Governing Body
To be held on Thursday 16 March 2017
Commencing at 1pm – 4pm
In the Boardroom, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ

PUBLIC AGENDA

1. Welcome and Introductions
   Presenter: Chair
   Enc: Verbal

2. Apologies
   Presenter: Chair
   Enc: Verbal

3. Declarations of Interest
   Presenter: Chair
   Enc: Verbal

4. Patient Stories / Questions from Members of the Public
   Presenter: Chair
   Enc: Verbal
   (See our website for how to submit questions – required in advance of the meeting)

5. Minutes of the previous meeting held on 16 February 2017
   Presenter: Chair
   Enc: A

6. Matters Arising
   Presenter: Chair
   Enc: Verbal

**Strategy**

7. Delivery of the CCG Commissioning Strategy
   Presenter: Mrs Leighton
   Enc: B

8. Future Child Health Service Model
   Presenter: Mrs Sherburn
   Enc: C

9. Continuing Healthcare Hosted Services
   Presenter: Andrew Russell
   Enc: D

**Assurance**

10. Quality & Performance Report
    Presenter: Mr Russell & Mr Fitzgerald
    Enc: E

11. Finance Report
    Presenter: Mrs Tingle
    Enc: F
Standing Items

12. Chair & Chief Officer Report
   Mrs Pederson
   Enc G

13. Locality Feedback
   Locality Leads
   Verbal

14. Standing Orders (SOs), Standing Financial Instructions (SFIs) & Scheme of Delegation (SoD)
   Mrs Tingle & Mrs Atkins Whatley
   Enc H

15. Receipt of Minutes from Committees
   - Minutes of the Audit Committee meeting held on 12th January 2017.
   - Minutes of the Quality and Patient Safety Committee meeting held on 1 September 2016, 3 November 2016 and 19th January 2017
   - Minutes of the Executive Committee meeting held on 4th January 2017
   - Minutes of the Primary Care Commissioning Committee held on 8th December 2016 and 9th February 2017
   - Remuneration Committee Terms of Reference
   Miss Morris
   Chair
   Enc I

16. Any Other Business
   Chair
   Verbal

17. Date and Time of Next Meeting
   Chair
   Verbal
   Thursday 20th April 2017 at 1pm

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
Verbal

Item 1

Welcome & Introductions
Verbal

Item 2

Apologies for Absence
Verbal

Item 3

Declarations of Interest
Item 4

Questions from Members of the Public
Item 5

Minutes of the previous meeting
Minutes of the Governing Body
Held on Thursday 16th February 2017 commencing at 1.00pm
In the Boardroom, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ

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
Mrs Sarah Whittle – Lay Member
Dr Emyr Wyn Jones – Secondary Care Doctor Member
Dr Nick Tupper – Locality Lead, Central Locality
Dr Jeremy Bradley – 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
Mr Andrew Russell – Chief Nurse

Formal Attendees present:
Mrs Sarah Atkins Whatley – Chief of Corporate Services
Mrs Laura Sherburn – Chief of Partnerships Commissioning and Primary Care
Dr Rupert Suckling – Director of Public Health
Mrs Deborah Hilditch – Healthwatch Representative (Attending on behalf of Mr Stephen Shore)

In attendance:
Mrs Jayne Satterthwaite – PA (Taking Minutes)
Mr Ian Carpenter, Head of Communications & Engagement
Mrs Karen Leivers, Head of Planned Care – Item 8, Cancer Alliance Delivery Plan

ACTIONS

1. **Welcome and Introductions**

   Dr Crichton welcomed everyone to the Governing Body meeting.

   There were 10 members of the public and 1 member of NHS Doncaster CCG staff in attendance at the meeting.

2. **Apologies**

   Apologies were received from:
   - Dr Andy Oakford – Locality Lead, North East Locality
Mrs Kim Curry – DMBC Representative

3. Declarations of Interest

The Chair reminded members of their obligations to declare any interest they may have on any issues arising at meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group.

Declarations declared by members are listed in the CCG's register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link www.doncasterccg.nhs.uk

The meeting was noted as quorate.

Declarations of interest from sub-committee/working groups:

None declared.

Declarations of interest from today’s meeting:

None declared.

4. Questions from Members of the Public/ Patient Stories

Patient Story

It was noted that there was no Patient Story this month.

In the absence of a patient story, Mr Carpenter played a short video of a recent ‘Dragon's Den’ event which took place at NHS Doncaster CCG in November 2016 where CCG staff presented their ideas for new initiatives and processes.

Dr Crichton stated that the event was a novel way of seeking ideas and reviewing processes and will be replicated in the future.

Public Question to the Governing Body

Dr Crichton informed the Governing Body that a question from Mr Wright had been received regarding the Public consultation of the South Yorkshire and Bassetlaw Sustainability & Transformation Plan (STP) proposals.

Mr Wright asked the following questions to the Governing Body on the formal Public Consultation on Sustainability & Transformation Plan proposals:

- When will the formal consultation with the public commence?
• Who will be carrying the consultation out?
• Who will be analysing the responses and producing the report, and in doing so will that person be using the Gunning Principles?

Dr Crichton stated that Healthwatch and the CVS organisations have been commissioned to carry out the communications and engagement process with the public in respect of the Sustainability & Transformation Plan (STP) and introduced Mrs Hilditch from Healthwatch to give a response to Mr Wright’s questions.

Mrs Hilditch explained that the statutory partners in the STP across South Yorkshire and Bassetlaw have asked each local Healthwatch organisation and CVS organisation to commence conversations with, and involve communities in, conversations about the STP, why it has been developed, what it covers and how detailed proposals will be developed. In Doncaster, Healthwatch Doncaster will be carrying out this communication together with the local Patient Participation Groups, Health Ambassadors and the CCG. At this stage it is important to understand that it is not a consultation exercise but a communication and engagement process to assist the public and patients to understand what the STP is. Once the partners begin to understand what changes they are thinking about, formal consultation will commence.

Mrs Hilditch gave the following responses to the questions posed by Mr Wright:

**When will the formal consultation with the public commence?**

In Doncaster we want to ensure we create the opportunity for local conversations and to be inclusive and connect with people who are not only interested in our health and social care services but with those who are least likely to be reached through mainstream initiatives. The initial communication exercise will commence week commencing 20th February and will run throughout March and possibly into April 2017.

**Who will be carrying it out, analysing the responses, producing the report?**

Healthwatch Doncaster is co-ordinating the communication and reporting process and will carry out the exercise with other partners across local communities. As a minimum we are expecting to hold at least 2 large focus groups yet to be determined, and talk to up to 10 to 12 different community groups over the next 6 weeks including Community Veterans, Travellers, Doncaster College, the Deaf School and also the South Yorkshire Police and Fire as they are actively involved within social care. In addition we will use social media and our newsletters and surveys to seek input from those who cannot meet us face to face. The conversations will look at raising awareness with people and communities, of the issues facing the NHS and social care in South Yorkshire and Bassetlaw and the thinking so far of the STP partners in addressing these.
Each local Healthwatch and CVS organisation has been asked to develop a report of the outcomes of the local conversations. A central report of these findings will then be produced, to describe the range and reach of engagement achieved; summarise from the conversations and focus groups; offer examples of good practice and enablers of healthy living; make suggestions for what the public sector could do to create the conditions for a shift in the balance of responsibilities between people, communities and public sector. Healthwatch Doncaster has been asked to provide the central report on behalf of all local lead organisations.

If a public authority embarks on a consultation it must do so properly and this means complying with the Gunning principles. Healthwatch will be using the Gunning principles throughout which fits well with NHS Doncaster CCG and the Local Authority’s transparent process.

Reports will be collated from across the South Yorkshire and Bassetlaw area and forwarded to Mrs Helen Stevens, Communications Manager for the STP and will be presented to the South Yorkshire and Bassetlaw Sustainability and Transformation Collaborative Partnership Board in Mid-April to May 2017. The reports will also be available on the NHS Doncaster CCG and Healthwatch websites.

Mrs Hilditch reported that she can share the details if required.

Public Question to the Governing Body

Dr Crichton acknowledged an STP governance question from Mr Davison. Mr Davidson requested information on whether the organisations in the first four bullet points in the plan on a page are:

- In place and meet on a regular basis
- Publish minutes that are available to the public
- Have provision for members of the public to attend and ask questions
- Send a copy of the agenda and minutes to partner organisations.

Dr Crichton advised that Doncaster CCG is a small part of the STP as a member. The Governance is in the early stages at the present time. We will pass these questions on to the STP programme and provide a full response in due course to provide a response which would be shared directly with the requester and noted in full in the minutes of this meeting as a post-meeting note.

Post-meeting note:

The STP is not a statutory body, it is a collaborative of partner organisations within South Yorkshire and Bassetlaw. It is not a decision making body, and any outputs from discussions that take place at the Executive Steering Group and Collaborative Partnership Board would need to be considered, and agreed, by all the partner organisations. The Oversight and Assurance Group has not yet been
established. It would be the decision of each partner as to whether this was considered at their public or private meetings.

In the interests of openness and transparency, the Collaborative Partnership Board minutes, once ratified, are published on the STP section of the Commissioners Working Together website – the link is here: http://www.smybndccgs.nhs.uk/what-we-do/stp

The provider Acute Care Federation and Joint Committee of Clinical Commissioning Groups (JCCCG) operate separately to the STP and do not report to it. The JCCCG, which is in shadow form, publishes minutes on its website – the link is here http://www.smybndccgs.nhs.uk/about-us/how-were-run and is recruiting lay members. It will be established from April 2017, when it will meet in public and publish its agenda.

The Acute Care Federation is currently considering changes to its governance framework and it is anticipated that a Committee in Common structure will be in place for 1st May 2017 and operate as a private meeting.

Public and staff engagement is also currently underway and people can have their say on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan by attending a focus group event or completing an online survey – see here for more details: http://www.smybndccgs.nhs.uk/what-we-do/stp/staff-and-public-conversations

Public Question to the Governing Body

Dr Crichton reported that a further question had been received from Mr Merriman regarding cancer services however it was received out with the timescale. Dr Crichton informed Mr Merriman that Healthwatch Doncaster had posed a similar question 2 months ago and that a formal response to his question would be forwarded to him in due course.

5. Minutes of the Previous Meeting held on 19th January 2017

The minutes of the meeting held on 19th January 2017 were agreed as an accurate record subject to the following amendment:

Question for the Governing Body

Page 2, Line 8, after 'expressed' add 'for example'.

6. Matters Arising

Department of General Practice
Dr Crichton reported that his enquiries with the Academic Unit of Primary Medical Care have revealed that ‘teaching status’ within general practice is not possible; however alternative options could be explored further in the future.

Assurance Framework – Quarter 3 Report

Mrs Atkins Whatley confirmed that Efficiency Programme Risk 1.4 score of 12 has been increased until further notice.

360 Stakeholder Survey

Dr Crichton informed the Governing Body that he has sent a letter to Member Practice Representatives and Practice Managers, reminding them to complete the survey if they have not already done so.

Primary Care Commissioning Committee Quarterly Report

Mrs Tully informed the Governing Body that, although the minute was correct regarding the requirement to submit quarterly reports to NHS England, Mrs Ogle from NHS England has since informed the Primary Care Commissioning Committee on 9th February 2017 that the submission of reports are required on an annual not quarterly basis. Mrs Tully requested that a post meeting note be added to the Governing Body minutes of the 19th January 2017 to reflect this update.

Post Meeting Note

Mrs Satterthwaite has made the necessary amendment to the minutes.

7. Clinically Effective Commissioning

Mr Fitzgerald explained that in recognition of the current financial climate, NHS Doncaster CCG must demonstrate that it is making the most effective use of public monies to maximise the health and wellbeing of the people of Doncaster. To achieve this we need to ensure that our resources are used wisely and we maximise the impact of the services we commission to improve health, reduce health inequalities and ensure our population receives appropriate high quality care.

In January 2017, the Commissioning for Value - Decision making and Prioritisation Framework was presented to the Strategy & Organisational Development Forum for discussion and comment and was adapted accordingly. It has also been presented and discussed in the Clinical Reference Group to ensure relevant clinical debate. Any further decisions under the proposed policy framework will be made by the Governing Body or Executive Committee meetings. The purpose of the policy is to establish a system for transparent and coherent prioritisation for the commissioning of health and wellbeing services. It
provides a framework for making decision about relative priorities at a strategic and planning and commissioning level and facilitates rational and reasonable decision about which services are commissioned in accordance with our strategy. The Appendices within the document are subject to further modification and a communication plan is under development.

Mr Fitzgerald requested that the Governing Body approve the Commissioning for Value – Decision Making and Prioritisation Framework.

Dr Barbour referred to the flow chart in Appendix 1 and requested that consideration be given to the addition of an option for ‘Consultant feedback’. Mr Fitzgerald commented that the diagram offers a 2 part explanation to the patient regarding the decision made and their ongoing management plan.

Dr Barbour referred to Appendix 3 and highlighted the necessity to use patient appropriate language. Mr Carpenter stated that the engagement plan is an internal document and would be adapted for the public. It is envisaged that the policy will be communicated to the public Mid-March 2017 and leaflets will be distributed prior to the implementation on 1 April 2017. Mr Carpenter requested that the Governing Body inform him of any further additions to the engagement plan / patient literature.

Dr Suckling stated that it would be helpful to know how resources were allocated and if equal weight has been applied to the criteria. Mr Fitzgerald reported there are challenges relating to how different conditions are affected by the criteria; it can be subjective and there is an element of ‘see how it goes’. Patient safety has been embedded at the forefront of decision making.

Dr Suckling referred to the diagram in Appendix 1 and questioned the risk of GPs referring on problems to secondary care. Engagement has taken place with both GPs and Consultants to develop a checklist mechanism before a referral is made.

Dr Jones, as Chair of the Clinical Reference Group, welcomed the recognition of the Group and assured the Governing Body of the significant clinical input from primary and secondary care and Public Health involved in the decision making of the policy. An increase in the volume of work is anticipated and we need to plan effectively as the Clinical Reference Group meets on a bi-monthly basis.


8. Cancer Alliance Delivery Plan

Miss Morris assumed the role of Chair of the Governing Body whilst Dr
Crichton presented this item.

Dr Crichton explained that in 2015 the Independent Cancer Taskforce set out an ambitious vision for improving services, care and outcomes for everyone with Cancer by 2021. There are 16 Cancer Alliances being established across England, key to driving the change needed to achieve the Taskforce’s vision.

The South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance, governed by the Cancer Alliance Board and reporting into the South Yorkshire & Bassetlaw Collaborative Partnership Board and the National Accountability Oversight Group, have developed and agreed a delivery plan based on best practice and evidence that sets out four key work-streams and six cross cutting themes leading transformation at scale to improve survival, early diagnosis, patient experience and long term quality of life:

Workstreams
- Cancer Intelligence
- Prevention, Early Identification, Screening and Diagnostics
- Treatment and Care
- Living with and Beyond Cancer

Cross Cutting Themes
- Workforce
- Infrastructure
- I.T.
- Engagement with people affected by Cancer
- Clinical Engagement
- Place based plans

This programme enables implementation of the Taskforce’s strategy locally, therefore providing detail to the cancer element of the Sustainability and Transformation Plans. The Cancer Alliance Workstreams will undertake meaningful engagement with the public and patients and other key stakeholders on the development of delivery plans and their delivery.

Mrs Leivers informed the Governing Body that the Cancer Alliance Delivery Plan has been developed using the cancer network footprint and links into Public Health. The Cancer Alliance priorities include:
- Increase in survival rates - anyone born after 1960 has a 1 in 2 chance of getting cancer.
- More work to be undertaken in respect of prostate cancer.
- Focus on screening uptake especially for hard to reach groups.
- Develop new care models and monitor and evaluate services.

Meaningful engagement with the public and patients and other key stakeholders will commence mid-March 2017.

Dr Suckling commented that the challenge will be to deliver the plan
with the resources available and queried if funding was available within existing resources. Dr Crichton reported that a national bid for funding has been submitted and should be a sufficient driver to deliver the plan.

Dr Crichton requested that the Governing Body note the key Workstreams enabled to implement the Taskforce’s Strategy locally, within the wider governance of the Cancer Alliance Board and Executive Group. He also requested that any comments from the Governing Body be forwarded to him via email.

The Governing Body noted the key Workstreams.

Dr Crichton resumed the role of Chair of the Governing Body meeting.

9. Quality & Performance Report

Mr Fitzgerald and Mr Russell stated that the Quality and Performance Report was for noting by the Governing Body however wished to highlight the following points:

**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT)**
- Diagnostics - Diagnostics met the target for the third consecutive month.
- All cancer measures were on target during November 2016 with the exception of the 62 day wait for first treatment from NHS Cancer Screening Service referral was 83.3% against a target of 85%. Patients are being transferred to tertiary hospitals for treatment.
- 18 week Referral to Treatment Times (RTT) - The position for incomplete pathways in December fell for the third consecutive month by 1.2% to 90.1% which is below standard (92% of patients waiting under 18 weeks). A recovery plan has been received from DBTHFT stating that the Trust anticipates the 92% target will be met by the end of March 2017. The 18 week RTT times continues to be monitored.
- A&E - January 2017 A&E performance was 85.0% against the NHS Improvement trajectory and national standard of 95%. Significant pressure has been experienced nationally in respect of the 4 hour target. There are effective mechanisms in place to ensure patient safety is maintained. Thanks were noted to provider staff for their response to the increased pressures on A&E in Doncaster, which are broadly similar to the increased pressures across the country.
- Never Event - A Never Event has been recorded during December 2016 however the patient suffered no harm as a result. The Trust has initiated an investigation and NHS Doncaster CCG remains closely involved.

**Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**
- Improving Access to Psychological Therapies (IAPT) Recovery Rate
reached 65% during December against a national standard of 50% and above the England average. Doncaster’s IAPT service is achieving above all the national access and waiting time targets.

Mr Russell informed the Governing Body that confirmation has been received of Mr Richard Parker’s successful appointment to the post of Chief Executive of Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHTFT).

Dr Wagstaff queried the ‘red and green days’ as detailed in the report. Mr Russell explained that, as a means of understanding patient flow, the Trust is currently piloting initiatives using a live system of red and green days. The pilot is also in operation at Mexborough Montagu Hospital. Daily operational and monthly length of stay meetings are taking place and where necessary issues are escalated to the System Resilience Group and the Doncaster and Bassetlaw A&E Delivery Board.

Miss Morris queried if the Trust A&E performance rate differed negatively to other areas, and whether we understand how far over the 4 hour target patients are seen. Where is the 95% target being met? We are assured that no patients hit the 12 hour rate. Mr Fitzgerald will liaise with the Performance team to ascertain if they can be added to the report.

Dr Pieri raised concerns regarding the cancer 62 day wait and the transfer of patients to tertiary hospitals. Mrs Leivers stated that this issue is noted across the Sustainability & Transformation Plan (STP) footprint and is discussed and monitored in the Cancer Programme Board meetings.

Dr Suckling commented that the Quality & Performance report is much improved and it is useful to see volumes and well as percentages recorded. He queried how the 50% target for IAPT had been established. Dr Seddon agreed to investigate this further.

The Governing Body noted the report.

10. Finance Report

Mrs Tingle stated that, as a comprehensive Finance report was presented to the Governing Body on 19th January 2017, this report was for noting by the Governing Body however wished to highlight that NHS Doncaster CCG is currently forecasting to achieve all of its financial targets for 2016/17. Mrs Tingle re-iterated the financial challenge for 2017/2018.

Dr Suckling queried if the surplus of £5,797k was a true figure. Mrs Tingle advised that NHS Doncaster CCG has a set of business rules which must be abided by. The 1% surplus must be met as we are unable to draw down if we over achieve. Mrs Atkins Whatley advised
that a Medium risk was applied at the beginning of the financial year.

The Governing Body noted the report.

11. Corporate Assurance Report – Quarter 3

Mrs Atkins Whatley presented the Corporate Assurance Report Quarter 3. The key points from this report to which the Governing Body’s attention were particularly drawn are:

- **Risk:** Our Governing Body Assurance Framework retains the same 21 risks as in Quarter 2 and a deep dive review of the Framework is scheduled for Quarter 4. As at the end of the Quarter, the Risk Register held 26 risks. 8 of these risks were being treated: A&E 4-hour wait, e-cigarettes prescribing position (new risk), completion of PUPOC reviews by the required deadline, primary care prescribing quality & cost effectiveness, data quality in respect of referrals and activity, ambulance handover times (new risk), cancer 62 day target achievement (new risk), and implementation of the Section 117 “Who Pays” guidance. The action plans were all running to schedule.

- **Incidents:** There have been six incidents reported in the last Quarter. Five of the incidents were information governance issues, and all originated from outside the CCG and were not breaches by our team members or for our organisation. This is a significant improvement on the position in previous quarters.

- **External assessments:** Audit Committee members held private discussions with Internal Audit in the last Quarter; no issues were raised for reporting.

- **Constitution & governance structure:** The Governing Body, under delegated authority from Member Practices, agreed to enter into a Joint Committee with other CCGs and NHS England for the Commissioners Working Together programme; this was formerly a collaborative partnership arrangement as referenced in our Constitution. The associated constitutional update required to capture this change will be consulted upon with our Members during Quarter 4 prior to being submitted to NHS England. We have also included an A&E Delivery Board in our governance structure (required by NHS England). The new Conflict of Interest Guardian role has been allocated to the Lay Member for Audit & Governance, in accordance with NHS England guidance.

- **Emergency Preparedness, Resilience & Response (EPRR):** We participated in Exercise Cygnus during October 2016, exercising the country’s plans for responding to a flu pandemic. The exercise was run from COBR downwards nationwide, and NHS Doncaster CCG participated at a South Yorkshire Health Tactical level. The learning will be fed back into the CCG. A Mass Treatment Plan has been developed across Doncaster’s statutory bodies to ensure preparedness for any situation which may require mass vaccination or treatment of the Doncaster population. A national report from Cobra is awaited.

- **Information Governance:** Work is progressing well on collating
evidence for the 2016/17 Information Governance Toolkit self-assessment, and an Internal Audit is scheduled for February 2017. A data quality audit on complaints had a positive outcome.

- **Information Technology:** The Local Digital Roadmap plan has now achieved final approval from NHS England and has been published on our website. Work is underway on the information sharing implications.

- **Counter Fraud:** NHS Protect have brought forward the deadline for the 2017 Counter Fraud Self-Assessment Tool. The standards are expected to be released in January 2017 for self-assessment and reporting by 31 March 2017. An Amber rating was awarded last year and it is forecast the same will be awarded for this year.

- **Organisational Development:** This quarter the Organisational Development Strategy and underpinning action plan were refreshed and have since been approved by the Governing Body. The Strategy is broken down into six areas with a sponsor for each area. Our Colleague Engagement Group is working towards the Healthy Workplaces Award Scheme, looking at a range of different potential initiatives.

