the committee that RDaSH have achieved all 2015/16 CQUINs, the committee agreed that the trust have done well and this has been recognised at RDaSH CQRG with thanks being passed to the team in the trust who provide the evidence. Dr Jones said that RDaSH achievement should be raised with Governing Body.

**Action 05 / 05.05.16:** Dr Jones to ask Governing Body to note that RDaSH have achieved 2015/16 CQUINs and to recognise this achievement.

Committee members noted the paper and had no further questions regarding this update.
Ms Stothard informed the committee that these are smaller and more focussed and include the national CQUINs, the committee agreed that the report provided by Mrs Stothard was excellent and that this should be taken to Governing Body, the committee asked that Mrs Twigg attach this report to the minutes of this meeting.

**Action 06 / 05.05.16:** Mrs Shepherd / Dr Jones to take to Governing Body. Mrs Twigg to attach the report to the minutes of this meeting.

Committee members noted the paper and had no further questions regarding this update.

### 5.9 Internal Audit / Assurance Plan – Verbal Update

Mr Russell updated the committee that Brian Jacobson has undertaken a Mental Capacity Act (MCA) Review on Safeguarding Adults. Mr Russell has seen the draft report and will let Mrs Twigg know when to include on the agenda.

**Action 07 / 05.05.16:** Mr Russell to let Mrs Twigg know when to include this on a future agenda for the committee.

### 6. PATIENT SAFETY

#### 6.1 Safeguarding Children & Adults Annual Report – Enclosure L

Dr Jones asked how we were doing. Mrs Cookson responded that when RAG rated we are doing well; there will be a Check & Challenge next week which NHS England has asked us to do.

Mrs Cookson said that Safeguarding Children is still a complex picture but building relationships, working together etc is robust. The Early Help Hub has now gone live but there are challenges for the Safeguarding Teams in both Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBHFT) and Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) and we continue to work with and support them. Mrs Shepherd said that she agreed with Mrs Cookson and that there is a strong Safeguarding Board and chair. Mrs Ibbeson added that referrals increased in November 2015 but the numbers accepted had decreased, Mrs Ibbeson added that she thinks this is the recording and is not concerned by this.
Mr Boldy updated that there was a Safeguarding Adults peer review in September / October 2015 and this raised concerns regarding process, the board and the whole system. There have been significant changes on the Board and within the team and a lot of work is now being done that is starting to come to fruition. Mr Boldy added that there are concerns that inappropriate referrals are being received. Mr Russell said that this was down to the Care Act which states that everything should be referred and that systems were required to deal with quality issues and added that it was difficult to extract outcomes and quality data information from the adult data and that a lot of work is currently being done with the NHS and Doncaster Council to look at this. Dr Jones asked if this needed to be highlighted to the Governing Body, Mrs Shepherd said this made sense and asked that Mrs Cookson and Mr Boldy attend Governing Body to give an update and ask for their recommendations. Dr Jones asked if this Committee need to escalate anything to the Governing Body and Mrs Shepherd responded that we do need to raise concerns regarding executive ownership in both Trusts but that we are working with them as the Adult Independent Chair is not in post and there is a lot of churn and change in Doncaster Council. Mr Russell asked the Committee to note that it is not all negative following the peer review and that the system still protects vulnerable adults.

**Action 08 / 05.05.16:** Mrs Cookson and Mr Boldy to attend Governing Body to provide an update and ask for recommendations on future actions. Mrs Shepherd to raise concerns regarding executive ownership in both Trusts.

Committee members noted the paper and had no further questions regarding this update.

**Looked After Children (LAC) Annual Report**

Mrs Cookson updated the Committee that the LAC Annual Report is not finalised and it will come to the next meeting on 7th July 2016.

Mrs Shepherd informed the Committee that she still has concerns regarding medicals for LAC with Mr Joseph adding that the Local Authority have responsibility to do an audit on the evidence of where we are etc. Dr Jones asked if this issue should be escalated to Governing Body and Mrs Cookson added that it should.

Committee members had no further questions regarding this update.

**Action 09 / 05.05.16:** Mrs Twigg to add Looked After Children (LAC) Annual Report to the agenda for the next Committee meeting on the 7th July 2016. Mrs Shepherd / Dr Jones to raise concerns to Mrs Shepherd / Mrs Shepherd /
Governing Body regarding LAC medicals.  

Dr Jones

6.2 Goddard Enquiry – Enclosure M

Mrs Ibbeson updated the committee that she and Mrs Rayner were looking at the children’s pathway as they want to be proactive and get a start on this work now. Dr Jones asked if the action plan would be brought to this Committee, and Mrs Ibbeson said that this would go to the Safeguarding Assurance Group (SAG) but that any exceptions would come to this committee.

Committee members noted the paper and had no further questions regarding this update.

6.3 Serious Incident (SI) Annual Report – Enclosure N

Mrs Stothard asked that the reports were taken as read but updated that Doncaster & Bassetlaw Hospital NHS Foundation Trust’s (DBHFT) Serious Incidents have reduced and this is down to better reporting across the Trust. They are reporting more delays and failures but less on pressure ulcers, falls etc.

Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) are also reporting less but this is attributed to the Pressure Ulcer strategy, reduced suicides etc. Mr Russell said that this shows that Sign Up to Safety is working.

Committee members noted the paper and had no further questions regarding this update.

6.4 Infection Prevention & Control (IPC) Report – Enclosure O

Mrs Feirn asked that the report was taken as read but added that the CCG do not have any attributed MRSA cases and that we are on trajectory for C Difficile.

Committee members noted the paper and had no further questions regarding this update.

6.5 Medicines Management Plan – Enclosure P

Mrs Bradley highlighted the following to the Committee:

*Draft MMT Workplan*

The Workplan is aligned to Delivery Plan priorities and Transformational Plans for consideration and approval.
**Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) Drug Error – MTX Admin Error**

This was discussed at the RDaSH Clinical Quality Review Group (CQRG) and the incident happened on Hawthorne. There was no patient harm and an internal investigation has been commissioned by RDaSH and will be brought to the RDaSH Medicines Management Committee and CQRG once completed. In the interim information has been requested regarding timescales and any actions to mitigate risk whilst electronic prescribing system is being further discussed.

**BlueTeq**

BlueTeq is a system to provide assurance regarding adherence to NICE and payment process for Payment by Results (PbR) excluded drugs. Initial implementation strategy agreed with Rheumatology but a recent pushback from DBHFT on implementation in Ophthalmology and Rheumatology, this has been escalated to the Finance Performance and Information Group (FPIG) and CQRG and there will be a multidisciplinary meeting next week.

**RightCare**

The approach to matrix working with other CCG teams has been agreed with a focus on the prescribing agreement at Strategy and Development Forum. Actions are agreed and Local Enhanced Service incentive scheme are to be developed in collaboration with Finance, with in-year savings as a priority and a focus on cost; this approach has been agreed by Governing Body.

Committee members noted the paper and had no further questions regarding this update.

---

6.6 **Caldicott Log – Enclosure Q**

Committee members noted the paper and had no further questions regarding this update.

6.7 **Care Quality Commission (CQC) Update – Verbal**

This was covered in agenda items 5.3 and 5.4.

6.8 **Patient Experience Report – Enclosure R**

Committee members noted the paper and had no further questions regarding this update.
6.9 Quality & Safety Risk Register – Enclosure S

The Committee discussed if anything raised today should be logged as a risk. Dr Britten asked if the issues impacting on Primary Care should be logged, and after discussion the Committee agreed that Mrs Shepherd would discuss this with Mrs Sherburn and Mrs Atkins Whatley.

Action 10 / 05.05.16: Mrs Shepherd to discuss issues impacting Primary Care with Mrs Sherburn and Mrs Atkins Whatley regarding if this should be considered a risk and logged as such.

Committee members noted the paper and had no further questions regarding this update.

7. Quality & Safety Workplan – Enclosure T

The Committee noted the plan covered the period 2015/16 and agreed that the 2016/17 plan should be brought to the next meeting in July 2016.

Action 11 / 05.05.16: Mrs Rayner to update the plan.

8. Doncaster Mentorship Policy – Enclosure U

Mr Russell updated the Committee that the policy has been developed by Shared Services and impacts on students and mentors. He asked Committee members to ratify the policy, and it was highlighted that on Page 5 it mentions ‘directors’ and this does not apply to NHS Doncaster CCG.

The Committee agreed to ratify the policy if ‘director’ is amended to read ‘Chiefs’ in the final draft.

9. Any Other Business

None was raised.