Mrs Whittle congratulated Mrs Atkins Whatley on the comprehensive Corporate Assurance report.

The Governing Body noted the report.

12. **Chair and Chief Officer Report**

Mrs Pederson stated that the joint report was for noting by the Governing Body however wished to highlighted the following:

**NHS England Assurance Review – Quarter 3** – Our Quarter 3 Assurance Review meeting with NHS England took place on 13th February 2017 and the following specific areas were discussed:
- GP 5 Year Forward View.
- System Commissioning and Models of Care. Ernst Young, our strategic partner, is supporting NHS Doncaster CCG and the Local Authority.

**360 Stakeholder Survey** - The national CCG 360° Stakeholder Survey commenced on Monday 16th January 2017 and runs until Friday 24th February 2017. A limited response has been noted to date and Mrs Pederson requested that Governing Body GPs encourage their Members to complete the survey. The outcome report from Ipsos Mori is expected to be received on 31 March 2017.

**Locality Lead Elections** - Two Locality Lead election processes completed during January 2017, resulting in the re-election of:
- Dr Nick Tupper to the Central Locality (1 vacant post still remains in the Central Locality);
- Dr Marco Pieri to the North West Locality.
Miss Morris queried the plan for the vacant post in the Central Locality. Encouragement is being given for Members to apply.

**Previously Un-assessed Periods of Care (PUPoC)** - The PUPOC Team completed the reviews of applications for the Previously Un-assessed Periods of Care current period project by the NHS England deadline of 31 January 2017. This is the result of intensive work and Mrs Pederson congratulated Mr Russell, Chief Nurse and the team.

The Governing Body noted the report.

13. **Locality Feedback**

Locality Leads gave the following feedback from their Locality meetings:

**Central Locality** – Dr Tupper reported the following items were discussed:
- Mrs Leivers gave a briefing in respect of Planned Care.
- Miss Sessions gave a briefing on OptimiseRx.

**North West Locality** – Dr Seddon reported the following items were discussed:
- A briefing from the Child and Adolescent Mental Health Services (CAMHS) was well received.
- Miss Sessions gave a briefing on OptimiseRx.
- IT Team discussed issues regarding remote consultation. The North West Locality will introduce the use of Skype in the future.
- Cancer – discussed the Referral management Service.

Dr Seddon highlighted that 1 hour meetings is a tight timescale to effectively discuss all agenda items. Dr Crichton acknowledged how a 1 hour meeting may be limiting however this was the Locality’s choice.

**North East Locality** – Dr Bradley reported the following items were discussed:
- Mrs Leivers gave a briefing in respect of Planned Care.
- Miss Sessions gave a briefing on OptimiseRx.
- A Prescribing update was given.

**South East Locality** – Dr Singh reported the following items were discussed:
- Mrs Leivers gave a briefing in respect of Planned Care.
- Miss Sessions gave a briefing in respect of Optimise Rx.
- A briefing was given by the Child and Adolescent Mental Health Services (CAMHS).

**South West Locality** – Dr Wagstaff reported that there was no feedback to be given from the South West Locality as no meeting had been held.
The Governing Body noted the feedback.

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

There were no minutes from Committees to be noted by the Governing Body.

15. **Any Other Business**

There was no other business discussed.

16. **Date and Time of Next Meeting**

1:00pm on Thursday 16th March 2017.
Verbal

Item 6

Matters Arising
Item 7

Delivery of the CCG Commissioning Strategy
At the November meeting of the Governing Body the Commissioning and Contracting Intentions for 2017 – 2019 were received. The Intentions reflected the:

- Focus of the Doncaster Place Plan
- Focus of the South Yorkshire & Bassetlaw Sustainability and Transformational Plans (STP)
- NHS Operational Planning and Contracting Guidance, including delivery of the 9 National “must be dones”
- Quality, Innovation, Productivity and Prevention (QIPP) requirements

Governing Body agreed that The CCGs 5 year strategic vision should continue to build upon three connecting service areas required for systematic transformational change:

- Care Out of hospital;
- Care of the Elderly;
- Co-ordinated Care.

The CCG Commissioning and Contracting teams enacted the intentions into the 2 year contracts with the main providers of care Rotherham Doncaster and South Humber Mental Health Foundation Trust (RDASH) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT). These contracts were signed on 23rd December 2016.

Individual Delivery Plans for the agreed priority areas have been developed in collaboration with Clinical Leads, CCG teams and partner organisations. These plans have been discussed and debated at CCG Strategy and Organisation Development sessions. The Delivery Plans on a page are included within this report and are presented to Governing Body for approval.

Each Delivery Area has a partnership delivery group and associated dashboard to monitor implementation and impact. It is the intention to present the dashboards at monthly Governing Body meetings as part of the current performance report.
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<td>Governing Body are asked to note and approve the following Delivery Plans for 2017 – 2019.</td>
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<td>Assurance Framework</td>
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<tr>
<td>Local Context</td>
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<tr>
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<tr>
<td>Frequent attender for all urgent care services</td>
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<tr>
<td>Link between levels of deprivation and use of urgent care services</td>
</tr>
<tr>
<td>Patients of all ages will be able to access a range of urgent care in different settings, dependent on clinical need</td>
</tr>
<tr>
<td>Vision/what will success look like?</td>
</tr>
</tbody>
</table>

| Timescale | Integrated response in place Q4 17/18 March 17 March 18 By 2020 By 2019 April 17 April 17 |
|-----------|---------------------------------|------------------|------------------------|--------|--------|--------|
| Strategic: | Implement the 5 elements of the A&E Improvement Plan, with a particular focus on: | - Reviewing the Doncaster model, in conjunction with the network, with regards to integrated call handling and management with 111, ultimately leading to a 24/7 integrated care response for physical and mental health service access |
| | | - patient flow within and between DBHFT and RDASH services | Further development of trusted assessor models |
| | Ensure the 4 priority standards for 7 day services are delivered | Implement the Urgent and Emergency Care Review, actions not captured within the A&E Improvement Plan, in particular: | - working in support of the Doncaster digital road map, ensure access to the summary care record for all parts of the Doncaster Urgent Care System as a minimum, working towards the enhanced summary care record and improved data flows across urgent care to support patient care |
| | | - supporting care home access to and use of urgent care services | Primary care access |
| | | Work with partners in the Yorkshire commissioning collaborative to understand barriers to the delivery of Ambulance Response times and on the re-procurement of PTS services |

<table>
<thead>
<tr>
<th>Timescale</th>
<th>Operational:</th>
<th>Review the Doncaster Urgent Care System as a whole, one year on from the changes made in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 17</td>
<td>- Review FDASS model and ensure recommendations are implemented to secure improved consistency of streaming and streaming rates to UCC, other departments within DRI and out of the acute hospital</td>
<td>- Work across SRG to ensure that 4 hour A&amp;E standard is delivered, including:</td>
</tr>
<tr>
<td>March 17</td>
<td></td>
<td>- specific action plan for A&amp;E dept</td>
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<tr>
<td>Dec 16-Sept 17</td>
<td></td>
<td>implementation of paramedic pathfinder</td>
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<tr>
<td>April 17 onwards</td>
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<tr>
<td>December 16 and ongoing</td>
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<table>
<thead>
<tr>
<th>Impact</th>
<th>Success Indicators</th>
<th>Impact on activity</th>
<th>Impact on finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 95% of A&amp;E attendances are treated, admitted or discharged within 4 hours</td>
<td>- 20% FDASS attendances streamed away from ED on average per month from April 2017</td>
<td>- Potential invest to save regarding FDASS, to ensure that there is no double funding between urgent care services on DRI site; increased streaming away from ED would result in £400k reduction in ED spend</td>
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<tr>
<td></td>
<td>- patients contacting 999 service receive an appropriate and timely response, in line with the national standards</td>
<td>- DTOCs reduced by 5% compared to 2016/17 baseline, by March 2018</td>
<td>- Reduced A&amp;E attendance cost of £53k during 2017/18 and £160k during 2018/19 resulting from reduced ambulance conveyance</td>
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<td></td>
<td>- fewer people are taken to hospital by ambulance</td>
<td>- 2.5% (455) reduction in ambulance conveyance rates to DRI compared to 2016/17 baseline, by March 2018 as a result of paramedic pathfinder; 7.5% (1366) reduction in ambulance conveyance rates to DRI compared to 2016/17 baseline, by March 2019</td>
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<td></td>
<td>- Delayed transfers of care are accurately monitored across all parts of the system</td>
<td>- Working towards delivery of all requirements of the 5 Improvement Initiatives and the Urgent &amp; Emergency Care Route Map</td>
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<tr>
<td></td>
<td>- Incidence of delayed transfers of care is reduced</td>
<td></td>
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<td></td>
<td>- Working towards delivery of all requirements of the 5 Improvement Initiatives and the Urgent &amp; Emergency Care Route Map</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Enablers and links to other plans | Doncaster Digital road map to enable all providers of urgent care to access relevant patient records | Primary care proactive specification and developing responsive and extended pillars will impact on numbers attending DBH and access to primary care |

| STP and Doncaster Place Plan | Implementation of changes in intermediate care system, following the review and early testing of rapid response for falls and use of bed base, will impact on both numbers attending DBH and support options following A&E attendance |
### Action

#### Workstream 1 - Right Care Programme and Pathway Redesign
- Del 16: Agreement and Implementation of a Planned Care Board and Task and Finish Groups
- By Dec 16: Commissioner and Provider sign off on Planned Care Plan
- By Dec 16: Agreement of contract and activity numbers for Planned Care and SDIP
- Dec - Feb 17: Review of current Planned Care Access Policy and procedures
- Dec - Feb 17: Development and Governing Body sign-off of CCG Disinvestment and Decommissioning Policy
- Jan-Mar 17: Engagement and Communication of Planned Care Workstreams and ambition to Primary & Secondary staff & Doncaster public

#### Workstream 2 - Threshold Management and Reduction in Procedures of Limited Clinical Value (POLCV)
- Dec 16 - Mar 17: Engagement with SY Commissioners on standardisation of thresholds agreed through the STP
- Dec 16 - Mar 17: Agreement on specific POLCV and thresholds locally
- Dec 16 - Mar 17: Clinical Engagement - Primary and Secondary Care development and sign-up
- Dec 16 - Mar 17: Process/system for ensuring implementation of the thresholds
- Dec 16 - Mar 17: Patient Engagement and Communication
- Mar 17 onwards: Communicate and launch referral guidance/criteria and planned care pathways
- Apr onwards: Ongoing Monitoring

#### Workstream 3 - Improvement in Primary Care Information and Referral Management
- a) Nov - Jan 17: Development of individual practices information packs
- b) Nov - Jan 17: Individual meetings with practices to discuss current referral demand
- Nov - Jan 17: Further development of Primary Care Consultation Notebook, including workstreams 1 & 2 development
- Nov - Mar 17: Further development and standardisation of primary care Locally Enhanced Services through Extended Primary Care stream
- Apr 17: Launch and continued meetings

#### Workstream 4 - Patient Engagement, Choice and Shared Decision Making
- Nov - Mar 17: Patient and Public awareness raising and communication regarding planned care
- Apr - Sep 17: Development of Shared Decision Making Strategy
- Apr - Sep 17: Review and enhanced use of patient decision aids
- Nov onwards: Review of current ERS booking and choice system

### Impact

- 2017/18 Reduction in planned care referrals by 6% (in line with peer group)
- 2018/19 Reduction in planned care referrals by 12% (in line with England average)
- Reduction of patients in Acute system
- Reduction in Acute sessions
- 2018/19 Reduction in planned care spend (DBH) 2017/18
- Reduction in planned care spend (DBH) 2018/19 (Not Yet Confirmed)

### Planned Care Programme Board
- Local Digital Roadmap
- STP
- Doncaster Place Plan
- Clinical Reference Group

### Provider CIP and Turnaround Plan
- CCG QIPP Plan

### Contract Management Processes (FPIP - Strategic Contracting Group)
### DRAFT Delivery Plan on a Page: Intermediate Care

#### Local Context

<table>
<thead>
<tr>
<th>Health &amp; Wellbeing Gap</th>
<th>Care &amp; Quality Gap</th>
<th>Finance &amp; Efficiency Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasingly aging population and growing numbers of people with Dementia. Several IC services in Doncaster.</td>
<td>Current Intermediate care services are configured in a way that means there is less emphasis on maintaining people at home and prevent admissions and A&amp;E attendances as well as stepping people down from hospital as early as possible.</td>
<td>The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services.</td>
</tr>
<tr>
<td>Intermediate Care will be simpler and more responsive. There will be fewer teams and less hand offs along the intermediate care pathway. Intermediate Care will do more to maintain people at home and prevent admissions and A&amp;E attendances as well as stepping people down from hospital as early as possible. Intermediate Care will be part of the local neighbourhood model to ensure continuity of care, maintenance of social networks and will build on existing community assets.</td>
<td></td>
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</tr>
</tbody>
</table>

#### Vision/What will success look like?

- The Intermediate Care workforce will be able to respond to physical, mental health and social care needs in an integrated way.
- The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services.
- The Intermediate Care workforce will be able to respond to physical, mental health and social care needs in an integrated way.

#### Actions

**November 2016-April 2017**

1. Test and refine delivery model by implementing and evaluating a series of discrete projects with providers
2. Undertake skills audit and agree workforce development plan
3. Further engagement with patients, carers and the public to develop the model
4. Complete financial and activity modelling
5. Continue to develop appropriate joint commissioning and provision model
6. Identify any procurement processes required and plan accordingly. (Intention is to work with current providers to develop existing services)
7. Develop a joint dashboard for intermediate care

**May 2017 onwards**

1. Sign off new service model following testing
2. Ongoing public engagement and formal consultation, if required
3. Jointly commission new service model and a phased implementation plan with existing providers 2017/18
4. Or procure early 2017/18 and implement with successful bidder
5. Or combination of 3 or 4
6. Evaluate new model and implementation

#### Impact

**Maintenance or improvement in reported patient experience of intermediate care services**

- More service users are supported to maintain their independence, live at home and in the community as long as possible
- A greater proportion of people feel supported to manage their long term condition (s)
- More service users will be enabled to reach their goals and maintain connections with their home and community environments
- More responsive to step up referrals

**Reduced A&E attendances for people aged 75 and over**

- Reduced emergency admissions for people aged 75 and over (or limited growth)
- Reduced ambulance conveyance to A&E for people aged 75 and over (or limited growth)
- Proposal 5% reduction initially - linked to YAS pathfinder target, increasing to x% of A&E attendances
- Reduced Delayed Transfers of Care
- More people remaining at home following discharge from an acute bed
- Fewer admissions to Intermediate Care beds, less intermediate care beds
- Reduce bed base by 50% initially
- Increase in community based intermediate care activity (linked to reduction in bed based activity)

**Reduce A&E attendances by a cost of - not yet quantified**

- Reduced emergency admission episodes by - not yet quantified
- Reduction in excess bed days - not quantified
- Reduced A&E attendances - refer to Urgent & Emergency Care Plan
- Reduced conveyance to A&E - refer to Urgent & Emergency Care Plan
- Implement new service model within or under existing financial envelope for intermediate care
- Reduction in social care costs:

**Doncaster Digital road map to support integrated working and timely access to information**

- Primary Care proactive specification and delivery plan
- Dementia Delivery Plan
- Community Led Support
- Adult Social Care Transformation Programme

**Enablers and links to other plans**

- Falls, community therapy, EoL and continence service elements of community services delivery plan
- Urgent Care delivery plan and YAS pathfinder
- Development and implementation of assistive technology strategy
**Local Context**

- Link between awareness of Cancer symptoms and survival, Survival deficit for older people, Smoking, alcohol and obesity link to incidence
- Variation across Yorkshire and the Humber in Cancer pathways per tumour site, Opportunity for improvements in efficiency and effectiveness
- Cancer will be diagnosed early and people will receive timely treatment, with more people surviving cancer after one year
- More people will live with and beyond cancer with good quality of life
- Patient satisfaction with their care will be excellent

**Care & Quality Gap**

- More referrals need to be made to achieve early diagnosis

**Finance & Efficiency Gap**

- Cancer incidence and survival are increasing requiring more capacity

**Vision/ what will success look like?**

- Patient satisfaction with their care will be excellent

**Actions**

**Prevention**

- TBD across SY&B Implement Bisphosphonates to prevent secondary cancers in women previously treated for early stage breast cancer (Impact measures 5,9,16,17)
- Ongoing Work closely with Public Health and RDaSH on prevention and awareness in line with the Doncaster JSNA (Impact measures 5,6,7,8,10,11,12,13,14,15,16,17) including links to hard to reach groups via Ambassadors.

**Early Diagnosis**

- By March 2017 Ensure 2015 2WW NICE Guidance implemented across Primary Care (Impact measures 5,6,12,15,16,17,21)
- by March 2018 Support increase in provision of straight to test (direct access diagnostic) pathways in line with 2WW NICE Guidance 2015 and within High Value Pathways work (Cancer Alliance footprint) and review innovative diagnostic solutions to increase capacity to meet demand (Impact measures 2,5,6,16,17,18)
- Ongoing Work closely with SHF and system partners (e.g. CRUK) to improve Screening uptake and awareness (Impact measures 5,6,7,12,13,14,16,17), including links to hard to reach groups via Ambassadors.

**TBD across SY&B**

- Ongoing Work closely with SY&B Cancer Alliance to jointly improve cancer pathways to meet the national waiting time standards (Impact measures 1,2,3,5,16,17)

**TBD**

- Ongoing Develop a regional Chemotherapy model (Impact measure 16)

**Ongoing**

- Ongoing Work closely with SY&B Cancer Alliance to jointly improve cancer pathways to meet the national waiting time standards (Impact measures 1,2,3,5,16,17)
- Ongoing Improve efficiency and effectiveness of cancer pathways through analysis and benchmarking of breaches and CWT data (Finance and Efficiency Gap, Impact measures 1,2,3,5,16,17)
- Ongoing Review NHS Rightcare information and understand where efficiencies can be made with peer group CCGs

**Living Within and Beyond Cancer**

- By March 2018 Ensure all patients have access to a CNS or other key worker (Impact measures 4,9)
- By March 2018 Ensure all breast cancer patients have access to stratified follow up pathways of care. Also work with DBHFT and Primary Care to develop ambitions and framework for access to urgent services for patients with re-occurrence
- By March 2018 Commission and implement the Y&H High Value Pathway Specifications
- By March 2018 Develop a regional Chemotherapy model (Impact measure 16)
- By March 2019 Ensure all prostate and colorectal cancer patients have access to stratified follow up pathways of care. Also work with DBHFT and Primary Care to develop ambitions and framework for access to urgent services for patients with re-occurrence
- Ongoing Ensure directory of local cancer support services held by main providers is up to date and work closely with all partner organisations to support patients with cancer (Impact measure 4,9)

**Local Context**

- Vision/ what will success look like?

**Care & Quality Gap**

- Cancer incidence and survival are increasing requiring more capacity

**Finance & Efficiency Gap**

- Cancer incidence and survival are increasing requiring more capacity

**Impact**

<table>
<thead>
<tr>
<th>Quality</th>
<th>Activity</th>
<th>Finance</th>
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<tbody>
<tr>
<td>National</td>
<td>National</td>
<td>National</td>
</tr>
<tr>
<td>1. The national standards for Cancer Waiting Times are met and maintained</td>
<td>18. Increased provision of GP straight to test pathways (direct access diagnostics)</td>
<td>None</td>
</tr>
<tr>
<td>2. Work towards 95% patients being informed of their diagnosis or cancer ruled out by day 28 from GP referral by 2020, and 50% within 2 weeks</td>
<td>19. Increased Chemotherapy treatments delivered in Doncaster (specifics to be determined by the pathway development)</td>
<td>Local</td>
</tr>
<tr>
<td>3. The majority of patients are transferred from DBHFT to the tertiary centre by day 38 from GP referral from October 2016 (threshold TBC)</td>
<td>20. Commission sufficient capacity to meet diagnostic demand</td>
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<tr>
<td>4. Patient Satisfaction levels are excellent (at, or above, the expected range in CPE5 or other surveys)</td>
<td>21. Increase the number of patients having first treatment (via timely referral, diagnosis and capacity to treat) compared to 2016/17. (Threshold TBD from C&amp;D work)</td>
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<tr>
<td>5. Work towards One year survival rates reaching 75% by 2020 and Ten year survival reaching 57% by 2020</td>
<td>22. Improve Elective spend against peer group average (Rightcare) for Breast, Lower GI, urology, Head and Neck, Haematological, Upper GI and Lung, where improvements can be made in efficiency (rather than volume)</td>
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<tr>
<td>6. More patients are diagnosed at Stage I or II - improving to the National Average by March 2018, and work towards 62% by 2020; with the percentage with a Stage recorded improving to the national average by March 2018.</td>
<td>23. Reduce Non-Elective spend towards peer group average (Rightcare) for Breast, Lower GI, urology, Head and Neck, Haematological, Upper GI and Lung where improvements can be made in efficiency (rather than volume)</td>
<td></td>
</tr>
<tr>
<td>24. Improve Procedure spend against peer group average (Rightcare) for Breast, Lower GI and Lung where improvements can be made in efficiency (rather than volume)</td>
<td>25. Improve Prescribing spend on Hormone Therapy against peer group average (Rightcare) where improvements can be made</td>
<td></td>
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<tr>
<td>Enablers and links to other plans</td>
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<tr>
<td>Local</td>
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<tr>
<td>7. Maintain Cancer screening above the England Average, and bring all screening rates by patients’ GP practice up to 60% by March 2019</td>
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<tr>
<td>8. Reduce smoking prevalence to 13% or less by 2020</td>
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<tr>
<td>9. Improve long term quality of life (national measure under development)</td>
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<tr>
<td>10. Reduce age-standardised incidence and a reduction in cases linked to deprivation by 2020</td>
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<tr>
<td>11. Reduce smoking to 21% in routine and manual workers</td>
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<tr>
<td>12. Reduction in survival deficit for older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Discernible fall in age-standardised incidence</td>
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<td></td>
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<tr>
<td>14. 75% uptake for FIT in the bowel screening programme</td>
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<tr>
<td>15. Improve diagnosis from a 2WW referral from 54.84% (July 2016) to 60% by March 2018. Conversely reduce diagnosis from emergency presentation for Colorectal and Lung cancers (RightCare)</td>
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<tr>
<td>16. Improve &lt;75 Mortality from breast and lung cancer towards the Peer Group average (RightCare)</td>
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<tr>
<td>17. Improve from 82% (Q1 2016/17) having non-palliative treatment to 92% by March 2018</td>
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</table>

Link to National Cancer Taskforce Report for ambitions and NHS England Planning Guidance 2017-2019; Cancer Alliance and underpinning regional workstreams (including STP, LWABC, Chemotherapy, CWT) for regional direction of travel

Planned Care Delivery Plan an enabler regarding demand management to support capacity for increased Cancer demand

Primary Care Transformation plan as an enabler for health promotion and prevention and access for early diagnosis
### Local Context

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Doncaster has substantially invested in mental health services locally and through out of area placements but has relatively poorer outcomes than its comparators.</td>
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</tbody>
</table>

### Vision/ what success look like?

- The 5 Year Forward View for Mental Health sets the challenge to improve the wellbeing of the public and development of early intervention, assessment, treatment and recovery services.