9. Date and Time of Next Meeting

Thursday 7th July 2016 at 09.30 – 11.30 in the Boardroom, Sovereign House.
<table>
<thead>
<tr>
<th>Schedule of Future Meetings in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 1st September 2016</td>
</tr>
<tr>
<td>Thursday 3rd November 2016</td>
</tr>
</tbody>
</table>
Minutes of the Primary Care Commissioning Committee  
Held on Wednesday 27th April 2016 commencing at 10.00am  
In the Boardroom, Sovereign House

Present:            Mrs Linda Tully – Lay Member (Chair)  
Miss Anthea Morris – Lay Member and Vice Chair of the Primary Care  
Commissioning Committee  
Dr Pat Barbour – Locality Lead, South East Locality  
Mrs Hayley Tingle – Chief Finance Officer  
Mrs Laura Sherburn – Chief of Partnerships Commissioning and Primary  
Care  
Dr Nabeel Alsindi – Clinical Lead for Primary Care and Long Term  
Conditions  
Mrs Carolyn Ogle – Primary Care Contract Manager, NHS England  
Mrs Suzannah Cookson – Head of Quality Designated Nurse for  
Safeguarding & Looked after Children  
Mrs Debbie Hilditch – Healthwatch Doncaster Representative  

In attendance:  
Mrs Jayne Satterthwaite – PA (Taking Minutes)  
Dr Lindsey Britten – Locality Lead, South West Locality (Attending on  
behalf of Dr Seddon)  
Dr David Gibbons – Doncaster Local Medical Committee (Attending on  
behalf of Dr Eggitt)  
Mrs Miller, Finance Manager, NHS Doncaster CCG (Item 12)  

ACTION

1. Welcome and Introductions

Mrs Tully welcomed everyone to the Primary Care Commissioning  
Committee meeting and introductions were made around the table.  

There was 1 member of the public in attendance at the meeting and  
introduced himself as Mr John Butler from the company AstraZeneca.  

2. Apologies

Apologies were received from:

• Dr Niki Seddon – Locality Lead, North West Locality  
• Mrs Jackie Pederson – Chief Officer  
• Dr Dean Eggitt – Medical Secretary, Doncaster Local Medical  
    Committee
• Mr Ian Carpenter, Head of Communications & Engagement
• Dr Rupert Suckling – Director of Public Health

3. Declarations of Interest

Mrs Tully reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of NHS Doncaster CCG.

Declarations declared by members of the Committee are listed in the CCG’s Register of Interest, (available either via Mrs Satterthwaite, or the CCG website http://www.doncasterccg.nhs.uk/about-us/public-meetings/)

Declarations from today’s meeting:

Item 11 PMS Premium – Phased Reduction Proposal
Item 12 PMS Contract Uplift 16/17

With reference to the business to be discussed at agenda items 11 and 12, Dr Barbour declared that she is a partner in a PMS practice. This is duly recorded in the register of interest. Mrs Tully declared that Dr Barbour was unlikely to gain direct benefit over and above any other practice and could remain at the table. Dr Barbour agreed to not be involved in the discussion.

4. Minutes of the Previous Meeting held on 16th March 2016

The minutes of the meeting held on 16th March 2016 were agreed as an accurate record subject to the following amendments:

Page 1, Members Present, amend spelling to read ‘Suzannah’.

5. Matters Arising

Terms of Reference

Mrs Tully confirmed that she has spoken with Mrs Atkins Whatley regarding Patient Public Involvement who will meet with Mrs Hilditch.

Primary Care Strategic Commissioning Framework

Mrs Sherburn stated that the Delivery Model is not yet completed and will be presented at the May meeting.

Feedback from Practice Event – 4th March 2016

Mr Carpenter has now returned from planned absence on medical grounds and will focus on producing a plan for Patient Engagement for
Primary Care.

Proposal for use of Transforming Primary Care Fund (£5 per head) 16-17

Mrs Tingle reported that this is an item on today’s agenda.

Chronic Disease & Medicines Optimisation Bid

Mrs Tingle reported that this was agreed outside of the meeting as instructed at the Shadow Primary Care Commissioning Committee meeting on 16th March 2016.

Primary Care Assurance Dashboard

Mrs Cookson reported that this is an item on today’s agenda.

Clinical Audit & General Practice Participation – HIV look-backs

Mrs Cookson informed the Committee that Mr Russell will hasten this and manage outside of the meeting.

Any other Business

Mrs Tully reported that the Declarations of Interest form has not yet been completed by Dr Eggitt and Mrs Atkins Whatley is in the process of hastening the completion.

6. Terms of Reference

Mrs Tully reported that the Terms of Reference for the Primary Care Commissioning Committee had been previously considered at various forums and that the version presented to the Committee was the final version.