### Actions

- From April 2017
  - Implementation of Single Point of Access for all age mental Health services;
  - Development of collaborative pathways to deliver physical health for people with severe and enduring mental health problems;
  - Development of community based model to improve perinatal mental health;
  - Modernise the adult mental health acute care and home treatment pathway
  - progress development of Early intervention in psychosis services
  - Deliver IAPT Plus and start the development of IAPT to include employment advisors improving access to employment opportunities
  - Develop the IAPT pathway to include joint care management of people with long term conditions

### Impact

- Reduce suicide rates by 10%, against 16/17 baseline
  - Ensure delivery of MH access and quality standards incl 24/7 access to community crisis teams, home treatment teams, and MH liaison services in acute hospitals;
  - Reduction in A&E attendances due to improved access to crisis prevention and crisis support services

- Expand capacity so that 53% of people begin a NICE recommended package of care within two weeks of referral; Additional psychological therapies, so that at least 19% with anxiety and depression access treatment through integration with Primary Care;
  - Increase access to individual placement support for people with severe mental illness in secondary care by 25% by April 2019, against 17/18 baseline;
  - reduction in A&E attendances of people who are supported to better manage their Long Term Condition. 50% reduction in avoidable A&E attendances by frequent flyers (£10,109)

- Increase baseline spend on MH services to deliver MH Investment Standard;

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**Doncaster Digital roadmap, Intermediate Care Review, CCG transformation plans, DMBC Adult Health & Wellbeing transformation plans**

**The 5 Year Forward View for Mental Health**

**Primary Care Strategy**

**STP and Doncaster Place Plan**
<table>
<thead>
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<td>Vision/ what will success look like?</td>
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**Local Context**

**Care & Quality Gap**

- A Health Needs Assessment for People with a Learning Disability and/or ASD was conducted in 2011 which identified that people from this cohort were dying from preventable cancers as they were not accessing screening programmes. 1500 people are on LD registers but only 32% of people with a learning disability who are on a GP register are receiving an annual health check during the year.

**Health & Wellbeing Gap**

- 15 people with complex care needs are receiving in-patient (Rehabilitation) care outside of Doncaster away from their families. 8 people have been placed in Low or Medium Secure services. Doncaster has a high number of independent and Private Sector complex care provision which attracts commissioners from out of area, which places a burden on local NHS service provision.

**Finance & Efficiency Gap**

- The average price per bed day rate cost for Locked Rehabilitation is £408, rising to £480 per day for Medium Secure.
- Current Cost to the CCG for Locked Rehab circa £2.7million

**Actions**

- Deliver the Core Principles of Building the Right Support in Communities for People with a Learning Disability and/or ASD
- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Prevent people from going into crisis, support people to live as independently as possible in the community and prevention of the need for out of area placements. Reduce cost pressures on spend for out of area placements.

**Impact**

- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population and 20-25 in NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Remodelled provision of step down / up services supported by an enhanced community service focusing on patient case management and supporting individual need. This will deliver patient care within the local community and within the least intensive setting by ensuring timely intervention, identification of preventative care, avoidance of out of area care. Rourced through remodelling of existing commissioned inpatient and community capacity to provide timely and efficient patient interventions.

**Enablers and links to other plans**

- Doncaster Digital roadmap, Intermediate Care Review, CCG transformation plans, DMBC Adult Health & Wellbeing transformation plans
- Building the Right Support for People with Learning Disabilities Primary Care Strategy
- NHS Operational Planning and Contracting Guidance 2017-2019

| STP and Doncaster Place Plan | Doncaster Digital roadmap, Intermediate Care Review, CCG transformation plans, DMBC Adult Health & Wellbeing transformation plans | Building the Right Support for People with Learning Disabilities Primary Care Strategy | NHS Operational Planning and Contracting Guidance 2017-2019 |
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## Vision/what will success look like?

| Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need. Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification. | Timely access to the right skilled clinician. Patients able to make informed decisions about their healthcare. Patient independence is supported. Patient care does not suffer as it moves between different services. | Access to primary care services will be timely. Primary Care will become more stable with working at scale and the establishment of accountable care organisations. Improved interoperability and integration between computer systems in primary care, the community and secondary care. |

## Actions

### Quality

- Implementation of the Quality Assurance Framework and Primary Care Dashboard to support general practice delivering good quality care. Launch with general practice December 2016, initial intelligence gathering and dialogue to take place Jan - June 2017.

### Investment:

- Investment in the Primary Care Strategy Model including the specifications for the Proactive Coordinated Primary Care Service, Extended Primary Care Service, Keeping People Well Service and Responsive Primary Care Service (from April 2017).

### Workforce:

- Ringfenced funding via CCG towards training for receptionists in active signposting and upskilling clerical staff to manage correspondence (Dec 2016 - March 2019).
- Practice Manager Development Programme.
- Second wave of the clinical pharmacist in practice scheme.
- Investment into the General Practice Nurse Development Strategy.

### Loadwork:

- Releasing Time for Care programme Support practice EOs by June 2017 & Implementation of the 10 high impact actions thereafter. Implement Productive General Practice programme in Doncaster April - June 2017.
- Support uptake of GP Improvement Leader Programme.
- Support update of Practice Manager Development Programme (national scheme).

### Finance & Efficiency Gap


## Impact

### Proactive Coordinated Care

- Identification of 2% most vulnerable and complex patients. Practice to proactively treat and coordinate care of this cohort of patients. All GP Practices will have a register of patients receiving proactive coordinated care as specified.
- Confirmation of named professional and their respective caseloads. All patients on the proactive coordinated care register will have a named professional.
- Patients on the proactive coordinated care register will have a single care plan that will be shared with all professionals involved in their care. Patients will be invited to participate in a holistic care planning process and develop a single care plan that be shared with teams and professionals involved in their care.
- Patients will feel more empowered and motivated to take responsibility for their health and wellbeing. All patients on the proactive coordinated care register will be asked Question 33 of the GP Patient Survey.
- Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. All patients will receive seamless joined up care from the appropriate professionals involved in their care.

### Extended Primary Care

- Equitable offer of the GP local services across Doncaster. Patients will have consistent access to commissioned primary care services. Shift of appropriate services from secondary care into primary care.

### Keeping People Well

- Impact of secondary care tariff changes on primary care.

- Reduction in activity to secondary care specialties covered by the commissioned local service as follows: methotrexate, Ring Pessary Change, Single Dose Vaccines, H Pylori, Glucose Tolerance Tests. Anticipated activity & cost reduction is XXXX.
Patients with clustered risk factors and aged between 18-40 will be identified and offered wellbeing interventions. Increase of patient self awareness and knowledge of the health and social care system, patients will be more equipped to reduce their own risk of developing LTC’s. Reduction in growth of disease areas. Evidence base suggests improvement of XXX in QUALYs. Increase in use of 3rd sector and community services. Reduction in secondary care referrals. Reduction in A&E attendances.

### Responsive Primary Care

| Use of GP Forward View Releasing Time for Care Programme and implementation of the reception/clerical staff training fund to upskill non clinical practice staff workforce. | More efficient demand management in primary care. Increased patient knowledge of the health and social care system. Increase primary care staff knowledge of other services hosted by community and 3rd sector organisations. | Potential reduction in inappropriate referrals & use of Same day Health Centre in-hours. Measurement of deployment of appointment capacity via national tool (to be determined). |

### Enablers and links to other plans

| Doncaster Digital road map to enable all providers to access relevant patient records GP Five Year Forward View STP Mental Health Five Year Forward View Pharmacy Forward View Urgent and Emergency Care Review Priority standards for 7 day hospital services | Primary care proactive specification and developing responsive, keeping people well and extended pillars | Intermediate care review and winter testing of rapid response for falls and use of bed base Funding streams identified in the GP Five Year Forward View |
### Local Context

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Wellbeing</td>
<td>Aging population and increasing complexity of needs</td>
</tr>
<tr>
<td></td>
<td>Supporting people in their own home as long as possible</td>
</tr>
<tr>
<td>Care &amp; Quality</td>
<td>Lack of true integration of health and care services leading to under utilisation/or duplication in services</td>
</tr>
<tr>
<td></td>
<td>Navigation of services difficult for patients and their carers</td>
</tr>
<tr>
<td>Finance &amp; Efficiency</td>
<td>Increasing number of avoidable non-elective admissions and attendances</td>
</tr>
<tr>
<td></td>
<td>Variable access</td>
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</table>

### Vision/what will success look like?

<table>
<thead>
<tr>
<th>Improvement Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved comm.</td>
<td>Improved communication and integration across all Health and Social Care stakeholders to increase efficiency and prevent duplication</td>
</tr>
<tr>
<td></td>
<td>People will have timely and appropriate access into community services and improved access to specialist intervention</td>
</tr>
<tr>
<td>Improved quality</td>
<td>Improved quality of community services provision</td>
</tr>
<tr>
<td></td>
<td>Patient feels supported and maintains independence longer</td>
</tr>
<tr>
<td></td>
<td>Improved patient experience of community services by providing continuity of care and holistic case management for their physical and mental health wellbeing</td>
</tr>
<tr>
<td>Improved interface</td>
<td>The Health and social care workforce has the skills to safely care for people outside acute care settings</td>
</tr>
<tr>
<td></td>
<td>All individuals, their families and carers are engaged in their care and have choice if their place of death</td>
</tr>
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### Actions

<table>
<thead>
<tr>
<th>Month</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>Continue the review of services included within the acute block contract [Dietetics, Orthotics, Podiatric surgery, MSK services, SALT]</td>
</tr>
<tr>
<td>Dec 2018</td>
<td>Continue to explore further opportunities within the community nursing model to transfer care and appropriate resources and ensure the interface between core and specialist advice and support (Continence, Lymphoedema, Parkinson's, community podiatry, wheelchair services)</td>
</tr>
<tr>
<td>March 2019</td>
<td>Influence the community nursing team and review the neighbourhood model for community based multi-professional team in partnership with MH teams.</td>
</tr>
<tr>
<td>Dec 2017</td>
<td>Evaluate integrated community specialist palliative care team and interfaces and explore opportunities for further activity shift</td>
</tr>
<tr>
<td>March 2018</td>
<td>Further increase the number of individuals within services to have undertaken GSF training across the Borough with a new focus on Care Homes and Domiciliary care providers</td>
</tr>
<tr>
<td>March 2018</td>
<td>Falls, ensure that all services embed risk assessment documentation within core offer, and work with existing services to develop Rapid Response</td>
</tr>
<tr>
<td>Phase 1 2018</td>
<td>Following the outcome from the NHSE Y&amp;H review of neurorehabilitation services we will ensure that local patient pathways are aligned during phase 1 and that local commissioned services are reviewed to improve and standardise the quality for patients with acquired brain injury during phase 2</td>
</tr>
<tr>
<td>Phase 2 2019</td>
<td></td>
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### Impact

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality, Outcome and Activity dashboard development</td>
<td>Review baseline position and agree improvement trajectories for reduction in:</td>
</tr>
<tr>
<td></td>
<td>Number of A&amp;E and Non Elective admissions into hospital (general and acute specialties, all age)</td>
</tr>
<tr>
<td></td>
<td>Number of A&amp;E and Non-Elective admissions into hospital for &quot;fast track&quot; patients</td>
</tr>
<tr>
<td></td>
<td>Reduction in A&amp;E and non-elective activity. Percentage reduction to be stated when trajectories agreed.</td>
</tr>
<tr>
<td></td>
<td>Productivity improvement, increasing efficiency and effectiveness and avoiding duplication</td>
</tr>
<tr>
<td>Experience of the quality of care in the last 3 months of life</td>
<td>People feeling supported to manage their condition based on CCG outcome indicator</td>
</tr>
<tr>
<td></td>
<td>Proportion of people who die in their usual place of residence</td>
</tr>
<tr>
<td></td>
<td>Improved patient experience of community services by providing continuity of care and holistic case management for their physical and mental health wellbeing</td>
</tr>
<tr>
<td>Improving communication and integration across all Health and Social Care stakeholders to increase efficiency and prevent duplication</td>
<td>The Health and social care workforce has the skills to safely care for people outside acute care settings</td>
</tr>
<tr>
<td></td>
<td>All individuals, their families and carers are engaged in their care and have choice if their place of death</td>
</tr>
</tbody>
</table>

| Primary Care Strategy development will support community based teams and more proactive care | Care Home Strategy | Digital care records | Urgent Care | Mental Health Learning Disability | Intermediate care review and winter testing of rapid response for falls and use of bed base |
### Delivery Plan on a Page: Children & Maternity

Dr Pat Barbour & Lee Golze

<table>
<thead>
<tr>
<th>Local Context</th>
<th>Health &amp; Wellbeing Gap</th>
<th>Care &amp; Quality Gap</th>
<th>Finance &amp; Efficiency Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High number of avoidable paediatric attendances and assessments</td>
<td>Challenges in paediatric expertise in certain areas of service provision</td>
<td>Costs incurred in acute due to current configuration of community services</td>
</tr>
<tr>
<td></td>
<td>Workforce sustainability in paediatrics and maternity</td>
<td>Inequity of care provision across the region for paediatric surgery and acute care (due to rota’s)</td>
<td>High locum costs</td>
</tr>
<tr>
<td></td>
<td>Gaps in emotional wellbeing and mental health system (Future in Mind)</td>
<td>Inequity of care across the emotional health and wellbeing system</td>
<td>High number of acute inpatient mental health admissions</td>
</tr>
<tr>
<td></td>
<td>Gaps in maternity services (Better Births)</td>
<td>Maternity ward closures and higher than region cesarian sections</td>
<td>High tariff costs</td>
</tr>
</tbody>
</table>

### Vision/ what will success look like?

#### Reduction in avoidable admissions and assessments
- Systemic approach to support around emotional health & wellbeing

#### Improved community paediatric expertise and multi-disciplinary offer
- Sustainable paediatric workforce model

#### CYP getting effective support by the right person at the right time
- Reduction in acute inpatient mental health costs

### Actions

**From Apr 17 to Mar 18**
- Commission a paediatric respiratory nurse
- Commission a responsive community provision for the mild to moderately unwell child
- Commission services to implement the Facing the Futures - together for child health standards

**From Apr 16 to Mar 2021**
- STP
- As part of the Working Together Programme look at new models of care for paediatric surgery and anaesthesia
- As part of the Working Together Programme look at new models of care for acute and community paediatric services

**From Apr 16 to Mar 17**
- Implement the Local Transformation Plan
- Map out current maternity provision against the Better Birth recommendations

### Impact

- **£172,188.58**
  - 12.5% reduction in paediatric assessments
  - 25% reduction in emergency admissions in asthma
  - 25% reduction in URTI emergency admissions
  - 5% reduction in LRTI emergency admissions
  - 20% reduction in children admitted to acute mental health ward
  - Reduction in Paediatric Assessment price and pathway price

### Enablers and links to other plans

- Working Together, Facing the Futures, Local Transformation, Better Births, Place Plan & STP
- JSNA, Other needs assessment documents
- Clarity in contract intentions
<table>
<thead>
<tr>
<th>Local Context</th>
<th>Care &amp; Quality Gap</th>
<th>Finance &amp; Efficiency Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of October 2016 Doncaster’s dementia prevalence was 3501 (over 65’s), the diagnosis rate was 75.2% and the number of people with a diagnosis of dementia is 2702. This leaves an estimated gap of 900 people without a diagnosis (all age)</td>
<td>There remains variance across Doncaster on screening, referral, assessment and treatment and the post diagnostic offer</td>
<td>Acute activity for dementia currently rises proportionately to all acute activity</td>
</tr>
<tr>
<td>Dementia rate will be remain above 2/3 of estimated local prevalence (1 of 9 must do’s in the NHS contract 2017-2019)</td>
<td>everyone with dementia will receive the same response and offer/opportunities across the dementia pathway by 2021. By 2021 achieve national ambition of 85% of people referred and accepted for assessment will receive a diagnosis and commence treatment within 6 weeks. By 2021 of those receiving a diagnosis, 100% will have an agreed care plan (moderate/severe stages) and in early stages where appropriate and an identified co-ordinator of care</td>
<td>Reduce levels of acute activity and prevent crisis from 2016/17</td>
</tr>
<tr>
<td>From April 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to raise dementia awareness, reduce dementia stigma and proactively promote dementia prevention</td>
<td></td>
<td>Increase number of people with dementia living independently</td>
</tr>
<tr>
<td>Create, apply and monitor evidence based dementia standards for risk prevention, screening, referral, assessment and treatment and post diagnostic support and end of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create equity and ageless assessment and treatment services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop and enhance post diagnostic offer through reconfiguration of existing contracts and resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor, analyse, report and manage all activity across the dementia pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with partners and educational colleagues to deliver the HEE dementia core skills education training framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia rate will be remain above 2/3 of estimated local prevalence (1 of 9 must do’s in the NHS contract 2017-2019)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Doncaster will continue to meet the national dementia diagnosis rate of 67% and increase this to nationally recognised top performance of 76.7% | Everyone with dementia will receive the same response and offer/opportunities across the dementia pathway by 2021. 85% of people accepted for an assessment will receive a diagnosis within 10 weeks and commence NICE approved treatment. (reducing to 6 weeks by 2021) 100% of people who receive a diagnosis will have an agreed care plan and a named care-coordinator by 2021 | Reduce the levels of acute dementia activity by 5% based on an annual basis in:
- A&E attendances (2015/16-977) (pts known to RDASH)
- non elective admissions (2015/16- 2327)
Reduce the levels of acute activity on an annual basis in:
- length of stay ( 2015/16- 9.56 days)
- delayed discharges (2015/16- 15)
- re-admissions (2015/16- 499)
Reduction in the numbers of PWD on an annual basis regarding:
- admissions from care homes (2015/16-910)
- Out of area placements (2015/16-9)
- deaths within 3 days of admission (2015/16-61)
- increase number of people with dementia with an advance care plan (TDAS) |
| Enablers and links to other plans | | |
| Doncaster Digital roadmap, Intermediate Care Review, CCG transformation plans, Joint Primary Care Strategy Care Home Strategy Commissioned Care and Support at Home (CCaSH) | Primary Care Strategy Intermediate Care review Joint Care Home Strategy | |
| STP and Doncaster Place Plan DMBC Adult Health and Wellbeing Transformation Plan | | |
## Delivery Plan on a Page: Medicines Management

**Dr Jeremy Bradley, Mark Randerson**

### Local Context

<table>
<thead>
<tr>
<th>Health &amp; Wellbeing Gap</th>
<th>Care &amp; Quality Gap</th>
<th>Finance &amp; Efficiency Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-development of self-care and healthy lifestyle strategies and services for minor ailments and the prevention and management of long term conditions</td>
<td>Variation in prescribing related health outcomes&lt;br&gt;(RightCare)&lt;br&gt;Antibiotic stewardship&lt;br&gt;Incidents relating to medicines&lt;br&gt;Quality and patient safety gaps highlighted through audit</td>
<td>Provider efficiency opportunities for medicines optimisation (e.g. Carter Review, OptimiseRx)&lt;br&gt;Growth and inflation in primary care prescribing&lt;br&gt;Significant growth on PbR-excluded drugs</td>
</tr>
</tbody>
</table>

### Vision/ what will success look like?

<table>
<thead>
<tr>
<th>Health &amp; Wellbeing Gap</th>
<th>Care &amp; Quality Gap</th>
<th>Finance &amp; Efficiency Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to medicines will be integral to the self-care philosophy for the management of minor ailments Access to selfcare and healthy lifestyle services will be equitable and tailored to meet the needs of the Doncaster population</td>
<td>Medicines optimisation services will work effectively across all parts of the system to deliver high quality clinical outcomes and minimise patient safety risks</td>
<td>The growth in medicines expenditure will be reduced</td>
</tr>
</tbody>
</table>

### Actions

| April 2017- | Develop OptimiseRx profile for release onto primary care clinical systems April 2017<br>Identify primary care rebates schemes suitable for implementation across Doncaster<br>Work with CCG contracting colleagues on the implementation of Blueteq<br>Work with CCG contracting colleagues on the rapid uptake of biosimilars<br>Drive procurement efficiencies and rebates through the Yorkshire and Humber Procurement Collaborative<br>Work with commissioning and provider colleagues to ensure the medicines management is integral to transformation of local clinical pathways<br>Oversee provider programmes for implementation of NICE guidance and medicines safety assurance<br>Work with providers on formulary development programme and monitoring/adherence schedule<br>Oversee provider programmes for monitoring use of antimicrobials in order to assure appropriate use |

### Impact

| More patients adopting self care for the management of minor ailments, leading to reduced pressure on Trust services for unplanned care<br>More patients with long term conditions accessing lifestyle advisory services leading to less reliance on medical interventions and services | Levelling up of medicines related health outcomes across Doncaster<br>Reduction in serious incidents involving medicines<br>Achievement of national quality premium targets for antibiotic stewardship and reducing antimicrobial resistance | The growth in medicines expenditure will be reduced |

### Enablers and links to other plans

| DMBC<br>Primary Care Strategy<br>Care Home strategy | Primary Care Strategy<br>Delivery Plans for Cancer, Mental health, Dementia, Learning Disabilities, Planned care, Emergency care, Diabetes<br>RightCare workstreams<br>IT Digital Roadmap<br>Hospital Pharmacy Transformational Plan | Primary Care Strategy<br>Yorkshire and Humber Procurement Collaborative<br>RightCare workstreams<br>IT Digital Roadmap<br>Hospital Pharmacy Transformational Plan |
Item 8

Future Child Health Service Model
Purpose of Paper - Executive Summary

1. Introduction / Background

1.1. The Working Together Partnership Vanguard has been progressing work to review the current provision of care for the acutely unwell child, and moderately ill child within the context of national standards for child health.
1.2. The enclosed strategic outline case for change provides an overview of the challenges and issues facing local Children’s Health Services, the work completed to date and proposed next steps.
1.3. The strategic case for change should be read in conjunction with the best practice review and scenario appraisal.
1.4. Children’s acute care is one of the areas identified as a priority within the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

2. Progress and Work to date

2.1. In December 2015 acute care providers within the Working Together Partnership Vanguard were asked to undertake a self-assessment of their hospital care provision against the national standards in “Facing the Future” which have been developed and published by the Royal College of Paediatrics for Child Health. These national standards cover the care provided within an acute setting in relation to child health.
2.2. At the same time, clinical commissioning groups (CCGs), as part of Commissioners Working Together, were asked to undertake an assessment of local provision against the national standards ‘Facing the Future, Together for Child Health’ published jointly between the Royal College of Paediatrics, The Royal College of General Practice and the Royal College of Nursing. These standards cover the care provided across hospital and primary care/community services in relation to supporting child health.
2.3. In April 2016 trusts and CCGs were invited by representation to a workshop to share the self-assessment feedback and discuss the case for change and challenges. At this workshop, clinicians and organisation representatives confirmed the challenges and that the current provision, including workforce profile, was not sustainable. There was broad acknowledgment that further work and exploration of the challenges was needed.
2.4. A subsequent workshop was facilitated in May 2016 with again representation from trusts and CCGs where consideration was given to steps to support the provision of sustainable care and actions to improve care pathways between primary and secondary care.