Dr Alsindi commented that the list of Members included in Page 3 of the Terms of Reference differed from those in the Appendix. Mrs Tully stated that the Members listed in Page 3 were the minimum recommended by NHS England and that CCGs are at liberty to make additions as they wish. Dr Alsindi noted that his job title was incorrect and should be changed to ‘Clinical Lead for Primary Care and Long Term Conditions’. Mrs Tully informed the Committee that Dr Khaimraj Singh is the formal deputy for the 2 Governing Body Locality Lead Clinical Leaders and is a non-voting member.

Dr Barbour queried if other GPs would be welcome to attend the open meetings if desired. Mrs Tully confirmed that Practice Partners and Practice Managers are welcome to attend as Members of the Public. The agendas and papers will be published on the NHS Doncaster CCG website.
Mrs Hilditch stated that Healthwatch has an information bulletin which could include details of future meetings etc. Mrs Satterthwaite agreed to forward the future dates to Mrs Hilditch.

Post Meeting Note

Mrs Satterthwaite forwarded the future dates to Mrs Hilditch on 3rd May 2016.

Dr Britten queried the difference between the Deputy GP Member and other GPs and highlighted that one of the GP Members and the Deputy are from the same Locality. Mrs Tully explained that the Deputy has been nominated to formally deputise for either of the GP Members if they are unable to attend the meeting. Any other GP would be attending the meeting as an observer only and cannot contribute to the meeting. Mrs Sherburn commented that the GP workload was a consideration when making the decision. The Committee can be flexible and review as it progresses.

Mrs Tully informed the Committee that a forward planner will be devised and NHS Doncaster CCG will work closely with Mrs Ogle on the forward agenda.

7. Primary Care Strategy – Progress update

Mrs Sherburn gave a verbal update on the Primary Care Strategy to the Committee.

The Strategy was considered at the Primary Care Commissioning Committee Shadow meeting on 16th March 2016. The first meeting of the Provider Engagement Group has taken place in which useful conversations were had. A service specification has been developed for a pro-active care model which is designed to avoid emergency hospital admissions and Care of the Elderly.

The Transforming Primary Care Fund (£5 per head) will be used to trial and deliver new services and the NHS Doncaster CCG Primary Care Team will work on the measures and success indicators for the May meeting.

Practices are requesting more knowledge on the Digital Roadmaps. The Care Home Strategy and the Local Authority social care tender must link in and connect.

Dr Barbour queried if the minutes of the Provider Engagement Group and the Primary Care Delivery Group will be presented to this Committee in the future. It was confirmed that this was the case and they would be a standing agenda item going forward and would be included in the Governance Structure. The Provider Engagement Group will receive its direction from the Primary Care Commissioning Committee.
8. **Investment of £5 per head monies 2016/2017**

Mrs Sherburn reported that the paper was initially discussed at the Primary Care Commissioning Committee Shadow meeting on 16th March 2016 and is presented again to this meeting for noting of the document and approval of the two part proposal for investment of £5 per head monies for 2016/2017.

The Transforming Primary Care fund which equated to £5 per head of population was made in General Practice for transformational schemes to improve quality of care and current schemes will continue to run until September 2016 from committed funds. The £5 per head is again available from April to September 2016 for investment in general practice in order to contribute to the development of Commissioning Service Specifications, to explore ways to design and innovate within practice and to trial new services aligned to the commissioning direction of travel. Guidance is available to practices on how they may wish to spend the money between April and September. From September onwards the £5 per head will be offered to practices to deliver service specifications within the Primary Care Delivery Model.

Dr Britten asked how we may encourage work streams across providers. Mrs Sherburn reported that this would be via the Provider Engagement Group, through pro-active collaboration and NHS Doncaster CCG facilitating conversations. Dr Alsindi suggested that the pro-active specification be shared with practices.

The Primary Care Commissioning Committee noted the content of the document and approved the 2 part proposal for investment of the £5 per head fund in 2016/2017. Reports are to be presented to the Committee in July and October and be included on the forward agenda. The pro-active specification is to be shared with practices.

1. **Approach to Transforming Prescribing**

Ms Sherburn explained that the purpose of the paper was for discussion and comment by the Committee.