2.5. A review of national best practice was undertaken and a scenario appraisal alongside the write up of the current challenges facing provision.

2.6. In September 2016 the clinical senate was requested to review the outline case for change and supporting best practice review and scenario appraisal, and provide comment and advice.

2.7. A subsequent workshop was then planned for November 2016 to consider progress undertaken within local areas and across acute providers and consider next steps.

2.8. The enclosed strategic case for change, scenario appraisal and best practice review is provided following review and revision from the clinical senate and Joint Committee of Clinical Commissioning Groups (JCCCG) that supports and guides the child health work streams.

3. Proposed Next steps

3.1 It is proposed that the outline case for change is supported as evidence of the need to further progress a more detailed piece of work— referencing other linked projects (e.g. children’s surgery and anaesthesia). The planned work should include, as a minimum:

- Options development and appraisal
- Equality Impact Assessments on options
- Financial planning / analysis against options
- Public engagement and potential consultation
- STP links and support
- Y&H Senate review of options
- NHS Assurance processes

Recommendation(s)

The Governing Body is asked to:

- Consider the outline strategic case for change and support the work-up of some options to support sustainable care across providers, within the context of the STP.
### Impact analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Quality impact</strong></td>
<td>The aim of the work is to improve quality of services, as demonstrated by case for change</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>Full equality analysis will be part of the work if approved by Governing Body</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Review and redesign is necessary for sustainability of these services into the future</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Not yet known, to be completed as part of the options appraisal</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Not known</td>
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<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Consultation / Engagement (internal departments, clinical, stakeholder &amp; public/patient)</strong></td>
<td>As per the enclosed paper</td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>As per enclosed paper</td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>As per enclosed paper</td>
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<tr>
<td><strong>Assurance Framework</strong></td>
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Joint Commissioner and Provider
Working Together Programmes

Care of the Acutely Unwell Child
Case For Change
February 2017

FINAL
<table>
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<td>V0.1</td>
<td>JCS</td>
<td>Initial Draft</td>
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<tr>
<td>13/7/2016</td>
<td>V0.2</td>
<td>JCS</td>
<td>Revised initial draft after comments, additional data inserted, appendix document created from previous closing section. Further alteration for subsequent comments</td>
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<td>29/7/2016</td>
<td>V0.3</td>
<td>SJ</td>
<td>Communications and Engagement input</td>
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<tr>
<td>8/11/2016</td>
<td>V0.4</td>
<td>JCS</td>
<td>Response to Senate comments – clarification and data updates. Change of name</td>
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<tr>
<td>10/11/2016</td>
<td>V0.5</td>
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<td>Incorporation of further comments, updated data tables and graphs</td>
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<td>Minor changes to section 1</td>
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<td>KL</td>
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<td>21/11/2016</td>
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<td>AP</td>
<td>Formatting + Appendices</td>
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<td>23/02/2017</td>
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incorporated following JCCC comment. Reversion to Original Name. Updates to governance route

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<td>28/02/2017</td>
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**Governance Route:**

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<th>Date</th>
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<th>Purpose</th>
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<td>29.07.16</td>
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<td>For comment</td>
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<td>Children’s Core Leaders</td>
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<td>V0.3</td>
<td>Support, steer and comment</td>
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<td>SMT</td>
<td>19.08.16</td>
<td>V0.3</td>
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<td>WTP – Commissioner only</td>
<td>05.09.16</td>
<td>V0.3</td>
<td>Discussion on next steps</td>
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<td>Acute Federation</td>
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<td>V0.3</td>
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<td>Y&amp;H Clinical Senate</td>
<td>Sep 16</td>
<td>V0.3</td>
<td>Comment and Assurance</td>
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<tr>
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<td>30.09.16</td>
<td>V0.2</td>
<td>For comment</td>
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<td>Joint Committee of CC Governing Bodies</td>
<td>04.10.16</td>
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<td>Sign off prior to GB consideration</td>
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<td>Comment on Senate observations</td>
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<td>December 2016</td>
<td>V.03</td>
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<td>January 2017</td>
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<td>21.02.17</td>
<td>V0.551</td>
<td>Comment on Senate observations; Assurance</td>
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   3.1 Process to Date

4. Scope of Document : Patients and Services Covered

5. Why Change? Outline of Rationale

6. CONTEXTS AND EVIDENCE : The Case for Change
   6.1 Demography and Demand
   6.2 Policy Background
   6.3 Local Services : Facilities and Workforce
   6.4 Meeting National Standards
   6.5 Summary and Conclusions

7. Next Steps : Proposal to Progress the Project
   7.1 Potential Areas for Further Work
1. Executive Summary

The document sets out the basic rationale for service change in acute paediatrics, recognising that any impacts in acute paediatrics will have wider implications, and tests that rationale in light of national policy, Trust activity and workforce data, and – most importantly – Trust and commissioner self-assessments against the key national standards. Whilst the document works within geographical and clinical service boundaries of scope, it should be read in conjunction with the wider South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) Maternity and Children’s (including neonates) work plan, and links with neighbouring STPs are also considered.

The data corroborates and strengthens the basic rationale, showing that there are clear operational risks (and non-adherence to standards) with particular reference to senior medical cover. This suggests significant sustainability and shorter term resilience issues, and cost pressures from use of agency and additional sessions.

Furthermore, there is evidence of a lack of joined up working by primary care, secondary care and community clinicians, and thus decreased system resilience, across local health communities – there needs to be strengthened planning and structure in place between the acute, primary care and community sectors.

The paper concludes that “doing nothing” is not an option and that a review of services to ensure sustainability needs to be undertaken through a strong collaborative framework. The document concludes that there is a clear mandate for further work and sets out some initial priorities, to be ratified by the STP Children’s and Maternity Transformation Group, for action. A companion document and project plan to look at the shape for the work going forward have been developed. As part of the development and planning process beyond this document, we will set out the assurance requirements to support transformation and how will articulate the ways in which potential service changes meet the four tests of service reconfiguration.
2. **Document Purpose: Introduction and Overview**

This document is part of the joint Working Together Programmes’ “Care of the Acutely Ill Child” project and sets out the national and local Case for Change in certain areas of children’s healthcare services. From the outset it is recognised that any such project has significant co-dependencies, although there is a need to ‘uncouple’ service change projects into manageable portions.

The basic rationale for changing services is around **sustainability of services:** there are some very significant challenges facing children’s services in acute (hospital) settings, and which have wider implications both beyond acute hospitals, and in terms of other acute services (including neonates and maternity) – The “Evidence” section (Section 6) goes into detail on this, however issues are particularly around the availability of a medical **workforce** sufficient to staff the current service configuration (including a current shortfall of 28 WTE senior posts across the area), which leads to concerns around **timely access to specialist opinion, continuity of care, and finances** as hospitals are forced to rely on expensive short term agency and locum doctors. There is also evidence to suggest that many children in our area are admitted to hospital when there could be alternative ways of safely caring for them nearer to home – hence this Case for Change suggests implications for community and primary healthcare services also. In some of our hospitals, **external review (e.g. CQC) has found significant problems with services,** which have already led to some collaborative working with the main tertiary unit.

This document **brings together the key pieces of evidence to support the above statements, and acts as the mandate to explore options to address our challenges.**

This Case for Change does not exist in isolation, it builds upon existing work and supporting documentation, including earlier work on Children’s Surgery and Anaesthesia, and the initial Children’s Services Project Initiation Document already agreed by the provider and commissioner Working Together Programme Executive Groups. The project also **sits within continuing work on the South Yorkshire and Bassetlaw (SYB) Sustainability and Transformation Plan (STP),** and it is through this umbrella structure that links to parallel work on maternity and neonates is maintained. It aims to provide an overview of the current equitability and sustainability of our services, with the intended outcome being to inform an options appraisal document for the improvement of those services.
Specifically, the document brings together material built up through:

1) A survey of local NHS organisations’ ability to meet relevant standards (from the Royal College of Paediatrics and Child Health’s “Facing the Future” revised 2015 standards set)
2) Activity and workforce data provided by local hospitals
3) The outputs of engagement sessions for NHS organisations held in April and May 2016, and
4) Learning and outputs arising from a parallel project looking specifically at Children’s Surgery and Anaesthesia.

This document will inform any resultant Options Appraisal and Outline Business Case (OBC) for proposed changes to children’s acute services, and will be included in the OBC as an appendix.

NHS England provides four tests of any potential service reconfiguration, to provide assurance. It is proposed that the project will use the following methodology to meet those tests:

**Test 1: Strong Public and Patient Engagement**
Building on the pre-consultation and formal public consultation which have formed part of the NHS England Level 2 Assurance process for the separate but related Children’s Surgery and Anaesthesia project, this project will utilise, develop and elaborate on that methodology, incorporating any lessons learned.

**Test 2: Consistency with Current and Prospective Need for Patient Choice**
This will be captured within the remit of the STP work around maternity and neonatal services and will also be a consideration as part of the consultation process.

**Test 3: Clear Clinical Evidence Base**
Referencing research and appropriate clinical standards, the project will demonstrate that there is strong justification to ensure services are transformed to provide the best outcomes for children.

**Test 4: Support from Commissioners**
A GP Lead (also clinical lead of a local CCG) is in place, and this supports engagement and leadership within commissioning organisations. Further close collaboration with clinical leads is assured through engagement and involvement at the project’s Core Leaders group and the Working Together
Clinical Reference Group, which is led by the Programme Medical Director
3. **What is Working Together? Background to our Programme**

The Working Together Programmes are two partnerships of NHS organisations which have come together to look at how we can better deliver services in a safe and sustainable way across our area. One programme, the Working Together Partnership Vanguard, is comprised of seven NHS Trusts who deliver hospital services from twelve sites (the “providers”). The other programme, Commissioners Working Together, is comprised of eight NHS Clinical Commissioning Groups (CCGs), who commission services for their local population, plus NHS England, who assure that CCGs operate effectively to commission safe, high-quality and sustainable services within their resources, deliver on their statutory duties and drive continuous improvement in the quality of services and outcomes achieved for patients (collectively, the “commissioners”). The two programmes are working jointly on children’s services, and will therefore be referred to collectively as the Working Together Programme (WTP) in this document, unless a distinction needs to be made.

The provider programme comprises the following NHS Trusts:
- Barnsley Hospital NHS Foundation Trust (hereafter BH)
- Chesterfield Royal Hospital NHS Foundation Trust (CRH)
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH)
- The Mid Yorkshire Hospitals NHS Trust (MYH)
- The Rotherham NHS Foundation Trust (TRFT)
- Sheffield Children’s Hospital NHS Foundation Trust (SCH)
- Sheffield Teaching Hospitals NHS Foundation Trust (STH)

The commissioner programme comprises the following NHS organisations:
- NHS Barnsley Clinical Commissioning Group (hereafter CCG)
- NHS Bassetlaw CCG
- NHS Doncaster CCG
- NHS Hardwick CCG
- NHS North Derbyshire CCG
- NHS Rotherham CCG
- NHS Sheffield CCG
- NHS Wakefield CCG
- NHS England

The WTP covers an area stretching from Chesterfield, Bolsover and Worksop in the south to Wakefield and Dewsbury in the north, with a total population of
over 2 million people (the number based on the nearest contiguous ONS data for 2015 is approximately 2.1 million – of these, around 487,000 or 23%, are children)

The geography of the project’s work has historically covered the seven WTP Trusts and their local CCGs. It is recognised that setting any geographical boundaries for a project of this nature will raise questions for those patient groups flowing into or out of the area. However the project scope does need to make reference to clear boundaries.

For the boundaries of the project to change, this would require specific agreement from all WTP partners. For an additional non-WTP organisation (e.g. NLAG for North Lincolnshire patients, of whom there is a tertiary flow into Sheffield, and some secondary care flow into Doncaster and Sheffield) to be brought in, this would require agreement from all WTP organisations, as it raises questions about e.g. external access to WTP project management support. Further, it should be noted that NLAG belong to a different STP region (Humber, Coast and Vale).

Given the organisational issues and likely delays inherent in considering inclusion of non-WTP Trusts, expanding the project’s membership or boundaries is not currently recommended. However, as an attempt to address the issue of external flows in, the following approach will be adopted:
a) In any service modelling resulting from the Case for Change, an initial assumption will be made that non-WTP patient flows will remain unchanged (unless there is clear intelligence to suggest a change) and that those flows will need to continue to be factored into any capacity projections.

b) At an early stage, prior to detailed modelling, WTP will work with adjacent CCGs from which there is significant patient flow both to inform them of the developing project work, and to gather information on any anticipated service changes in their areas. This does not constitute an invitation for those areas to participate in this work, but it does attempt to provide clear, updated intelligence on likely patient numbers and needs.

WTP’s collaborative approach is designed to ensure that patients can continue to receive services that are safe, sustainable, equitable and delivered as close to home as possible. WTP projects cover a wide range of clinical and non-clinical services and all of the projects ensure that the relevant clinicians or other appropriate professional groups are the ones who agree the current state of their service, and the issues facing it, and who design our responses to those issues.

Both commissioners and providers felt that a review of children’s services should be considered jointly (see section 5 – “Why Change?”). In doing this, WTP recognised that they would need to ensure that they adhere to NHS best practice around change management, competition law and procurement. Governance for this Case for Change, and any work resulting from it, is secured through the WTP children’s core leaders group, which reports into the Commissioners Working Together programme board and the provider Working Together Programme Executive/Acute Federation Board.

3.1 Process to date

WTP’s work on children’s services began in 2014 with work around Children’s Surgery and Anaesthesia, an area which has faced some particular challenges. This document covers a different area of children’s services (principally unplanned inpatient care, see section 4 “Scope”) and this project and Children’s Surgery should be taken as two separate entities, albeit projects which do have some significant areas of overlap.

With work on children’s surgery services at an advanced stage, this second project was inaugurated in early 2016, building upon learning from the ways in which we had organised our previous work.

In the initial phase, the focus has been upon developing a baseline
assessment of the issues facing our local hospital paediatric services. In order to do this, each NHS Trust within the WTP area was asked to complete a questionnaire requesting:

- A summary of the local service’s workforce and facilities (beds, etc.)
- A self-assessment against the Royal College of Paediatrics and Child Health (RCPCH)'s “Facing the Future: Standards for Acute General Paediatric Services" on acute paediatric care\(^1\).
- Acute paediatric activity

Separately, Trusts were also asked to complete:

- Self-assessment against the Paediatric Intensive Care Society (PICS) Care of the Critically Ill Child standards (2016)

At the same time, CCGs within the WTP area were asked to complete for their areas the Facing the Future Together for Child Health standards (2015) developed jointly by the RCPCH, the Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN).

Stakeholder feedback: To further inform the baseline assessment, the organisations, providers and commissioners, were brought together at a “Confirm and Challenge” event on 27 April 2016, where the collated evidence was fed back to the group, key themes explored and agreement reached that we, collectively, needed to pursue this work further. This Case for Change document summarises the presented evidence.

A second event was held on 18 May 2016, where the same organisations came back together and began to outline how we could collectively begin to approach the common challenges. This document is not a detailed proposal for further actions, but, because it does conclude that further work is needed to improve children’s services, it makes reference to some of the broad potential areas for further action. Information can be accessed via the commissioner WTP website, www.smybndccgs.nhs.uk

This initial phase, which is concluded by the Case for Change, has also offered organisations an opportunity to network and to begin developing a more integrated and system-wide view of the future of children’s acute care, as supported by the aims of the local Sustainability and Transformation Plan.

STP: Subsequent to the initiation of this project, all health communities in England have been asked to develop a Sustainability and Transformation Plan (STP) which requires them to consider ways in which they deliver health

\(^1\) RCPCH (revised 2015) Facing the Future: Standards for Acute General Paediatric Services. RCPCH.
(and related) services across their entire geography. The STPs are a collaboration between all healthcare organisations, plus Local Authorities, voluntary sector and research and education organisations within their “footprint” area. The Working Together area is covered mainly by the South Yorkshire and Bassetlaw STP with Chesterfield and Wakefield services included in discussions as “associate members”.

The South Yorkshire and Bassetlaw STP contains a clearly-defined Children’s and Maternity Care workstream. Work to date on the STP shows correlation in evidence and aims between STP and WTP children’s work, and it is envisaged at the time of writing that this WTP project will be the means of delivering some of the STP’s aims.

As the Scope section (section 4) below also explains, WTP are highly conscious of the co-dependencies for any work on acute children’s services – notably upon maternity and neonatal services, but also upon non-acute children’s services and upon social care and public health. The STP workstream, in its current form, covers all of these elements within its scope, with the intention that there is an overarching governance structure to ensure that all co-dependent services are considered appropriately.
4. **Scope of document: patients and services covered**

The project relates to the “care of the acutely ill child”, i.e:
- Children and young people, from birth to their 19th birthday, experiencing:
  - Unplanned / unscheduled / non-elective incidences of acute illness, or
  - Acute exacerbations of existing chronic conditions,
  - **Encompassing the 36 hour period** from onset of illness until the child is either discharged or active management is underway,
- Excludes children and young people admitted to adult wards under the care of clinicians who provide solely adult services (and also due to differences in adult-child transition ages in different locality contracts across the region) and neonates in neonatal units and maternity wards (see below)

It is recognised that any change to acute paediatric services is likely to require an improved or changed offer in terms of community or primary care based services. Consequently, the Project Initiation Document (PID) for the overarching children’s services project, of which this is part, suggests that this project should cover care functions delivered both inside and outside hospital:

**In-Hospital workstream**

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<th>Excluded aspects</th>
</tr>
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<tr>
<td>Urgent and acute activity for high volume children’s and young people’s pathways, and non-elective admissions for common childhood diseases with short lengths of stay.</td>
<td>Obstetric and maternity services</td>
</tr>
<tr>
<td>Current and predicted medical and nursing workforce numbers.</td>
<td>Adult ward areas</td>
</tr>
<tr>
<td>Provider initiatives to integrate paediatric practitioners into rotas</td>
<td>Neonatal units</td>
</tr>
<tr>
<td>Minor injuries/illness units</td>
<td>Theatre and recovery areas</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Home care / hospices</td>
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<tr>
<td>Short stay assessment units</td>
<td></td>
</tr>
<tr>
<td>Paediatric ward areas</td>
<td></td>
</tr>
</tbody>
</table>

No other element of either specialist or general paediatrics will be considered at this stage unless the evidence base suggests this would be appropriate.
Pre-Hospital workstream

<table>
<thead>
<tr>
<th>Included aspects</th>
<th>Excluded aspects</th>
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</thead>
<tbody>
<tr>
<td>• Urgent activity for high volume children’s and young people’s pathways, and non-elective admissions for common childhood diseases with short lengths of stay.</td>
<td>• Obstetric and maternity services</td>
</tr>
<tr>
<td>• Outpatient and community-based services aimed at managing demand, reducing admission and supporting discharge</td>
<td>• Adult ward areas</td>
</tr>
<tr>
<td>• GP practices</td>
<td>• Neonatal units</td>
</tr>
<tr>
<td>• OOH/walk in centres</td>
<td>• Theatre and recovery areas</td>
</tr>
<tr>
<td>• Children’s community nursing teams</td>
<td>• Home care / hospices</td>
</tr>
<tr>
<td>• Community pharmacy</td>
<td>No other element of either specialist or general paediatrics will be considered at this stage unless the evidence base suggests this would be appropriate.</td>
</tr>
</tbody>
</table>

This can involve both medical and surgical conditions (i.e. there are some acute onset conditions which require surgical management), and there is a degree of overlap in medical and surgical cases because both of them may require intervention and/or monitoring by senior paediatric medical staff or their equivalents, and in some cases resuscitation by paediatric-skilled staff may be required. However there are also important areas of distinction – this project (Care of the Acutely Ill Child) does not include within its scope any of the planned / elective surgical and anaesthetic procedures included in the Children’s Surgery and Anaesthesia (CS&A) project, and the CS&A project does not include any solely medical conditions (e.g. viral or bacterial illness). Volumes of patients affected by the project are shown in Section 6.1, below.

Whilst initial contact with health services can be through a number of routes (e.g. primary care / GP, A&E, 111, Walk In Centre or direct to the ward or Children’s Assessment Unit), there is an assumption under the current models that the large majority of care will be delivered in a hospital setting, either in A&E, a children’s ward/inpatient area, or Children’s/Paediatric Assessment/Observation Unit (hereafter shortened to CAU for convenience).

This is a useful way of categorising this group of patients based upon existing service use. Whilst this document is a Case for Change relating to those existing services, and whilst it does not make any detailed or binding
proposals for future work at this stage, it is important to note that a major consideration moving forward, based upon the evidence (e.g. provider responses to standards) presented elsewhere in this document, may be that current models of provision are not the best suited to children’s needs, and/or may not be sustainable in the longer term.

Therefore, consideration will need to be given to the scope of the project as it progresses into design, OBC and implementation phases – aspects of future models for care might be delivered in other settings than solely hospital based ones (e.g. community facilities, at home with in-reach care, etc.) and might involve a different clinical workforce, or existing staff being used in new ways. Whilst the Case for Change does not make assumptions or recommendations around future service models (which would be developed through a consultative process with local clinicians, managers, commissioners and other stakeholders before a full public consultation), there is likely to be a much greater emphasis upon the role of primary and community care services in screening and / or filtering demand, and potentially in managing and supporting discharge and in coordinating post-discharge care outside of the hospital.

At present, input from NHS providers to the project is almost exclusively from acute hospitals, but given the possibilities above, careful attention will need to be given both to the scope of, and stakeholders in, the evolving project.

Whilst reference to the Paediatric Intensive Care (PIC) standards is made, the project does not include neonatology within its scope. As stated previously, there is a clear recognition throughout this document of the co-dependencies between a paediatric medicine service (comprising in and out of hospitals aspects) and neonatal services, and also by extension, maternity care. There are clear overlaps as paediatric medical rota patterns within individual hospitals may also have to cover neonatal services, and any potential change to acute paediatric rotas will have an impact downstream.

However, in order to break the wider children’s and maternity workstream into achievable elements, and because of the overarching governance of the STP as previously described, maternity and neonates are intended to be addressed as separate but parallel projects under the STP.

Similarly, the management in the community and through outpatient services of long term conditions, including Neurodisability, to reduce the numbers of exacerbations and thus demand for unscheduled paediatric care must be a consideration. By extension, this would also extend to the effective management of social factors which impact upon healthcare provision. Prevention, early intervention (including child health surveillance) and
education (including parenting aspects) are highlighted within the overarching STP rationale as key drivers for delivering new models of care. Transition to adult care is also an important consideration.

A particular consideration will be links to CAMHS services, for the longer term management of patients with mental health needs, mental health liaison, and also in terms of crisis care / management of acute episodes and management of mental health aspects in an acute physical care environment.

It might be helpful to view this Case for Change as the ‘first 36 hours onset’ element within a suite of related Cases for Change for the STP, which are likely to include:

- Maternity services
- Neonatal services and the Neonatal Intensive Care network
- Children’s Surgery and Anaesthesia (progressing through consultation)
- Inter hospital transfers both for neonates and paediatrics, including the Embrace service
- Community care services – likely to have one Case for Change per CCG, in common format
- Primary care services for children, with similar considerations to community care
- Specialised commissioning aspects
- Transitional care aspects
- Local authority services, to include screening and surveillance

This Case for Change considers the rationale for making changes to acute paediatric services and does not in itself propose models: As work progresses on the project and models of care begin to form, these will need to explicitly consider how a hospital can maintain effective neonatal and maternity (and other co-dependent) services even if it does not maintain 24/7 acute paediatric cover on site. As models develop, best practice examples from within SYB and beyond will be incorporated, and impacts upon co-dependent services will be a key consideration.

It is not envisaged that any decision upon future models for child health services can or should be made without a clear view of the impact upon co-dependent services.
5. Why change? Outline of rationale

The key reason for reviewing and changing our services is that currently, **local Trusts, collectively and individually, are not able to meet national standards for the safe care of acutely unwell children** (RCPCH, Facing the Future 2015), especially with regards to consultant cover arrangements at peak hours. However, there are other pressures on the system at the same time as this.

This is happening at a time of **renewed focus upon quality and safety** right across the acute healthcare sector following the Francis report into failings at Mid Staffordshire Hospitals (2013) and the Keogh report into increased mortality rates and quality concerns in some NHS hospitals (2013). CQC findings on local paediatric services in the WTP area have themselves raised specific quality concerns. NHS policy over the last few years has attempted to address these parallel funding and quality ‘gaps’ (e.g., the NHS Five Year Forward View, and the Dalton review, both 2014) and has tended to focus considerably on new models for delivering services in the face of this challenge.

Additionally, the acute hospital sector overall faces **unprecedented financial challenges**, with the size of the financial ‘gap’ in South Yorkshire and Bassetlaw alone expected to be around £300 million over 5 years. This means that, for children’s services as well as adult services, it is not possible to continue delivering services as they traditionally have been. This is exacerbated by falls in funding for Local Authority/social care services.

However, aside from the financial and general quality issues facing services there are a number of **specific challenges** which suggest that a more radical approach could be taken in the planning and delivery of children’s healthcare services across the WTP area.

Evidence suggests that children’s healthcare in the WTP area is under significant pressure on a number of fronts. Paediatrics is by its nature a 24/7 service. As every paediatrician, parent or carer knows, the nature of childhood illnesses is that very often there is rapid progression of symptoms and increasing severity of illness in a very short space of time. This can be coupled with an inability of the child or young person to articulate their symptoms.
As a result of medical advances over the last few decades, children's services are becoming increasingly complex and intense, encompassing general and specialist care provision across an age spectrum from neonates to adolescents and young adults. Additionally, an increase of higher dependency nursing care is delivered within hospital wards and a greater amount of acute complex and continuing care is being provided in community and primary care settings, highlighting the importance of having staff with the right knowledge, skill and competence across the child’s care pathway.

The ability of providers to deliver such high quality services has come under significant pressure for a variety of reasons. Based upon the SYB population, as the largest constituency within the WTP area, key issues include:

a) Health Outcomes

- The UK has one of the worst child mortality rates in Europe, and has amongst the worst morbidity rates for <5 years. Infant mortality rates exceed the England average in several WTP CCGs (PHE Health Profiles by CCG 2016)

- Nationally, 19.1% of Year 6 children are obese; 3 of SYB's 5 boroughs exceed this, and one other is very close to the average (PHE Health Profiles by Borough 2015)

- Child poverty is a factor in healthcare, and 6 of the 8 WTP CCGs score significantly worse on this indicator than the England average of 19.2% (PHE Health Profiles by CCG 2016)

- The UK has been ranked bottom out of 25 industrialised countries for the wellbeing of children

The key Child Health Profiles set for the WTP in 2016 is shown here:
There is a consensus that child health outcomes should be improved and that location of patients should not impact on provision of healthcare access or quality of care received.

### b) Community-Based Provision

- GP knowledge and confidence in the management of acute care of children is variable leading to greater reliance on secondary care services.
- In some areas there is poor co-ordination of services between primary/secondary care, with fragmented provision. This is demonstrated by the responses to the RCPCH standards in section 6.
- Community provision, investment and models vary across the patch.

### c) Acute Paediatric Services

- There are high levels of A&E attendance and acute admissions, with growth in recent years. Changes in primary care out of hours provision have resulted in increased attendance at emergency care departments. Trusts face serious medical workforce issues, including recruitment problems, thus leading to concerns around the sustainability of individual services. This applies to trusts across the WTP area, as shown in Section 6.
  - The numbers of children’s doctors coming through medical schools is expected to drop by 45% between 2012 and 2017.
  - The European Working Time Directive (EWTD) - a law which looks after the health and safety of patients and staff by ensuring staff do not work excessively long hours – has impacted on children’s services. There is a shortage of medical staff in the service as stated above, making it harder to meet the legal requirements of safe staffing levels. Implementation of the European Working Time Directive (EWTD) has made it...

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2 R CN Defining staffing levels for children and young people’s services. RCN standards for clinical professionals and service managers .2013
extremely difficult to provide safe and sustainable levels of staffing in many paediatric units³.

- There is an increase in the number of nursing students and others requiring supervision and support in clinical environments on top of clinical care requirements⁴.

- Because of the inability to fill medical rotas through permanent/substantive staff, Trusts are incurring high costs of locum/agency staff at consultant and middle grade levels to support their paediatric units to run 24/7. This is not sustainable, and does not lend itself to a committed workforce. This is evidenced through feedback from stakeholder events for the project.

- As well as cost issues, heavy reliance upon agency and locum staff brings with it quality concerns, both in terms of a) disrupted continuity of care and lack of effective handover, and b) familiarity of transient or temporary staff with local policies, procedures, facilities and equipment.

- Trusts are not able to meet national standards for the safe care of acutely unwell children (RCPCH, Facing the Future 2015), especially with regards to consultant cover arrangements at peak hours – see Section 6.4, this forms a core part of this Case for Change document.

- Trust services also currently have substantial numbers of 24/7 beds (see section 6.3 below), although throughput to those beds can be low at times (particularly overnight) and lengths of stay are low (see section 6.1 below). Evidence (e.g. the Salford PANDA model) shows that effective triage for admissions avoidance, plus supporting discharge, can reduce demand on those beds. Whilst the Case for Change does not recommend models, one potential cost saving mechanism (in context of the financial gap as described above) might involve a consolidation of acute beds.

The challenges facing children’s services are multifactorial, complex and deep rooted. These were presented, along with some of the evidence presented in Section 6 to the Confirm and Challenge event on 27 April 2016. The WTP team had proposed that the factors described here gave a strong rationale to a project aimed at re-evaluating and redesigning services for the acutely ill child. This view was endorsed by stakeholders at the 27 April event.

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³ RCPCH Facing the Future: A review of paediatric services. 2011
⁴ Temple, J Time for training: A review of the impact of the EWTD on the quality of training. 2010
⁵ RCN Defining staffing levels for children and young people’s services. RCN standards for clinical professionals and service managers .2013
6. CONTEXTS AND EVIDENCE: The Case for Change

This section brings together a range of evidence and data aimed at assessing whether the rationale previously discussed is valid, and whether there is indeed an evident case for change.

Data discussed here takes in numerical data (activity, workforce, etc.) but pays particular reference to Trusts’ ability or otherwise to meet current standards.

6.1 Demography and activity

Based upon 2015 ONS data, the Local Authorities most closely relating to the WTP area serve a population of around 487,000 children and young people (ages 0-19, in line with ONS bands).

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<tr>
<th>Region</th>
<th>Local Authority</th>
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<th>15-19</th>
<th>Subtotal</th>
<th>LA Total</th>
<th>0-19 % of LA</th>
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<tbody>
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<td>East Midlands</td>
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<td>5676</td>
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<tr>
<td></td>
<td>Rotherham</td>
<td>16004</td>
<td>16208</td>
<td>14697</td>
<td>15382</td>
<td>62291</td>
<td>260786</td>
<td>23.9%</td>
</tr>
<tr>
<td></td>
<td>Doncaster</td>
<td>18794</td>
<td>19224</td>
<td>16714</td>
<td>17145</td>
<td>71877</td>
<td>304813</td>
<td>23.6%</td>
</tr>
<tr>
<td></td>
<td>Sheffield</td>
<td>33527</td>
<td>33839</td>
<td>29937</td>
<td>38177</td>
<td>135480</td>
<td>569737</td>
<td>23.8%</td>
</tr>
<tr>
<td></td>
<td>Wakefield</td>
<td>20736</td>
<td>19842</td>
<td>17758</td>
<td>18584</td>
<td>76920</td>
<td>337579</td>
<td>23.0%</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>103744</td>
<td>103265</td>
<td>91776</td>
<td>102945</td>
<td>401730</td>
<td>1708414</td>
<td>23.5%</td>
</tr>
<tr>
<td>WTP Area Total</td>
<td></td>
<td>125219</td>
<td>124711</td>
<td>111976</td>
<td>125516</td>
<td>487422</td>
<td>2104773</td>
<td>23.2%</td>
</tr>
</tbody>
</table>

This equates to around 23% of the total population for those areas.

Public Health England’s 2015 Health Profiles show a pattern across the WTP of above England-average deprivation levels (for the communities as a whole – particular children’s indicators are discussed in the rationale section). WTP’s Yorkshire areas score worse than the East Midlands areas, with only North East Derbyshire (served largely by CRH) demonstrating low deprivation levels:
The acute Trusts within WTP demonstrate a range of activity volumes. The data below shows 1) self-reported non-elective children's admissions data (for all specialties) by Trust, 2) national HES-derived Finished Consultant Episode data for paediatric medical specialties by Trust, and 3) A&E activity by Trust and time band (although data is incomplete for some Trusts on this aspect).

There are some issues in using this comparative data, particularly Trust-derived, as some organisations may count, e.g. short stay assessment visits in different ways. This, therefore, is an attempt to show a best-guess consistent picture, with the HES data as a comparator:

Based upon trust self-reported data, there were 40801 non-elective admissions in 2014-15, corresponding to 8.4% of the total population (but not excluding multiple admissions for the same child):

**Figure 3 : Deprivation (PHE 2015)**

<table>
<thead>
<tr>
<th>Region</th>
<th>Trust</th>
<th>Non Elective Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>National ENGLAND</td>
<td></td>
<td>20.4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>Chesterfield</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>Bassetlaw</td>
<td>27.9</td>
</tr>
<tr>
<td></td>
<td>Bolsover</td>
<td>27.4</td>
</tr>
<tr>
<td></td>
<td>North East Derbyshire</td>
<td>10.3</td>
</tr>
<tr>
<td>Yorkshire &amp; The Humber</td>
<td>Barnsley</td>
<td>32.7</td>
</tr>
<tr>
<td></td>
<td>Rotherham</td>
<td>33.4</td>
</tr>
<tr>
<td></td>
<td>Doncaster</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Sheffield</td>
<td>34.9</td>
</tr>
<tr>
<td></td>
<td>Wakefield</td>
<td>28.7</td>
</tr>
</tbody>
</table>

**Figure 4 : Non Elective Admissions 2014-15 (Trust Data)**
HES FCE data shows a higher number (61414), although there may be multiple consultant events per admission:

![Figure 5: FCEs 2014-15 (HES)](image)

Trusts were asked to provide admissions data for two years, although this has been complicated by counting changes as described above (e.g. in Doncaster). Where year on year data is available, and seems reliable, there are large variances in growth rate. An average, however, of available growth data suggests a year on year increase of 6%.

A&E volumes are high. Although data is missing for several Trusts (MYH and CRH – outside the STP area of this analysis – and BH – not able to identify children within A&E data), volumes in 2015-16 are around 118,000 for the known Trusts (including Sheffield Teaching Hospitals as children present at A&E there on occasion). The end of the year saw a sharp rise in activity:

<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>
</tr>
</thead>
<tbody>
<tr>
<td>BHNFT</td>
<td>3213</td>
<td>3333</td>
<td>3597</td>
<td>3341</td>
<td>2819</td>
<td>3349</td>
<td>3161</td>
<td>3015</td>
<td>2720</td>
<td>2800</td>
<td>2802</td>
<td>3341</td>
<td>37491</td>
</tr>
<tr>
<td>TRFT</td>
<td>1498</td>
<td>1565</td>
<td>1593</td>
<td>1486</td>
<td>1136</td>
<td>1461</td>
<td>1542</td>
<td>1581</td>
<td>1552</td>
<td>1379</td>
<td>1447</td>
<td>1538</td>
<td>17778</td>
</tr>
<tr>
<td>CDH</td>
<td>4801</td>
<td>4682</td>
<td>4792</td>
<td>4406</td>
<td>3590</td>
<td>4365</td>
<td>4728</td>
<td>5188</td>
<td>4703</td>
<td>4994</td>
<td>4681</td>
<td>5493</td>
<td>56023</td>
</tr>
<tr>
<td>MYH</td>
<td>502</td>
<td>491</td>
<td>491</td>
<td>525</td>
<td>506</td>
<td>602</td>
<td>677</td>
<td>633</td>
<td>496</td>
<td>536</td>
<td>537</td>
<td>535</td>
<td>6518</td>
</tr>
<tr>
<td>STH</td>
<td>5054</td>
<td>5071</td>
<td>5079</td>
<td>5568</td>
<td>5048</td>
<td>6048</td>
<td>9777</td>
<td>10208</td>
<td>10417</td>
<td>9471</td>
<td>99299</td>
<td>9467</td>
<td>10907</td>
</tr>
</tbody>
</table>

TOTAL  | 10014  | 10071  | 10479  | 9558   | 8048   | 9777   | 10208  | 10417  | 9471   | 99299  | 9467   | 10907  | 117810 |
Given that BH, CRH and MYH together make up 46.1% of admissions activity, an uplift by this factor in terms of A&E activity would give a WTP-wide picture of around **218,500 attendances**.

In terms of pattern of A&E attendances, this bears out the anecdotal view that overnight activity is very low (in terms of both A&E and admissions):

![Figure 5b: A&E Activity % by Time Band (via Attain re STP)](image)

There are variances recorded in **average length of stay**, and again these may be complicated by the individual Trusts’ counting methodologies / mix of assessments and admissions. Complexity of case mix (e.g. at SCH, the tertiary centre) is also likely to influence this:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHNFT</td>
<td>1.12</td>
</tr>
<tr>
<td>CRH</td>
<td>N/A</td>
</tr>
<tr>
<td>DBH</td>
<td>1.49</td>
</tr>
<tr>
<td>MYH</td>
<td>1.8</td>
</tr>
<tr>
<td>TRFT</td>
<td>2.5</td>
</tr>
<tr>
<td>SCH</td>
<td>2.06</td>
</tr>
</tbody>
</table>

**Average** 1.79

*Figure 6: Average Length of Stay (Trust Data)*
Most Trusts were able to provide a breakdown of their non-elective admissions by day of the week. Responses were broadly consistent and suggest an average of **76.63% of admissions occurring on weekdays**. Fewer Trusts were able to provide data on time of day, but from available consistent timing data, linked to day of the week data above, an average of **59% of patients present “in hours”** (i.e. Monday-Friday, 08:00-22:00). Irrespective of day of the week, **a range of between 24% and 34% of admissions arrived between 00:00 and 08:00**.

### 6.2 Policy background

National policy and the political environment have been cited in the “Why Change?” section above. This section looks specifically at policy documents around acute children’s care arising from the Royal College of Paediatrics and Child Health (RCPCH), the “Facing the Future” series.

The initial Facing the Future document, published in 2011, states that “The primary purpose of this report is to set out a series of service standards that the [RCPCH] believes are necessary to ensure that high quality healthcare is delivered to all children and young people. It is written against a backdrop of large-scale workforce pressures in many inpatient paediatric units and relatively poor health outcomes for the UK childhood population.” As collated evidence shows, it therefore operates in a similar space to this Case for Change.

The 2011 document included a series of standards for delivery of safe, high quality inpatient paediatric services. These were reviewed and amended in 2015, and were accompanied by an additional set of standards from a companion document entitled “Facing the Future Together” – these new standards relate to whole health community aspects. It is these two sets of reviewed/new standards which inform the self-assessment in section 6.4 below, which is the key component of this Case for Change.

Of key importance in the 2011 document, is a **recognition of severe medical workforce shortages** which, the report proposes, will require a **change in service configuration**. The report suggests, as at 2011, a national shortage of 300 junior posts, and problematic consultant: trainee ratios, where the cited figure is 1:21, the ideal would be between 1:3 and 1:4. The paper also requests an increase in consultant WTEs nationally from 3084 to 4625 – a 50% increase which has not yet been attained.

The RCPCH have also advocated moves to enhance primary care training
in paediatrics.

As evidence below shows, these issues of medical staffing shortages at consultant and middle grades relate closely to the current experience of WTP Trusts.

### 6.3 Local services: Facilities and workforce (Including workforce gaps)

Consultant **workforce coverage**, based on self-declared returns from the Trusts, is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Acute Cons in Post</th>
<th>Acute Cons Vacancies</th>
<th>% Vacant</th>
<th>Number on Acute Cons Rota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnsley</td>
<td>5.5</td>
<td>0.0</td>
<td>0.0%</td>
<td>6.5</td>
</tr>
<tr>
<td>Chesterfield</td>
<td>7.4</td>
<td>0.0</td>
<td>0.0%</td>
<td>7.4</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw</td>
<td>12.4</td>
<td>3.0</td>
<td>24.2%</td>
<td>14.4</td>
</tr>
<tr>
<td>Mid Yorks</td>
<td>21.9</td>
<td>1.8</td>
<td>8.1%</td>
<td>23.9</td>
</tr>
<tr>
<td>Rotherham</td>
<td>5.0</td>
<td>3.2</td>
<td>64.0%</td>
<td>6.6</td>
</tr>
<tr>
<td>Sheffield Children’s</td>
<td>7.3</td>
<td>0.0</td>
<td>0.0%</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59.5</strong></td>
<td><strong>8.0</strong></td>
<td><strong>13.4%</strong></td>
<td><strong>66.1</strong></td>
</tr>
</tbody>
</table>

*(Figure 7a: Workforce – Consultant Vacancies (Trust Data, 2016))*

(Note DBH are using 2.0 locums to cover rota gaps at present and TRFT are using 1.6) Some Trusts (e.g. BH, MYH) supplement their acute rotas with sessions from Community Paediatricians.

The service shows consultant gaps of 8.0WTE as the Standards section below shows, this is not adequate coverage to meet the revised RCPCH standards.

The Trusts declare larger numbers of middle grade vacancies against expected trainee numbers:
There are also gaps in some services relating to non-training grade middle grade doctors (i.e. Specialty Doctors, Trust Grades, Associate Specialists):

Combining these three numbers, there are therefore 28.1 WTE senior paediatrician gaps or vacancies across the WTP area at the time of writing. This is a significant number.

This is also shown by expenditure on agency, locums and additional sessions. There were variable responses to trusts in response to this question (including a nil response from DBH – although the data above shows that they do rely upon locum consultants), however, there are some significant figures involved.

In Barnsley, whilst there was no expenditure on or use of additional consultant sessions, the middle grade picture showed 60 additional sessions in 2014-15 at a cost of £34,126. In 2015-16, at the time of submission, data suggested a decrease to 36 locum sessions, but a year-end cost projection of £36,800 due to a greater reliance upon (internal) additional sessions.
CRH, whilst not specifying cost and relying only upon 2 middle grade additional sessions, note that they have had to cover consultant posts with locums over the last year, to the extent of around **1.5 WTE over the year**, plus the need for additional sessions has been “covered mostly internally.”

MYH show very large figures. They do not specify the number of sessions, but for the calendar year from January 2015, they show additional cost for consultant sessions of £255k locum / agency, plus £600k additional sessions. This is added to middle grade locum/agency spend of £591k and a further £10k on additional sessions, giving a Trust total of over **£1.45 million** for the year recorded.

Rotherham also show considerable reliance upon additional medical capacity. Consultant data does not include costs, but shows 22 (internal) additional sessions for 2014-15 rising to 26 sessions plus 3 agency / locum shifts for 2015-16 year to date (projecting to around 32 shifts in total). Locum and agency cover for middle grades is a particular issue, with expenditure of £63,494 on locums in 2014-15 rising to £146,451 in 2015-16 year to date, with an additional £4166 of consultant time covering middle grade shifts – predicting a total spend of **£181,000** on middle grade cover for the year.

SCH note that consultants usually swap and cover shifts internally, rather than having to take on any additional sessions. In winter 14/15 the Trust did put on a number of ad hoc twilight and weekend sessions in addition to the basic rota throughout the winter months to cope with winter pressures. In winter 15/16 this was included as extra sessions within job plans. Going forward the rota will allow for this to happen within extant job plans. The Trust do not usually experience middle grade rota gaps, but had to cover 26 short term sickness rota sessions (of which 14 used agency) over the year, at a total cost of circa **£14,000**.

In terms of sites, care has been delivered from six inpatient wards across the Trusts (with DBH having inpatient beds at only the Doncaster site from February 2017) and 7 CAUs/assessment units (Barnsley’s operates 10:00-20:00 on weekdays only, there was a new CAU opened at Bassetlaw from February 2017, and MYH has CAUs at both Wakefield and Dewsbury):
However, this situation is evolving: Work is underway between TRFT and SCH on an arrangement which may affect 24/7 bed provision (but which will not diminish CAU provision) at Rotherham. MYH undertook a reconfiguration process with the 24/7 CAU at Dewsbury having reduced hours from 24 to 12 in late 2016. Planned CAU changes in Barnsley and Chesterfield (where there is no current CAU) require clarification.

High bed numbers in Doncaster are explained by the total also including assessment bed spaces on the CAU area, and 2 x higher dependency level beds. SCH bed total shown include only medical and assessment beds – surgical areas are excluded from the total.
6.4 Meeting national standards

Evidence was sought from all local acute Trusts and CCGs with regards to meeting the relevant standards set out in the two 2015 RCPCH “Facing the Future” publications. The following summarises responses in respect of both the provider and commissioner standards and shows the responses by organisation, along with an overall summary showing key areas of adherence or non-adherence. There is a further section in this document relating to the adherence to the Paediatric Intensive Care (PIC) standards.