NHS Doncaster CCG is facing a significant financial challenge in 2016/2017 in respect of Primary Care and high cost drugs. Prescribing has been identified as a particular financial risk for the CCG with the Doncaster spend relatively more than comparable CCGs for similar outcomes. A menu of measures could be explored in the CCG in an attempt to address the challenges as follows:

- Equip practices with an awareness and understanding of prescribing budgets and share the budgets on a monthly basis with all practices.
• Reduce the variation in prescribing between practices, assist vulnerable practices by re-focussing the Medicines Management Team role to provide targeted support.
• Develop a Local Enhances Service (LES) on a gain share proposal in order to incentivise a change in practice.
• Medicines optimisation commissioned within the pro-active specification.
• Initiate a ‘Deep Dive’ into prioritised areas of Rightcare opportunities, potentially Diabetes and Respiratory.

The approach was discussed at the Strategy Development Forum on 7th April and the next step is to work up the dimensions of the approach in more detail. Any schemes that involve incentives or gain shares for GP practices will be presented to this Committee for approval. Mrs Sherburn, Mrs Tingle and Dr Bradley will meet to scope and design an incentive scheme.

The proposed timescales are as follows:
April – June 2016
• Engage on the proposed approach and its five dimensions, with all partners.
• Identify and allocate required resource to deliver the plan.
• Scope and design gain share/incentive scheme.
• Approve within the CCG via the Primary Care Commissioning Committee and Governing Body as appropriate.

July 2016 onwards
• Implementation of the approach and ongoing monitoring.

Dr Barbour requested sight of the Rightcare report.

Miss Morris advised to be aware of unintended consequences and be mindful of those vulnerable practices. Mrs Tingle commented that the work is multi-faceted and Rightcare indicates where we have variations and where ‘Deep Dives’ can be done.

The Committee noted the proposed approach.

2. National Primary Care Transformation Fund (Capital Infrastructure & IT) – Update

Mrs Ogle reported that the definitive guidance for CCGs in relation to the submission of requests for funding is still awaited. It is specifically about increasing access for patients and collaborative working. There will be a separate tranche for premises and IT which will look at the use of Skype for example, and the introduction of paperless practices. It is anticipated that by June 2016, the CCG will submit bids, which have met the criteria, via a portal in order of priority therefore CCGs will need to be fully prepared in advance. The criteria is set by NHS England and we need to understand the process as decision could be
Mrs Tingle expressed concerns regarding the ongoing revenue and the consequences of fitting in our priorities and the pressures on the Primary Care budget. Mrs Ogle stated that bids are assessed and NHS England will look for sign off by the CCG. It is difficult to understand the revenue risks. CCGs will need to design a survey on the condition of premises and build in an estates plan within the Strategic Framework.

Dr Barbour stated that, although there may be no impact for CCGs regarding capital investment, she has concerns regarding the revenue risk in relation to Proto and the rent increase, and questioned if the CCG is obliged to reimburse to the practice. Mrs Ogle replied that it would depend on the percentage. NHS England recognises the difficulties for practices. Mrs Tully stated that it is important to be open and transparent and pro-active on how we prioritise bids.

Mrs Hilditch raised how we may galvanise information and what can be done in advance to harvest patient opinion of patient’s wants and needs. The Patient Participation Groups (PPGs) may need the assistance of Healthwatch. Miss Morris reported that NHS Doncaster CCG had invested a lot of effort into encouraging PPGs in practices with minimal success. Mrs Ogle informed the Committee that PPGs in practices is contractual and they will receive payment if they have one.

Mrs Sherburn commented that the final guidance is expected in the forthcoming week and will forward to Mrs Hilditch when received. Dr Alsindi suggested this agenda item be included on the rolling programme.

The Committee noted the update.

3. PMS Premium – Phased Reduction Proposal

Mrs Tingle presented the paper to the Committee for consideration and agreement on the option to be adopted.

During 2013, NHS England commenced a review of the funding of PMS practices which revealed that significant variations in funding had developed over time which appeared unrelated to population differences or additional services being provided. In line with National Strategy, we intend to achieve equitable funding levels within General Practice over a period of 4 years, Year 1 being 2014/2015.

In order to support practices to manage the changes in their funding, the intention is to provide some non-recurrent financial support over the 4 years. This will ensure those practices affected have time to make any necessary internal changes. The pace for implementation for Doncaster is:

- 2014/15 0% reduction – Year 1
- 2015/16 0% reduction – Year 2
- 2016/17 50% reduction – Year 3
- 2017/18 75% reduction - Year 4
- 2018/19 100% reduction

NHS England and NHS Doncaster CCG have completed the review of each practice affected by the changes to identify the impact as a consequence. The affected 12 practices have been informed of the outcome of the review and the financial impact however discussions are still ongoing regarding the posing of the financial impact. Mrs Tingle presented the following 3 options to the Committee for consideration and agreement:

Option 1 – Looks at reducing the PMS contract in 2016/2017 from October 2016 onwards, thereby the 50% full year reduction is reduced by 25%. The total reduction for reinvestment into General Practice over the remaining 3 years would be £1.463k.

Options 2&3 – Looks at reducing the PMS contract in 2016/2017 by the full 50% but the reduction would not take effect until October 2016. The 2 options look at different phasing reductions which look to support practices from a cash flow perspective. The total reduction for reinvestment into General Practice over the remaining 3 years would be £1.647k.

The rationale for agreeing this is it would coincide with the development reinvestment plans.

The Committee discussed the options and agreed by vote to support the principle set out in Options 2&3, a reduction of £1.647k would be made over the 3 year period and separate conversations would be held with individual practices to agree the phasing of the contract.

4. PMS Contract Uplift 2016/2017

Mrs Tingle reported that the purpose of the paper was for consideration and agreement by the Committee to implement the uplift in line with national recommendations.

GMS contracts are national contracts and any uplift negotiated nationally is automatically applied through the Exeter system. PMS and APMS are locally held contracts and NHS Doncaster CCG has the authority to decide whether to apply the recommended uplift figures provided by NHS England. NHS England recommends that PMS and APMS contracts should be uplifted in line with GMS contracts in order that all GP contracts operate in an equitable way.

Mrs Miller, Finance Manager explained that in the PMS Premium review process, the 2018/2019 GMS rate used to compare was £78.53, the national published estimate of the GMS rate in 2014/2015.
As the GMS rate is increased so should the PMS/APMS rate, so that by April 2018 all contractor price per weighted patient should be aligned. The financial impact to NGS Doncaster CCG is estimated at £302k, less the cost of the Dementia LES which gives a total impact of £234k.

Mrs Sherburn commented that this information was very useful in gaining a greater understanding.

The Committee supported the implementation of the uplift in line with national recommendations.

5. Draft Quality Assurance Strategy

Mrs Cookson presented the draft Quality Assurance Strategy to the Committee which has not yet been sighted by the Quality & Safety Committee. The document makes reference to the Quality Assurance Framework and details the process for escalation in relation to Quality Assurance as follows:

- Routine quality assurance monitoring
- Local enhanced quality assurance
- Regional enhanced quality assurance
- Formal action

The Primary Care Quality Dashboard and risk matrix is quite dynamic and will be jointly reviewed and information will be shared through the Primary Care Delivery Group. Quality metrics are included and the IT team is working on and assisting with this.

Mrs Tingle queried if additions could be made to the Dashboard. Mrs Cookson confirmed that this would be possible and there may be a different suite of options.

Dr Barbour commented that the document was very objective and would like to see that the CCG has personal knowledge of practices to understand all about them and sufficient time should be allocated for visits to meet all partners, Practice Manager and Receptionists. Mrs Cookson reported that the CCG is currently in the process of recruiting a Quality Clinical Manager who will work closely with practices.

The Committee approved the Quality Assurance Strategy.

6. Vulnerable Practice Support Programme

Mrs Ogle explained that this is a national pilot programme and we are now entering Year 2. Using the national criteria, the Primary Care Delivery Group discussed and identified 3 or 4 vulnerable GP practices in Doncaster which would benefit from the support programme. The practices will be required to provide 50% funding.
The next step is to present the findings to the Primary Care Commissioning Committee to ‘sense check’ and approve the practice shortlist. Consideration should be given to whether this is discussed in the private section of the meeting.

7. Any Other Business

Mrs Tully informed the Committee that the next meeting is scheduled to take place on Tuesday 24th May at 1pm. The plan is for the dates to change from June onwards, subject to the introduction of the new Governance Structure, and it is anticipated that the meetings will be held on the 2nd Thursday of the month at 12.30pm in the Boardroom, Sovereign House therefore the June meeting may be held on 9th June 2016. As the two meeting dates fall closely in succession, the meetings may be shorter as a consequence and could be used to develop how the Committee will manage Conflicts of Interest as this poses a significant challenge.

Dr Gibbons queried if it was acceptable to inform GPs that the agendas and papers will be published on the NHS Doncaster CCG website and Mrs Tully confirmed that it was.

8. Date and Time of Next Meeting

Tuesday 24th May 2016 at 1pm

9. It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard 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.