6.4.1 Provider acute care standards

The ten RCPCH provider standards from Facing the Future (2015) are as follows:

1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.

3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.

4. At least two medical handovers every 24 hours are led by a consultant paediatrician*.

5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children’s nurse who has completed a recognised advanced children’s nurse practitioner programme and is an advanced children’s nurse practitioner.

6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.
7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the ‘consultant of the week’ system.

8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

10. All children, children’s social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.

Providers submitted a self-assessment against these standards and their self-declared results are shown here. It is important to note that there can be a degree of subjectivity in the responses, and where this is open to challenge, comment has been made at the end of the section.

Sheffield Teaching Hospitals did not respond to this in full, as acute children’s services in Sheffield are provided by Sheffield Children’s Hospitals (SCH). Results from Mid Yorkshire Hospitals (MYH) have not been received, although prior consolidation of services onto the Pinderfields site might suggest that MYH would have less difficulty complying than smaller Trusts.

This material should be taken in context of the 2015 CQC report into TRFT, which cites a number of concerns around the Children’s and Young People’s Service (http://www.cqc.org.uk/provider/RFR/reports).
The headline degree of compliance against each standard is as follows:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>0% Full Compliance</th>
<th>20% Full Compliance</th>
<th>80% Full Compliance</th>
<th>100% Full Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consultant present at peak times</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Seen by professional within 4 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Seen by consultant within 14 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2 x consultant led handovers per day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Case discussion before discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Consultant opinion at all times</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Consultant Of The Week in operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Rotas all EWTD compliant and 10+ posts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Immediate specialist advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Consultant available for Child Protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are clear (and unresolved) compliance issues around consultant paediatrician cover.

No Trust is able to guarantee consultant presence at peak times (Standard 1). Chesterfield Royal Hospital (CRH) initially submitted a red rating on this measure, but upgraded to an amber on the grounds that they expect to comply by December 2016. SCH similarly rate themselves amber and have plans to achieve this but are not currently compliant. However, compliance is predicated upon recruitments which had not, at the time of self-assessment, come to fruition.
For **Standard 3** (child to be seen by a consultant within 14 hours), only Barnsley Hospitals (BH) self-declare themselves green, however, they note that they cannot meet the standard at weekends and need to recruit to additional posts to achieve that. Therefore, this could more accurately be rated red-amber depending upon their progress towards recruitment.

Doncaster and Bassetlaw Hospitals (DBH) declare themselves red and currently face a similar situation to BH. The situation for CRH and SCH (the two amber ratings) equates closely to the responses for Standard 1 – CRH upgraded from an initial red response and compliance in both cases is predicated upon currently incomplete recruitment processes.

Therefore a revised BH score for this standard might see a 0% compliance rating.

For **Standard 9** (access to specialist consultant opinion), views are split with Barnsley and Doncaster self-declaring themselves green on the basis that specialist advice is available from the tertiary centres – usually (and explicitly in the case of BH) from SCH. However, SCH themselves declare a red rating on the basis that only three specialties offer round the clock immediate advice. Therefore, there is potential challenge to the ability to meet this standard right across the region.

There are also issues around medical cover below consultant level. For **Standard 8** (all training rotas being European Working Time Directive (EWTD) compliant and consisting of at least 10 people), Barnsley and Doncaster (but not Bassetlaw) declare themselves compliant, but both note that they are generally not able to demonstrate this in practice due to gaps in the trainee numbers coming through to them. Doncaster also note that they frequently have difficulty in securing short term locum cover to meet these gaps. As the tertiary centre, SCH are compliant, however CRH and Rotherham (TRFT) self-declare red and TRFT notes difficulties in recruiting to posts which would make them compliant.

Other red ratings across the other Standards are distributed across Trusts. However, from the data described above, it is clear that medical staffing at both consultant and middle grade levels is not currently compliant, and that the situation looks even more challenging when some self-declared green ratings are challenged.

A full set of compiled self-assessment returns is included as Appendix A.
6.4.2 Facing the Future Together Child Health Standards

The eleven RCPCH Facing the Future Together standards build upon the Facing the Future (2015) acute care standards in the unscheduled pathway, aiming to reduce unnecessary attendances at the emergency department and admissions to hospital by providing quality care closer to home, and are as follows:

1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a:
   a) Consultant paediatrician
   b) Paediatrician in Training ST6 or above
   c) Advanced nurse practitioner

2. Each acute general children’s service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.

3. There is a link consultant paediatrician for each local GP practice or group of GP practices

4. Each acute general children’s service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs

5. Each acute general children’s service is supported by a community children’s nursing service which operates 24 hours a day, seven days a week for advice and support, with visits as required depending on the needs of the children using the service

6. There is a link community children’s nurse for each local GP practice or group of GP practices

7. When a child presents with unscheduled care needs the discharge
summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.

8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.

9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child’s shared electronic healthcare record.

10. Acute general children’s services work together with local primary care and community services to develop care pathways for common acute conditions.

11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

CCGs submitted a self-assessment against these, and their self-declared results are shown here. It is important again to note that, as with provider responses, there can be a degree of subjectivity in the responses, and this is potentially open to challenge.

North Derbyshire and Hardwick CCGs submitted a joint response. The headline degree of compliance against each standard is as follows:
In a clear link to the medical staffing concerns prevalent in provider responses, **Standard 3** shows that no CCG area was able to demonstrate a link consultant paediatrician for local practices.

This also resonates with a further theme apparent in CCG responses that there is of a **lack of joined up care planning overall**. As well as the lack of link consultants, no CCG is able to demonstrate a positive response to **Standard 11**, regular/scheduled formal meetings. Whilst Hardwick and North Derbyshire, who score themselves amber, are able to demonstrate some interaction under Children’s Locality Partnership Groups, the other amber score (for Rotherham CCG) adjudges itself better than red only because there are plans for a new post (not yet appointed) to pick up the issue.

Similarly, **Standard 10** shows that common/shared care pathways are in place only in Doncaster and North Derbyshire/Hardwick. Again, Rotherham scores amber on the basis of an ambition to do this, although there does not appear to be concrete evidence of progress and so a red score might be more appropriate. The overall lack of a shared electronic health record under **Standard 9** exacerbates this further, although this may have different underlying causes (finance/resources, IT infrastructure, etc.). Sheffield, and to some extent Wakefield, are able to demonstrate the common use of SystmOne, although not all practices use this.

Whilst children’s community nursing services exist to some extent in all areas except Sheffield and Wakefield, none of these services have yet been able to demonstrate a clear link back to each practice (**Standards 5 and 6**).

A full set of compiled self-assessment returns is included as Appendix B.

### 6.4.3 Paediatric intensive care standards

The Care of Critically Ill & Critically Injured Children (2016) standards cover a wide range of factors across numerous areas of acute hospital care for children. There are over 45 standards, which are grouped in specific combinations depending upon the clinical area being assessed. Each organisation is required to fill in assessments for:
hospital-wide factors, ED, Children’s Assessment, Inpatients, L1 and L2 critical care and Adult ICU as appropriate.

Standards cover a range of themes, which include: access and involvement for families, environment, staffing levels, information, clinical leadership, policies and protocols and specific clinical teams.

As such, these standards do not lend themselves to an easily digestible visual presentation as do the RCPCH standards. Furthermore, analysis of the WTP Trust returns suggests a less homogenous picture of adherence/non-adherence than to the RCPCH standards. Returns had not been received from either TRFT or DBH, but of those who did return data, only Barnsley recorded any red-light non-adherence.

These red lights were in two main areas. Firstly, there is a perceived lack of access to Point of Care testing in both CAU and inpatient areas – this does not represent a systematic issue for the wider WTP area, and is for the Trust to resolve locally. Secondly, there is a lack of an ED liaison consultant and an ED trauma team – the return notes that it is an executive level decision to appoint a new consultant. Clearly whilst this is a local issue, it links to the wider concerns about medical workforce. CRH record an amber rating (“Partially meets”) in terms of nurse staffing levels in A&E and inpatient areas, with a focus on resuscitation skills in A&E, not all shifts are covered.

Beyond this, there are a small number of amber lights recorded across the Trusts, around a number of areas (family support, data collection, environment, et al.). Emerging themes show that a number of amber ratings relate to either patient and family information, or to operational policies. This suggests that there is scope to share best practice and to standardise policies and information in any future WTP-wide service model.

6.5 Summary and Conclusions

Taking current ability to meet RCPCH Facing the Future standards as a key factor, no one provider in primary or secondary care, nor any local health community overall, is able to demonstrate full adherence to all of the standards.
Furthermore, two strong and highly pertinent themes emerge from an analysis of performance against standards:

1. **There is a widespread and significant inability of acute providers to meet standards around medical workforce.** Indicators around consultant cover are largely not met, or rely upon incomplete and uncertain recruitments. Trainee rotas largely do not meet the 10-person standard and there are acknowledgements that even compliant rotas are full of gaps, and rely upon short term locums. Data from the RCPCH further suggests that these medical staffing elements will not alleviate in the foreseeable future. Numerical and financial data from Trusts on medical vacancies shows 28.1 WTE senior vacancies or gaps across the area at the time of writing, and heavy reliance upon agency, locum and additional session capacity across many Trusts, with MYH’s £1.45 million expenditure on this in 2015 as the largest recorded figure. Furthermore, there are some specific gaps in terms of, e.g. links to A&E.

2. **There is a clear lack of system-wide/joined up planning and activity between acute and primary care/community services.** This is expressed though a lack of link consultants, no demonstrable joint planning meetings other than in Derbyshire, limited evidence of shared care pathways and very few electronic shared health records.

This suggests that, whilst acute services struggle – and will continue to struggle – with staffing, there are not currently the structures in place to address this problem.

These key issues from the self-assessments against standards validate and strengthen the over-arching rationale which led the project to be established.

These are systemic problems, which cannot be tackled without integrated approaches. Furthermore, the lack of medical workforce suggests that a number of issues should be considered, either singly or in combination. Particularly, do we have the right configuration of service both to make best use of the current workforce and to offer the best and most effective service to patients? And, given shortfalls in medical workforce, have we made the best use of all aspects within our overall workforce – nursing, community assistants, et al?
Expressed as **risks**, this suggests clear risks around:

- Service sustainability in individual trusts
- Immediate local service resilience
- Quality and safety (through lack of continuity of care)
- Cost
- Health-community wide systems resilience

These suggest that there is **clear scope, and a mandate**, to consider reviewing and re-modelling approaches to care of the acute child across the WTP area, and that this **review should encompass the nature of the service, the locations where it is delivered, and the workforce to deliver it.**
7. **Next steps: Proposals to progress the project**

The Case for Change exists primarily as a compilation of evidence and a mandate for further work - it is not a detailed proposal in itself. Nevertheless, the Case for Change does need to make a small number of concrete proposals in order that the project can progress. This section sets out the immediate steps which should be taken in order to move the project on. Developing Project Plan documents are providing further detail some of the direction which the project might take beyond that.

It is proposed that delivery on the steps included here and in the accompanying paper continues to be led via the Working Together Programme’s children’s project team, responsible to the STP Children’s & Maternity Transformation Board. Individual NHS organisations will be represented through their places on WTP executive groups and any task and finish groups set up to support the work.

As stated above, there are some **immediate steps** which should be taken on the back of this document:

1. Sign off of Case for Change at provider and commissioner WTP governing bodies, having taken the document via the appropriate clinical sub group for their comments.
2. Detailed work plan to be updated on the basis of this – referencing other linked projects (e.g. children’s surgery and anaesthesia). This should include, as a minimum:
   a. Options development and appraisal
   b. Equality Impact Assessments on options
   c. Financial planning / analysis against options
   d. Public engagement and potential subsequent consultation
   e. STP links
   f. Y&H Senate review of options
   g. NHS Assurance processes
3. Communications and Engagement Plan as an early priority
### Appendix A - Facing the Future - Acute Standards, Response Summary

<table>
<thead>
<tr>
<th>Standard</th>
<th>Barnsley</th>
<th>Chesterfield</th>
<th>Doncaster &amp; Bassetlaw</th>
<th>Mid Yorks</th>
<th>Rotherham</th>
<th>Sheffield Children's</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.</td>
<td></td>
<td>Paediatric consultant currently on site 9 am to 5 pm 7 days a week. Peak activity 4pm to 9 pm every day. Recent expansion plus one recruitment to one additional post (recruiting at present) brings us to 10 consultants to enable compliant rotas to be in place from December</td>
<td></td>
<td></td>
<td></td>
<td>Plan to achieve. We currently have a resident consultant paediatrician 9.00am – 5.30pm Monday to Friday and 9.00am – 1.00pm Saturday to Sunday. We have a recruitment plan and proposed timetable/rota to achieve by 2019 which will mean increasing resident consultant paediatrician cover until 10pm, 7 days per week (our peak activity in terms of non-elective attendances/admissions is generally 5-10pm). This plan has been taken to the Trust Executive Group, who are supportive of the proposal.</td>
</tr>
<tr>
<td>2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.</td>
<td>Yes. The Trust does meet this standard however does suffer from deanery gaps at middle grade which can give rise to operational difficulties in meeting this standard 100% of the time</td>
<td>Current challenges with regard to sustainability: 1WTE trainee on maternity leave until September, 1WTE post filled by 0.6WTE trainee until Feb 2017. Covered by LT locum.</td>
<td>Expect to have in place by Dec 2016</td>
<td></td>
<td></td>
<td>Yes, with plan to improve. Wed do achieve a 4 hour review in the majority of cases. We currently have 2 middle grade paediatricians available at the busiest times and with the introduction of an additional twilight Consultant Paediatrician and day time acute assessment consultant cover this will become a more robust system.</td>
</tr>
<tr>
<td>3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned</td>
<td>Yes. The Trust currently meets this standard Monday to Friday however although met, this can be a challenge at weekends until additional consultant posts recruited to</td>
<td>Yes. Sustainability challenge = Gaps in rotations , shortage of Paeds locum staff and continual difficulty in staffing full rotas on two sites</td>
<td></td>
<td></td>
<td></td>
<td>Plan to achieve. We are not currently compliant as we only have resident consultant cover between 9.00am and 5.30pm so any patients admitted between 5.30pm and 7.00pm will not be reviewed by a consultant within 14 hours. However, we have a recruitment plan and proposed changes in rotas in place to ensure resident consultant cover until 10pm, 7 days per week by 2019. Only risk to this is if we are unable to recruit but this is unlikely to be a problem based on recent numbers of applicants to such posts.</td>
</tr>
</tbody>
</table>
4. At least two medical handovers every 24 hours are led by a consultant paediatrician*. Yes. 2 handovers are led by a consultant daily. No sustainability issues currently. Yes. This is sustainable at present. Yes. Morning handover (08:30) and afternoon handovers (16:00) are Consultant led. Night handover (20:30) is between middle-grades, unless consultant called back to deal with emergency. No consultant twilight shift in place to cover night handover. Insufficient consultant staff / funding to achieve this currently. Yes. We have 2 handovers led by a consultant paediatrician in the week – one at 9am and one at 4.30pm and at the 9 am and 1pm at weekends. We have no issues with sustainability of this as we have just recruited several consultant paediatricians and will be doing further recruitment in the next 2 years. The timings of the handovers may change slightly once we introduce twilight shifts but that will ensure that there at least two medical handovers every 24 hours, 7 days per week.

5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children’s nurse who has completed a recognised advanced children’s nurse practitioner programme and is an advanced children’s nurse practitioner. Yes. There can always be a discussion with an appropriate paediatrician. Yes. Sustainability issues = Gaps in rotations, shortage of available Paeds locum staff and continual difficulty in staffing full rotas at two sites. Yes. All patients are seen and / or discussed with middle grade and / or consultant prior to discharge. No sustainability issues, consultant of the week system in place. Yes. We have issued guidance to consultants to ensure that all patients are at least discussed with an appropriate clinician before being discharged. Currently 95% of admissions are reviewed by a consultant and all are reviewed by a middle grade paediatrician. With the additional consultant presence it is increasingly likely that they will be reviewed by a consultant. Unlikely to face issues with sustainability.

6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*. Yes. Yes. This is sustainable at present. Yes provided by consultant of the week / on-call consultant. Yes. Access is available 24/7 via telephone from the consultant paediatrician on-call but they are currently non-resident between 5.30pm and 9.00am. Yes. Well established ‘consultant of the week’ system. The Trust has recently implemented a second consultant ward round in the mornings, 5 days per week in the summer and 7 days per week in the winter so there will be 2 attending consultants at these times. No anticipated issues with sustainability.

7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the ‘consultant of the week’ system. Yes, the Trust operates a 1:6 ‘hot week’ rota. Yes. Currently on a 1:8 rota - moving on to a 1:10 rota from December 2016. Yes. This is sustainable but inevitably impacts on clinic capacity, review lists etc as clinics are cancelled for COTW. Yes. Consultant of the week system in place, currently recruiting to vacancies however Consultant of the week is always provided as a minimum.
8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

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<th>Hospital</th>
<th>Description</th>
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<tr>
<td>Yes. Although we have an establishment for 10/10 rotas we rarely have this actual number because of gaps at both levels.</td>
<td>This is met at Doncaster but there are always gaps on the rotations and frequent difficulties in securing locum cover. This is not met at Bassetlaw.</td>
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9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

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<tr>
<th>Hospital</th>
<th>Description</th>
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<tr>
<td>Only some specialties supported across current networks. Diabetic advice is available internally for consultant paediatricians through 2 diabetes consultants. PICU/ Neonatal advice available through the network 24/7. Renal advice is available through renal on call consultant from Nottingham 24/7. For all other specialties advice from tertiary consultants is available directly during 9 – 5 hours from tertiary centre at Sheffield and out of hours for any sick patient via the PICU / Embrace team who are able to access all specialist advice needed for us.</td>
<td>Yes. Specialist advice is sought from tertiary centres if needed, or from our own specialist consultants e.g. Paed diabetes.</td>
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10. All children, children’s social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.

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<tr>
<th>Hospital</th>
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<tr>
<td>Yes.</td>
<td>Yes. We anticipate joining a regional service for CSA at some point when established.</td>
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<tr>
<th>Hospital</th>
<th>Description</th>
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<tbody>
<tr>
<td>Yes.</td>
<td>Yes. Child Protection clinics held 5 days per week plus out of hours covered on Children’s Assessment Unit. CP clinics frequently empty so not best use of consultant time.</td>
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<tr>
<th>Hospital</th>
<th>Description</th>
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<tbody>
<tr>
<td>Yes.</td>
<td>Yes – general paediatric on-call rota is available 24/7 and staffed by clinicians with the required level of training. No anticipated issues with sustainability.</td>
</tr>
</tbody>
</table>
Appendix B - Facing the Future Together: Child Health Data Collection Tool - Response Summary

No. Respondent | Barnby's CCG | Baslow's CCG | Cameron's CCG | Derbyshire & Hardwick | Nottingham CCG | Sheffield CCG | Wakefield CCG
--- | --- | --- | --- | --- | --- | --- | ---
1 | GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician. | Access to consultant although activity and calls not monitored | Access to consultant although activity and calls not monitored | Access to consultant although activity and calls not monitored | GP access available from ward based consultant and on call consultant | On call admission service is place but this doesn't work as an advice service. Some advice from elective consultant paediatricians for GPs where consultant paediatrician available | No such arrangements currently exist
2 | Child(ren) in Training ST5 or above | Consultant paediatrician | Consultant paediatrician | Consultant paediatrician | Consultant paediatrician | Consultant paediatrician | Consultant paediatrician
3 | There is a link consultant paediatrician for each local GP practice or group of GP practices. | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist

4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with 50 and other healthcare professionals who work with children with unscheduled care needs. | No such arrangements currently exist | The education session GP led this Consultant Paediatrician led | COT already does PCT events and this can be monitored | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist

5. Each acute general children's service is supported by a community's nursing service which operates 24 hours a day, seven days a week for advice and support, with access as required depending on the needs of the children using the service. | A community nursing service is available to support the acute general service. Additional support is provided by the District and Inpatient Community Children's Team. | There is a community Nursing Team managed by a different provider to facilitate discharge for complex children and those with some nursing needs. It operates 09:00 - 17:00 Monday to Friday. | A community nursing service is available to support the acute general service. It operates Monday to Sunday 09:00 to 17:00. | The CCN team is staffed during "office hours" of 09:00-17:00 and through a pager call system out-of-hours to provide cover to children and young people who are on the service's caseload. Although data on this aspect of the service is not monitored, the service has recently undertaken an audit of on-call activity. | COT service is currently provided by the Complex Needs Team operating weekdays and limited hours on a weekend. The focus is upon children with complex disability but limited capacity to deal with acute illness follow up and hospital admission. | No such arrangements currently exist

6. There is a link community children's nurse for each local GP practice or group of GP practices. | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist

7. When a child presents with unscheduled care needs their discharge summary is sent electronically to their local relevant healthcare professionals within 24 hours and the information is given to the child and their parents or carers. | Discharge summary received electronically by the GP. Summary received within 24hrs of discharge. Parents and carers only receive copies if requested | Discharge summary received electronically by the GP. Summary received within 24hrs of discharge. Parents and carers only receive copies if requested | Discharge summary received not sent electronically or received within 24 hrs, parents received copies of this information | Discharge summary received not sent electronically or received within 24 hrs, parents received copies of this information | Discharge summary received electronically by the GP. Summary is reviewed within 48hrs of discharge. Parents and carers do not currently have copies of this information | No such arrangements currently exist

8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand. | Discharge advice is provided to parents / carers in written format for some conditions. Discharge advice is provided to parents / carers verbally. There is an open / direct access policy in place on the ward. | Discharge advice is provided verbally. Written advice depends on illness and injury. There is open access to the ward. | Discharge advice is provided to parents / carers verbally. Written advice is not in written format. Open access to ward. Activity not currently monitored or audited. | Discharge advice is provided verbally. Written and verbal format. Open access to ward. Activity not currently monitored or audited. | Discharge advice is provided verbally. Written and verbal format. Open access to ward. Activity not currently monitored or audited. | No such arrangements currently exist

9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record. | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist

10. Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions. | Care pathways require developing care pathways only in place for self-harm. Care pathways in place | Care pathways in place for common acute care conditions. Activity not monitored | Care close to home and Clinical Referral Management Committee need to undertake, approve and embed common acute care pathways into practice | Care pathways not in place for common acute care conditions. Activity not monitored | Care pathways not in place for common acute care conditions. Activity not monitored | No such arrangements currently exist

11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services. | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist | No such arrangements currently exist

Note: The table above provides a summary of the responses received from various healthcare providers regarding the implementation of various child health data collection tools and the impact of the COVID-19 pandemic on these initiatives. The responses highlight the challenges faced in implementing these tools and the need for continued efforts to improve the effectiveness of the tools in supporting the delivery of high-quality care for children with acute care needs.
Best Practice Guidance for the Configuration and Provision of Children’s Acute Care.

Owner
August 2016
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Definition:
In this document the term ‘children’ should be taken as meaning ‘children and young people’. The term ‘child’ refers to all people under the age of 18 years unless separately specified.
1.0 INTRODUCTION AND CONTEXT

The Francis report into the events at Mid Staffordshire NHS FT\(^5\) and the subsequent Berwick review into patient safety\(^6\) serve as a reminder of what can go wrong if key standards are not met; patients must receive high quality safe care in every setting in the UK. However, despite significant improvements in child health in recent decades child health outcomes are far from perfect. Compared with other equivalent European countries the UK fares worse for childhood mortality for children between 0 – 14 years of age\(^7\) and according to the NHS Atlas of Variation, wide regional differences exist across a range of indicators.

Despite strong consensus amongst Royal Colleges\(^8\) and the availability of substantial evidence making the case for change in paediatrics, consideration of children’s services is limited in current national policy. NHS England’s strategic business plan has few explicit priorities for children other than mental health, although the needs of children can be addressed through all of its 10 priorities. The NHS Five Year Forward View (2014) encouraged new models of care to be developed but aside from some aspects of prevention, most do not explicitly focus upon children.

In addition to the need to improve the care delivered, service providers are facing considerable challenges in continuing to provide safe, sustainable services that meet the needs of children and their families. Workforce pressures, medical and technological advances, children’s changing care needs in terms of complexity and the economic climate all contribute to the need for change. The Working Together partnerships recognise these challenges and are clear that they are beyond the ability of individual organisations to solve.

1.1 Challenges to the future provision of child health services

Caring for sick babies and children requires specialised knowledge and skills. For several years a number of key documents published by the Royal Colleges (Royal College Paediatrics and Child Health (RCPCH), Royal College General Practitioners (RCGP), Royal College Nursing (RCN), Royal College Emergency Medicine (RCEM), Royal College of Anaesthetists

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7 Wolfe I et al (2013) Health Services for Children in Western Europe. The Lancet 381;9873,1224 - 1234
(RCOA), and Royal College Surgeons (RCS)) have highlighted the issues and challenges facing the provision of children’s acute care. These are summarised below:

- **Providing a comprehensive 24/7 range of effective and sustainable acute children’s care services.**

Demand for urgent care is growing rapidly, and this is putting a strain on acute children’s care services. Whilst the vast majority of children’s illnesses are minor requiring little or no medical intervention, more than a quarter of emergency department attendances are for children. The largest sub group of these are for one and two year olds with minor illness.

Hospital admissions of less than 24 hours duration have also doubled during the last decade. The reasons for this may be attributed to:

- Increases in short stay paediatric assessment units.
- Systems failure in emergency departments, where admission to hospital becomes a default or preferred option.
- Reduced capacity of general practice to manage children in the community.

Parents’ preference for initial advice is their General Practitioner (GP) and children make up to a quarter of a typical GP’s workload. Yet less than half of GPs are given the opportunity to undertake a paediatric placement during their training. Of those GP’s who completed a six month paediatric placement some may not be relevant to dealing with children in primary care (e.g. neonatal work). Similarly the expertise gained by hospital-based paediatricians is less transferable when dealing with community management of minor illness or health promotion.

As GPs are responsible for early intervention additional opportunities to improve recognition and management of serious illness presenting non-specifically can only improve outcomes for children. The RCGP and RCPCH are working together to ensure that in future all GP trainees receive specialist-led training in children’s health. However, in the interim this leaves many GPs without the skills and confidence to assess and treat children in their surgery,

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10 RCPCH, RCGP, College of Emergency Medicine, NHS Direct, Joint Royal Colleges Ambulance Liaison Committee, University of Leicester and University of Nottingham. To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature). 2010
leading many to refer children to hospital for conditions that could be managed in general practice or other community settings.

It is essential that children receive care from the most skilled and experienced practitioners possible. The RCPCH biennial workforce census (2016) indicates a number of trends impacting upon service planning and provision.

A reducing supply of trainees through a combination of reducing specialist trainee numbers and evidence that hospital medicine is being seen as a less attractive career choice.

Maintaining compliance with European Working Time Regulations is a further driver for carefully planned workforce numbers as revealed in the Rota Vacancies and Compliance Survey (RCPCH Jan – March 2016):

- There is now a 10% tier 1, and 20% tier 2 rota vacancy rate; averaged across both tiers there has been an increase in the vacancy rate from 12% in January 2015 to 15% in 2016
- The rota vacancy rate is highest on tier 2 general paediatric rotas (28%), a rise from 18% in January 2015
- 60% of tier 1 and 77% of tier 2 rotas comprise fewer than the recommended 10 staff per rota, the standard set in the RCPCH “Facing the Future” report *
- 89% of clinical directors are concerned about how the service will cope in next six months; up from 78% last year
- Consultants are increasingly providing unplanned cover (35% in January 2015 rising to 38% in 2016), an average of 3.1 occasions over the 4 weeks preceding the survey compared to 2.4 in January 2015. Just under half (46.5%) of all vacancies are filled by locum doctors however it is important to consider the potential cost and quality implications of relying on locum cover.

Changes to working patterns is evident with 20% of consultant grade workforce working less than full time, whilst the RCPCH Modernising Medical Careers study cohort of trainees indicates that 48% would like to work less than full time in their consultant careers. This change may be due to the steady move toward a female workforce which tends to increase the demand for more flexible working patterns. The entrants to ST1 in August 2013 are 75% female. The Trainees Committee Survey indicated that many trainees want to train part time suggesting a growing interest in this way of working.

Limited exposure for clinicians to low volume high risk clinical events. Clinical practitioners (paediatricians, emergency department physicians, anaesthetists, nurses and allied health professionals) within District General Hospitals (DGHs) are key in the initial, often most hazardous, part of stabilisation. The unique challenge faced by practitioners involved in
these high risk infrequent clinical events necessitates regular updating and refreshment of skills. Changes in activity flows from smaller DGH’s towards larger centres can lead to de-skilling

**Current junior rotas** in paediatrics are not solely comprised of paediatric trainees (GP trainees, and FY doctors) and as such the necessary expertise, skills or experience required to provide appropriate services for paediatric inpatients may not be available.

- **Implementation of RCPCH standards lead to challenges that are beyond the ability of individual organisations to solve.**
  The suite of standards developed by the RCPCH RCGP, RCN and RCEM are designed to improve the experience and outcome of children throughout the pathway. There is widespread recognition that meeting the standards in full may be a challenge for providers. The view among clinicians is that there are options for addressing these through new models of care (section 2) but that these would require joint working, as well as the development of new roles, etc.

- **Patient experience, expectation and health literacy.**
  Some children appear to be bypassing general practice and heading straight to the emergency department, while others are having numerous encounters with different healthcare professionals before also ending up at hospital. Each one of these attendances tells us that a parent/carer was worried, and either unable or unsure how to access a more appropriate service. Engaging and educating parents and carers so they understand the health care system and how to navigate it, as well as how to manage their child’s acute and chronic illness where appropriate builds upon their capability and confidence to self-care. The family cares for the child 365 days a year, while the health professionals only have a few appointments a year with them. Hence, there is a need to proactively and continuously work with parent and carers, listen to their needs and views, and support them so they can build trust in their providers as well as the confidence to raise their concerns and self-care when appropriate. Every encounter with the family should be used as an opportunity to provide better support for parents and carers to self-care or signpost to services outside of hospital to get the right advice in the right place, first time.

- **The need to consider clinical interdependencies**
  The provision of children’s services is dependent on the provision of other acute services and vice versa. Therefore, changes to individual services can have an impact on the overall ‘portfolio’ of services offered by a particular Trust.
Maternity, neonates, ED, children’s surgery, and ambulance services play a significant role as constraints or enablers in the configuration of acute paediatric services. Maternity and gynaecology services are interlinked; in some general hospitals, obstetricians and gynaecologists and their teams are one and the same.

1.2 How do these challenges affect children’s acute care?
The Working Together partnerships recognise the challenges facing children’s acute care services due to workforce shortages, increasing attendances of minor illnesses to emergency departments and reduced opportunities for paediatric placements for GP trainees.

A baseline assessment and gap analysis of current inpatient children’s services has been undertaken, to provide:

- A summary of the local service’s workforce and facilities (beds, etc.)
- A self-assessment against the RCPCH’s “Facing the Future: Standards for Acute General Paediatric Services” on acute paediatric care\textsuperscript{12}.
- Acute paediatric activity

At the same time, CCGs within the WTP area were asked to complete self-assessments for their areas with regards to the Facing the Future Together for Child Health standards (2015), developed jointly by the RCPCH, the RCGP and the RCN.

To further inform the baseline assessment, a “Confirm and Challenge” event held on 27\textsuperscript{th} April 2016 invited stakeholders (paediatricians, service managers, GP’s, commissioners) to collectively review the collated evidence and to determine the need to pursue this work further. The resultant Case for Change document summarises the accumulated evidence.

The overwhelming view from stakeholders was that there is a clear need for change as current service provision is not sustainable. The following themes emerged from conversations:

- Workforce data identified acute service rota gaps, with many slots being filled by locum / agency staff, thus highlighting that service provision is not sustainable across the current number of sites.
- Variation in services meeting RCPCH standards (leading to potential inequalities, potentially further exacerbated by deprivation).

\textsuperscript{12} RCPCH (revised 2015) Facing the Future: Standards for Acute General Paediatric Services. RCPCH.
The wider impact of any reconfiguration of services outside the immediate project must be considered, with interdependencies acknowledged as complex. Issues include:

- Internal initiatives such as pre-existing change programmes (Mid Yorkshire NHS Trust centralisation of inpatient children’s services at Pinderfields).
- Current patient pathways and flows from providers outside WTP into the geography (North Lincolnshire and Goole NHSFT)
- Sub regional work-streams with similar aims regarding children’s services (West Yorkshire –Healthier Futures)
- National change programmes (Urgent Emergency Care review, GP Five Year Forward View) including specialised services reviews.

Given the 5YFV mandate for new models of care and the increasing pressures on children’s acute care services with the WTP geography the following drivers for change are highlighted below:

- Across the geography there is variability to reliably provide permanent staff to deliver children’s services to meet the needs of acutely ill children.
- There is variability to meet with permanent staff, the middle and consultant grade rotas in accordance with RCPCH standards.
- The amount of staff required to maintain the service and on-call rotas at all grades is disproportionate to the number of cases in some areas. This is particularly relevant at night where there is felt there are few acute children’s admissions after 22:00 hours.

As identified in the Case for Change document there are pressures on our children’s acute care services. What is also clear from the Case for Change is the lack of connection between primary and secondary care - and at the stakeholder event there was consensus to strengthen the interface to support primary care services where the needs of the child and family are known.

2.0 THE FUTURE OF CHILD HEALTH SERVICES: NEW MODELS OF CARE.

The RCPCH, RCGP and RCN have worked together to develop a set of standards in the Facing the Future suite; Facing the Future: Together for Child Health (2015), which apply across the unscheduled care pathway of acutely mild to moderately unwell children. The standards build on Facing the Future: Standards for Acute General Paediatric Services (2011 revised 2015) and the Standards for Children and Young People in Emergency Care Settings (2012), expanding them into care outside the hospital to improve health outcomes for children.

There are three overarching principles and 11 standards in total.
Standards one to six focus on supporting primary care to care safely for the child in the community, preventing unnecessary attendance at an emergency department or unnecessary admission to hospital.

Where children do need to be cared for in hospital, standards five to eight focus on reducing the length of stay, enabling these children to go home again as safely and as quickly as appropriate, while preventing unnecessary re-attendances and readmissions.

Standards nine to 11 look more widely at connecting the whole system between primary care, the hospital and community services; streamlining the patient journey and improving the patient experience.

The Royal Colleges play a leading role in setting and ensuring the highest standards of care for children. The standards are intended to be a tool and resource for healthcare professionals, commissioners, planners, providers, managers, regulators and inspectorates to help plan, deliver and quality assure children’s healthcare services. Services need to be designed and developed in partnership with children, their parents and carers and other local stakeholders.

The following practice examples compiled by the RCPCH sourced from across the UK illustrate a range of ways standards are being implemented. The examples have been organised under the following sub-headings:

- Strengthening primary and secondary care interface.
- Facilitating discharge and early repatriation home - community children’s nursing teams

2.10 Strengthening the primary and secondary care interface

2.11. Children and Young People's Health Partnership - Evelina Children's Hospital, Guy's and St Thomas’ NHS Foundation Trust
The Children and Young People’s Health Partnership is a coalition of clinical commissioning groups, local authorities, acute providers, third sector and family and patient representatives, funded by the Guy’s and St Thomas’ Charity and focused on improving the everyday health needs of children in Southwark and Lambeth. A three-pronged strategy was developed to ensure that general children’s services worked closely with primary care to develop better care pathways.

Firstly, a series of guidance covering the most commonly seen conditions in primary care, for example, asthma, fever, constipation and mental health conditions was developed. These consisted of one page flow charts of how to identify conditions, what to look out for (red flags) and top tips. Each piece of guidance was localised with specific information on when to refer and where. The guidance was designed with primary care to ensure they are user friendly
and the information sits within the IT system of primary care, making it accessible and functional.

Secondly, a hotline service was developed at the Evelina and King’s to ensure there was a strong link to the general paediatric service. This service enables primary care to access real time advice via email or telephone from a consultant paediatrician. Outcomes of a call or email are advice, transfer to the Emergency Department, booking into the next available outpatient slot or a hot clinic appointment. This service helped build a strong relationship between primary care and the hospital and provides a mechanism by which concerns can be directed to the relevant guidance.

Thirdly, by doing in-reach clinics with GPs, a further opportunity to guide people to the new guidance has been created. During in-reach clinics, a consultant paediatrician sees children alongside a GP. These children are a mix of children about whom the GP has concerns, those who attend the Emergency Department frequently or those who would otherwise have been referred to the hospital.

2.12 Supporting Primary Care - King’s College Hospital, London

Service development in Ambulatory Paediatrics at King’s has evolved over a period of years. The overall vision is to deliver high quality healthcare for children, streamlining their patient journey and thereby optimise their patient experience. This approach has enabled the development of a comprehensive portfolio of clinical services targeted at meeting the needs of children and their families.

**GP Education:** An annual paediatric GP conference is convened at King’s College Hospital. This utilises the expertise of the wide variety of paediatric subspecialties represented at King’s to deliver interactive lectures on clinical topics of importance to GPs. The GP feedback collated is proactively utilised to refine the programme content in subsequent years in order to ensure ongoing relevance to a primary care audience. Through collaborative CCG arrangements, a further three formal paediatric educational events are delivered per annum for local GP’s.

**Paediatric Phone Line:** A phone line has been in operation since July 2014, whereby GPs can speak directly to a paediatric consultant between 0800-2200 on weekdays and 0800-1730 at weekends. The aim is to optimise patient care by facilitating timely, reciprocal communication with the most appropriate hospital based paediatrician. This enables acutely unwell children and outpatient referrals to be directed appropriately. It has streamlined the outpatient referral pathway, reduced the numbers of inappropriate paediatric emergency department (PED) attendances and serves to strengthen professional relationships between primary and secondary care. A supplementary function of the phone-line is that it is also used as a means of communication for junior doctors seeking senior advice from the duty
paediatric consultant within the hospital. This has facilitated more timely decision making in the paediatric emergency department (PED) and improved clinical care, as well as directly preventing 26 hospital admissions within the first year of operation.

**Rapid Access Clinic:** This clinic has been operational for 6 years. In July 2014, there was expansion to facilitate rapid access clinic provision every weekday. Primary care referrals are accepted by phone, email or fax. The aim is to see every patient within two weeks of referral, although this can be expedited on clinical grounds as required.

**Email advice:** Utilising the facility contained within the established ‘choose and book’ system, local GPs can send email enquiries for clinical advice to a consultant paediatrician. There is a 24 hour response time during weekdays.

**Outreach Clinics:** Working in partnership has also facilitated the delivery of paediatric outreach clinics in primary care. A consultant paediatrician delivers a monthly primary care clinic alongside a GP partner. Together, they see patients who would otherwise have been referred to a hospital based general paediatric clinic. Each clinic is preceded by a lunchtime teaching session with the wider primary care team. There is also an opportunity for discussion of specific patients’ management following the clinic. These clinics provide reciprocal learning opportunities for both clinicians as consultant paediatricians develop an increased appreciation of the clinical challenges faced in primary care. The patient feedback is overwhelmingly positive.

### 2.13 Reducing avoidable presentations and admissions and improving the quality of care for children and young people – Wessex Healthier Together SCN

Over the last 10 years, unplanned paediatric admissions have risen by 28% nationally. The rises are most marked for children under the age of 1 (52% increase) and the 1-4 year age group (25%). There are increasing rates of paediatric admissions with acute ambulatory-care sensitive conditions such as upper (URTI) and lower (LRTI) respiratory tract infections and gastroenteritis. Across Wessex there has been a 22% increase in rates of admission of URTI and 40% increase in LRTIs.

Steering groups and project specific groups have been formed consisting of commissioners, clinicians, and other key partners such as Public Health from across Wessex. A governance process has been established with an Oversight and Planning Group, consisting of partner organisations, overseeing the work of all SCNs. This transformational project has been agreed through this process.

The 5 year vision for this project is to strengthen the primary and secondary care interface to improve the management of children and young people in the community to ensure that unwell children and young people are able to
access the 'right care' at the 'right time' in the 'right place' and from the 'right person'.

This will support a reduction in the number of unplanned hospital presentations and improve the quality of care for children and young people across Wessex.

Objectives - Year 1:

To develop and agree a whole-system model for delivery of high quality, safe, acute paediatric care across Wessex involving primary care, secondary care and community nursing and local authority/ public health England.

Delivery:

- Primary care - model for delivery of acute paediatric care within primary care, including shared working between GP's and community nurses developed. (Inc options for urban and rural settings). Clear pathways for delivery of paediatric care in and out-of hours developed - Oct 2014
- Community nursing - models of working involving primary care, secondary care and delivery at care at home developed. (Staffing requirements and training needs evaluated) - Dec 2014
- Data - shared dashboard across services developed – Jan 2015
- Primary care - education needs evaluated & a primary care education program developed - Mar 2015
- Primary/secondary care interface - model to integrate primary and secondary care and deliver secondary care paediatrics in primary care settings agreed – March 2015
- Secondary care - feasibility and impact of a front-of house model for appropriately triaging children presenting to A+E evaluated. Appropriate triage pathways developed- March 2015
- Commissioning - commissioning models for acute paediatric care delivery to facilitate integrated care across organisation agreed. March 2015

Improved Outcomes:

- 5% increase in the percentage of children and young people being managed in the community.
- 5% decrease in the number GP referred unplanned admissions and A&E attendances.
Objectives- Year 2:

To implement the model developed in year 1 for delivery of high quality, safe, acute paediatric care across Wessex involving primary care, secondary care and community nursing.

Delivery:

- Parent education to address inappropriate health-seeking behaviour - April 2015
- Models of delivery of acute paediatric care are in primary care, involving GPs and community nurses, with support from secondary care paediatricians implemented – Aug 2015.
- Primary care education packages introduced – Sept 2015
- Role of community nurses expanded to include the delivery of acute paediatric care. Review of current workforce and delivery of training underway – Dec 2015
- Scope & identify education and pathway modifications required to incorporate NHS 111 & the Ambulance service in clinical decision making – Nov 2015. Commissioners to include appropriate training in contracts.

Improved Outcomes:

- Further 5% increase in the percentage of children and young people being managed in the community.
- Further 5% decrease in the number GP referred unplanned admissions and A&E attendances.

2.14 Imperial Child Health General Practice Hubs - St Mary’s Hospital, Imperial College Healthcare NHS Trust

The Imperial Child Health General Practice Hubs comprise groups of two to six general practices, within inner North West London, working with paediatric consultants to provide care to practice populations of approximately 4000 children. The hubs were established in response to high outpatient and emergency department attendances by children.

At the heart of this model is an openness to discuss cases, share ideas and learn together. GPs in the hub practices might have a telephone or email conversation with a consultant to discuss the most appropriate approach for a particular patient. Where patients do not require face-to-face consultant input but discussion by the broader team would be beneficial, the case is brought to a monthly Multi-Disciplinary Team (MDT) meeting in the GP Hub. Any member of the team can bring cases, including health visitors, practice
nurses, community therapists, mental health workers and social workers. The majority of cases are resolved within the MDT. The MDT also allows senior triage of patients who require treatment in a paediatric sub-speciality directly to the appropriate clinic, rather than having an initial general paediatric appointment as before. Some patients are seen by the GP and paediatrician together in the joint-clinic that follows the MDT.

A culture of education and learning is key and each MDT meeting includes a short learning session run by the visiting consultant. Following the meeting, a joint outreach clinic is held by a consultant with a hub GP. Clinical governance responsibility for patients referred to the outreach clinic rests with the consultant. Responsibility for patients discussed at an MDT meeting or over email or telephone is retained by the GP. Evaluation of the pre-pilots shows that the hubs have the potential to decrease the number of referrals to hospital outpatients and attendance at paediatric emergency departments.

2.15 Care pathways - Luton and Dunstable University Hospital NHS Foundation Trust, Luton CCG and Cambridge Community Services

Luton has long recognised that there are high volumes of children presenting to the Emergency Department and Secondary Care Paediatric Services with common conditions that could sometimes be treated more appropriately elsewhere. The team also recognised the need for consistent assessment and care wherever a child presents and, since 2009, have worked collaboratively across the whole health system to develop shared urgent care pathways for use wherever children present. The pathways chosen were the highest volume conditions including fever, diarrhoea, vomiting, seizure, asthma, bronchiolitis, abdominal pain and head injuries. Some pathways for conditions with good evidence-based national guidance were easy to develop whereas others were more challenging. The pathway development included workshops with children and parental involvement. Information sheets were developed for families and educational tools with lessons for school-children, exploring their understanding about where to go for illness and the different services available.

An audit of the fever pathway identified that implementation of the pathway changed which patients are referred to the Paediatric Assessment Unit (PAU). It also showed an increase in the number of necessary tests and a decrease in the number of unnecessary tests. Commissioners reported a notable decrease in short-stay and long-stay costs as a result of change in the care pathway. Developing these pathways further enhanced an ethos of collaboration between acute and community services and children’s commissioners. The ongoing challenge has been to embed these pathways into multi-professional practice, particularly into GP surgeries, and also to keep them up-to-date and continuously rolled out to professionals working locally.
In October 2010, research at University Hospital North Staffordshire (now known as University Hospitals of North Midlands) identified that the number of children with acute health problems admitted to paediatric wards was about twice the admission rate of other hospitals in similar communities. It also identified the top ten conditions where children referred into the hospital by a GP were discharged within four hours without active clinical intervention.

An interactive up-skilling programme for primary care was developed through a business case model. The work was supported by Partners in Paediatrics. The main objectives of the programme were to:

- Increase the competence and confidence of GPs and nurses in the clinical management of children with acute health problems
- Reverse the year-on-year rise in inappropriate referrals to the Paediatric Assessment Unit by primary care clinicians
- Improve the patient experience, particularly providing services closer to patient homes

Ten master-class sessions, run by paediatric consultants, were held in spring and summer 2011 to increase competence and confidence in managing acute paediatric conditions in primary care. Approximately 250 clinicians took part, including 114 GPs (40 percent of the GP cohort), 79 nurses and participants from other clinical backgrounds, including student doctors, clinical educators and community midwives.

Master-class topics included respiratory problems, failure to thrive, gastroenteritis, abdominal pain, constipation, fever management/febrile child, fits, faints and “funny turns”, mixture of acute admissions, rashes and skin problems. Paediatric pre-referral guidelines and urgent care referral guidelines were produced and made readily available to all clinicians in primary care.

The overall response to the programme was extremely positive. Participants welcomed the wide range of practical tips for managing conditions in the community working with parents and many rated the explanation of the NICE and locally developed urgent care guidelines particularly highly. After 18 months, GPs and nurses who took part in the up-skilling project indicated that they felt more competent and confident in the clinical management of children with acute health problems, that they are retaining more care within general practice and that they are referring more appropriately. They also felt better able to advise and support parents and carers. Of the 28 GPs who responded to the post master-class evaluation, most believed that the master-classes had increased their ability and confidence in the clinical care of children, particularly those with acute health problems. Specific changes in practice identified from attending the master-classes included use of saturation probes
to check oxygen saturations in respiratory paediatric cases and use of pulse oximetry for children.

2.17 Electronic Personal Child Health Record (ePCHR) - RCPCH

The Personal Health Care Record (PCHR) is the main record of a child's health and development. The parent or carer owns and retains the PCHR, in which they enter their child’s health information, access and use information contributed by healthcare professionals and share this record with any organisation or individual they choose to. Healthcare professionals should update the record each time the child is seen in a healthcare setting. The ePCHR is an electronic version of the PCHR which is currently being piloted at two sites across Liverpool and South Warwickshire.

As does the PCHR, the ePCHR supports the Healthy Child Programme, recording details of screening tests, immunisations and reviews as well as signposting to relevant information. With the information kept electronically in a secure system, a child’s parent or guardian can have the convenience of managing the child’s care online.

Designed for parents and guardians to easily enter information and check their child’s health status, these are online records owned by the parent or carer and intended to be used as they would the paper PCHR. Users of a personal health record decide who has access to their information - they are the ‘custodian’ of the record. Users explicitly give consent to the use of each data item and there is no implicit consent and no global consent. As a custodian, users decide what level of access to grant others. ePCHR has the potential to substantially improve cross-care setting information sharing between primary, community, acute and social care. Developing parental access to and management of their child’s health records will lead to new communication models and healthcare delivery models within the NHS.

‘Indications overall are that where we find increased patient involvement in personal healthcare, so we expect to find better health outcomes alongside lower service cost.’

2.2 Facilitating discharge and early repatriation home

2.21. Extended hours community children’s nursing team - Islington Community Children’s Nursing Team

The Islington CCNT Hospital@Home service began in August 2014 and runs from 8am to 10pm with the aim of facilitating early discharge from hospital and preventing and reducing unnecessary attendances and admissions to hospital. The borough serves an estimated child population of 40,000, which is due to increase by approximately one-sixth by 2030.
It has been developed with input from acute paediatricians and a referral criterion is that the child has a working diagnosis and physical signs and symptoms within set parameters. Accountability for the care of the child remains with the consultant paediatrician with a nurse-led discharge. The CCNT provide safety netting information following a visit and parents and carers can call the CCNT for advice from 8am to 10pm (support is provided by the Whittington Hospital outside these hours). GPs can refer directly to the CCNT and the CCNT also run primary care clinics supporting the education of practice nurses.

The CCNT is made up of 17.5 Whole Time Equivalent (WTE) nurses, 1.5 WTE administrative support and 0.5 WTE consultant paediatrician. From August to December 2014, 107 referrals were made with 376 face-to-face contacts. Positive feedback has been received through patient and parent surveys.

Recommendations for consideration in developing a similar service are:

- Be reasonable in your expectations
- Research how other services have developed their service and adapt local pathways
- Find a paediatrician to champion the service
- Consider involving other services such as physiotherapy and dietetics
- Develop a good working relationship with commissioners.

2.22 Healthcare at Home, King’s College Hospital London

In April 2014 a novel paediatric ambulatory service was established at King’s, with ‘Healthcare at Home’ (HAH). It is a clinical service providing consultant led, nurse delivered acute paediatric care in the home.

The HAH nurses are integral members of the general paediatrics team. They attend the morning general paediatric handovers 7 days a week and this serves to optimise the referral rate. Once a child has been referred, they meet with the family whilst they are still inpatients and this practice provides continuity of care for children and their families once their care is transferred to the home setting.

The nurses have facility to visit children up to four times a day, to administer medication, provide wound care, perform observations and provide clinical reviews. The care episode notes are all recorded electronically on tablets in the home and these notes are linked to the hospital based electronic patient record. All of the patients are reviewed during a daily consultant-led virtual ward round conducted in person with the HAH nurses. The innovative use of IT facilitates this process and provides an accessible, continuous record of patient care until their discharge date. The initial goal was to enable early discharges from hospital and this has been achieved. The service has subsequently evolved to facilitate direct admission to HAH from the paediatric emergency department (PED) following a paediatric consultant review. This
new pathway thereby completely avoids hospital admission for some children. Children are accepted onto the service based on clinical need and capacity. This therefore ensures equity of the service which is available to children who reside in a range of boroughs.

2.23 DIY Health - Bromley by Bow Health Partnership

The DIY Health project aims to provide parents and carers of children under the age of five with the knowledge and skills to confidently manage their children’s health at home and to know when to seek further help. With funding from Higher Education North Central and East London, the Bromley by Bow Health Partnership worked with University College London Partners, the Bromley by Bow Centre, healthcare professionals, parents and the local community to create an education programme that would give parents and carers the confidence to know when and where best to access health services for children with minor ailments. The project created a curriculum of 12 sessions that focussed on the most common problems in the under-five age group, as well as needs relevant to the local community.

The weekly sessions take a participatory family learning approach and are co-facilitated by a health visitor and an adult learning specialist with support from local children’s centres. The sessions place strong emphasis on parents’ experiences and the importance of understanding these in order to support and direct self-care for the future, leading to greater engagement and understanding of how to use services most effectively. The project has recorded promising preliminary results and seen positive anecdotal behaviour changes in the attendees; for example, parents attending for coughs and colds are now comfortable seeking advice from a pharmacist. The pilot reported that parents who had participated in the most sessions had reduced attendance, not only for GP appointments, but also for the emergency department.

Next steps include a robust evaluation by the Anna Freud Centre, which will develop outcome measures. The project will also be modelled economically to ensure it is delivering value for money. To facilitate wider rollout a comprehensive training package is being co-produced.

2.24 Children’s Acute Nursing Initiative (CANI) Newcastle upon Tyne Hospitals

CANI stands for Children’s Acute Nursing Initiative and is a team of nurses who help with the early discharge of children from hospital. The service looks after children from the Newcastle area who have been unwell in hospital but have improved enough to go home - with the support from CANI’s team of experienced children’s nurses.

To help children go home earlier, we can:
• support families to administer the child’s medication
• provide clinical advice
• monitor things like temperature, oxygen levels and heart rate
• give intravenous antibiotics.

A consultant paediatrician at the hospital will still have overall responsibility for your child’s care while the CANI team care for your child. If necessary, the CANI nurse can arrange for your child to be seen again by the doctor at the hospital.

Working in partnership with you

The nurses work in partnership with you to develop a plan of care for your child. We may ask you to monitor and record information about your child’s condition on a simple chart. This will be fully explained to you by a member of the CANI team.

Operational hours

CANI nurses work shifts that cover from 8.00am to 10.00pm, seven days a week all year round. You will be given a phone number so you can speak to one of the nurses if you have any concerns. After 10.00pm, you can speak to a doctor.

3.0 ORGANISATION AND PROVISION OF NEW MODELS OF CARE.

The RCPCH believes in order to deliver expected standards and improve outcomes in the future, there needs to be service redesign and reconfiguration, underpinned by a workforce strategy and plans that bring together medical and non-medical education and training for all staff involved in the care of children. The drivers for this redesign i.e reduction and unwarranted variation, childhood mortality and morbidity rates are covered earlier. RCPCH is clear that networks, supported by strong clinical leadership and sound management and service reconfiguration, with a focus on care being delivered closer to home, are fundamental to improving the quality of paediatric care.

3.1 Configuration of services

The original “Facing the Future” publication (2011) recommended a model of fewer larger inpatient units which are better equipped to provide safe and sustainable care supported by short stay paediatric assessment units (SSPAUs), networked services and more care delivered closer to home.

through community children’s nursing teams and better paediatric provision in primary care. Modelling assumptions considered hospitals on the following basis:

<table>
<thead>
<tr>
<th>Unit Description</th>
<th>Activity: Emergency admissions /year</th>
<th>General paediatric consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very small</td>
<td>&lt; 1500</td>
<td>7.7 Whole Time Equivalents (WTE)</td>
</tr>
<tr>
<td>Small</td>
<td>1500 – 2500</td>
<td>9.3 WTE</td>
</tr>
<tr>
<td>Medium</td>
<td>2501 – 5000</td>
<td>10.9 WTE</td>
</tr>
<tr>
<td>Large</td>
<td>&gt; 5000</td>
<td></td>
</tr>
</tbody>
</table>

The above expression of consultant WTE's required to deliver general acute paediatrics in each size of unit did not include other clinical commitments such as consultant of the week. Since the revision of standards in 2015 the College has revised its modelling assumptions on the basis that the sessional commitment or number of Programmed Activities (PA's) allocated for general acute paediatrics would need to rise.

The following analysis shows the weekly number of general acute PAs required to meet the revised standards for a range of different types of unit. Individual units may need to adapt these models to suit their individual configuration.

To undertake the calculations a number of assumptions have been made:

- Prospective Cover is 20% i.e. a consultant is on leave, study leave etc. for one-fifth of a year
- Outpatient clinics last for one PA (four hours) plus one hour for administration (this is a change from the original Facing the Future which allowed one PA per consultant for administration)
- One hour allowed for handover
- Ward rounds will be undertaken by the consultant present in the hospital (this is a change from the original Facing the Future)
- All contribute equally to the resident and on-call rota
- On-call time is calculated at 25% e.g. for a 12 hour on call shift at night the consultant will be paid for three hours (one PA)
The RCPCH expects that a number of the small and very small paediatric inpatient units will either convert to SSPAUs or potentially close. When considering options the College suggests considering the proximity to other providers.

- Proximal within 30 mins drive to another unit
- Distal greater than 30 mins drive to another unit

The likelihood of closure is far more likely for those that are proximal and very small, although decisions to reconfigure are not just based on factors such as workforce sustainability, volume of patients and distance but also local politics and public consultation.

Planners and commissioners will need to consider what kind of SSPAU units are required. The report identified at least two models:

- The 14 hour SSPAU with consultant support
- The 24/7 consultant led SSPAU.

The main advantage of the former is that it would be less expensive; however the lack of senior medical presence would necessitate very clear operational policies and protocols for the treatment of children and options for transfer to units where more senior medical input is available.

For medium and large hospitals, there is likely to be less change, and whilst they will continue to retain their three tiers of staff, the staffing structure of tier 1 and tier 2 rotas will change. The College anticipate that the reduction in ST trainees will be offset by an expansion of GP trainees and advanced nurse practitioners.

### 3.2 Workforce Implications

The RCPCH standards have workforce implications for three principal staffing groups: children’s nurses, paediatricians and general practitioners (GPs).

#### 3.21 Community Children’s Nursing Services and Link Community Children’s Nurse

<table>
<thead>
<tr>
<th>Size of unit</th>
<th>Daily consultant presence (hours)</th>
<th>Acute paediatric outpatient clinics per week</th>
<th>Acute PAs per week required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very small</td>
<td>8</td>
<td>10</td>
<td>48.1</td>
</tr>
<tr>
<td>Very small</td>
<td>12</td>
<td>10</td>
<td>56.1</td>
</tr>
<tr>
<td>Small</td>
<td>8</td>
<td>15</td>
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</tr>
<tr>
<td>Small</td>
<td>12</td>
<td>15</td>
<td>62.3</td>
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<tr>
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<td>12</td>
<td>20</td>
<td>68.6</td>
</tr>
<tr>
<td>Large</td>
<td>12</td>
<td>25</td>
<td>74.8</td>
</tr>
<tr>
<td>(Very) Large</td>
<td>12 (2 consultants)</td>
<td>25</td>
<td>118.4</td>
</tr>
</tbody>
</table>

The RCPCH standards have workforce implications for three principal staffing groups: children’s nurses, paediatricians and general practitioners (GPs).
Standards five and six will have the most impact upon the nursing workforce and potentially will necessitate the most sizeable increase and/or change. Data is not currently available for the number of children’s nurses currently practicing in these roles in the UK, so this analysis concentrates on the workforce implications of implementing the standard for a single service.

The RCN\textsuperscript{14} recommends that for an average sized district with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children’s nurses are required to provide a holistic CCN service.\textsuperscript{1}

The RCN standards\textsuperscript{15} on staffing levels state that all Community Children’s Nursing (CCN) teams must be led by a registered children’s nurse. The RCN standards further state that in the average CCN team the minimum ratio of registered nurses to unregistered staff should not fall below 70:30, with a minimum of 25\% of the registered nurse component being CCNs who have completed a recognisable community education and development programme.

The RCN recommendation is reflected very closely by current practice in Islington, London where the CCN team which provides a hospital at home service comprises approximately 17.5 WTE nurses for an estimated child population of 43,000 (prior to setting up the hospital at home service, there were five CCN nurses in the team). However, it should be noted that while the Facing the Future: Together for Child Health standard is for a 24/7 CCN service, the Islington service operates to 10pm with overnight on-call advice provided by the Whittington hospital. The Islington team are also reliant on 0.5 WTE of a paediatric consultant who is closely involved in service development and staff support. In addition, a CCN team needs administrative support and the Islington team has 1.5 WTE staff in these roles. This CCN workforce does not include specialist children’s nurses working in community settings such as epilepsy, asthma, diabetes etc.

The CCN service in Islington was expected to see around 400 referrals a year. This represents approximately 15\% of children’s inpatient admissions at the local hospital. If such a reduction in admissions was matched by a reduction of inpatient beds at the hospital, this could potentially reduce the number of inpatient children’s nurses required on the children’s ward in line with RCN standards – although a minimum number of registered children’s nurses would need to be on duty for a safe service. However, any such reduction would need to be undertaken only after proper evaluation of the impact of the CCN service had taken place.

\textsuperscript{14} RCN (2014) The future of community children’s nursing: challenges and opportunities.
\textsuperscript{15} RCN (2013) Defining staffing levels for children and young people’s services
A further example of a CCN team is from the North East (South Tyneside) where the inpatient service has been replaced by a Short Stay Paediatric Assessment Unit (SSPAU) and a strengthened CCN team. This CCN has a team of approximately 9 WTE but as this service only provides a service between 8am and 6pm and covers a smaller child population, the ratio is broadly in line with the RCN recommendation.

The RCPCH is also aware that the relationship between CCN teams and acute hospitals varies across the country and rural areas in particular may need different solutions.

### 3.22 Standards impacting on the paediatric workforce

There will be a range of impacts on the paediatric medical workforce, particularly from standards 1 to 4 and standards 10 to 11. Calculating the impact or cost is an imprecise art and can only be done presently through drawing on specific practice examples. In many cases it is too early to provide evidence about how increased staffing in one area may mean consequent reductions in services elsewhere.

**Standard 1 – Immediate telephone advice from a consultant paediatrician**

The introduction of a consultant hotline in a large urban unit in Nottingham was allocated five PAs per week (not as part of the standard consultant of the week (COW) cover, as the COW would not have capacity to undertake this work) and this model is proving successful. Five PAs equates to more than 0.5 WTE consultant time as prospective cover must be accounted for, therefore extra resource would be 0.625 of consultant time. The unit also specified that a full time administrator was required for the operation of this system.

The hours of operation of a hotline will vary according to local need, for example, a unit with fewer admissions in North West London operates their hotline for two hours per weekday between 12-2pm. In units with fewer admissions it may be appropriate for the consultant of the week to provide the telephone advice service, at no extra cost, but this should be subject to regular workload review.

It can also be argued that advice from a consultant to a GP supports and enhances the skill of the latter group, indeed the outcomes of the trial in the Midlands show that 15% of calls were subsequently managed by the GP and that such discussions have given GPs confidence to keep children at home. There are therefore two further benefits; the support for the development of GP skills and the appropriate care of cases avoiding unnecessary admissions which will have a wellbeing benefit to both the patient and their family.
Standard 2 - Rapid access service

Rapid access clinic services have been implemented in different ways across the UK. Some rapid access services operate on the basis of appointments being added in an ad hoc manner to existing consultant clinics or the child being seen in the paediatric assessment unit. Elsewhere the rapid access service is formally rostered and included in consultant job plans.

Standards 3 and 11 - Link consultant paediatrician and whole system meetings

The implementation of child health general practice hubs in North West London has in effect combined the implementation of these two standards by holding regular multi-disciplinary meetings in GP practice hubs followed by joint outreach clinics run by the consultant and a GP. To hold 10 such meetings per year in each practice hub for a standard District General Hospital (DGH) could mean the investment of approximately 0.45 WTE of consultant time to be added to a team's job plan within a typical DGH area serving 60,000 children. The North West London scheme’s business case estimates that to break even on this investment, there would need to be a 20% reduction in outpatient attendances.

Standard 4 – Education and knowledge sessions

The University Hospitals of North Midlands programme to raise skills in primary care in 2011 reached 40% of the GP cohort by providing 10 master class sessions and this would indicate that 25 such sessions a year could potentially reach all GPs within a given district in a year to comply with the standard. If each of these sessions required the contribution of a consultant for one day (including time for preparation of course materials), the average impact on each consultant’s workload in a team of 10 consultants would be approximately five PAs per year. Set against this time commitment is of course the increased confidence and ability for GPs in the clinical care of children with acute health problems. The evaluation of this programme did show some reduction in non-elective paediatric admissions.

Standard 10 - Pathway development

Developing care pathways is an important part of improving quality in healthcare services and as such should be viewed as an intrinsic part of healthcare professionals’ roles. Therefore, the College do not view this as an additional workforce resource, but that it is important for clinical leaders to prioritise and collaborate on this type of work.
3.23 Standards impacting on the GP workforce

Standards 1 and 2 - Immediate telephone advice and rapid access service

Immediate telephone advice and rapid access services involve GPs working differently, but it is not the view of the College that this will create an additional workload or increased workforce need.

Standards 3 and 11 - Link consultant paediatrician and whole system meetings

Using the North West London hub scheme as a guide would infer that each GP would attend two multidisciplinary team meetings per year and approximately one outreach clinic per year. Broadly this may equate to a commitment on 1.5 to 2.5 days for each GP per year. In this example GP’s attendance at multidisciplinary team meetings is paid for from Clinical Commissioning Group (CCG) budgets.

Standard 4 – Education and knowledge sessions

GPs are encouraged to take advantage of these opportunities and the sessions should be factored into GP’s job plans.

Standard 6 - Link community children’s nurse for each cluster of GP practices

If multi-disciplinary meetings are implemented, the time commitment needed from GPs can largely be incorporated into that calculated for standards 3 and 11. However, it would be advisable to add a small additional element of GP time in order to attend meetings with the CCN team to highlight the CCN service, referral mechanisms, clinical protocols and audit outcomes.

Standard 7 - Discharge summary is sent electronically to the GP

This standard will not have an impact on workforce but may require changes in practice.

Standard 10 - Pathway development

Developing care pathways is an important part of improving quality in healthcare services and as such should be viewed as an intrinsic part of healthcare professionals’ roles. Therefore, the College do not view this as an additional workforce requirement, but that it is important for clinical leaders to prioritise and collaborate on this type of work. As per multidisciplinary team meetings in the North West London example, GP time to develop pathways was also paid for by the CCG.
3.3 NETWORKS

The overall intention of networks is to improve the child's journey and their families' experience of services and thereby improve outcomes for both child and family. Integrated care pathways and clinical networks are not new to paediatrics. There are strong examples of this model working well, which are detailed in RCPCH publications. However, resources are not infinite and the network also needs to balance the effectiveness, efficiency and equity of service provision for the individual, as well as the whole population covered.

At the heart of the managed network there are three concepts that are fundamental for success.

- The first is assembling the component parts of the pathway, from the many organisations involved, in a way that is seamless from a patient perspective.
- The second is to deliver the pathway in the real world, with attention to evidence, competence of practitioners and the place/environment of delivery.
- The third is to design a system to identify where the pathway is not working optimally and build a system to learn from, and then improve the identified areas.

These three concepts tend to respectively map onto the roles of commissioners, providers and regulators; and in practice all need to work together collaboratively, with the patient voice represented at all levels. Within the network it must be possible to move resources from one part to another, sometimes across organisations, in order to strengthen weak links in the pathway, and thereby achieve greatest health with the resources available.

Successful development depends on the relationships and a common understanding that develops between users, service planners, commissioners, providers and regulators.

The following factors are essential for network development and service improvement:

- A simple model of service delivery in which networks are built around patient pathways
- Pathways based on collaboration not competition

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16 RCPCH (2012) Bringing Networks to Life- An RCPCH guide to implementing Clinical Networks

• Involvement of clinicians and other professionals who are best placed to advise on the care needed at each stage of the pathway
• Joint leadership and working across organisational boundaries - integrated care
• A shared philosophy and principles for all professionals involved
• Clarity of purpose to improve the safety, outcomes and experience of services
• Being patient centred with family engagement and influence on service delivery
• Quality metrics to identify the weakest links in the system
• Innovation and improvement to eliminate any problems identified

A practical example of successful specialist network establishment is the development of neonatal networks in England. Within each network, different hospitals provide a mix and range of levels of care as agreed by that network, based on resources, capacity, geography and the availability of appropriately skilled and trained staff. Each network ensures that every infant has access to the right level of care, with the right resources and that they are cared for by staff with the right skills.

Children’s health care crosses many organisational and professional boundaries. Networks support the movement of patients through the healthcare system and can address the boundary issues ensuring good communication across organisational boundaries.

Clinical leadership is crucial to the success of clinical network function and is recognised as an essential component to shape future health policy across the UK.

4.0 SUMMARY

From this review of literature, i.e. Royal College standards and practice based examples, the WTP think that teams locally could work more effectively and usefully utilise the materials in this document. Closer working with primary care, including the regular and out of hours GP service, as well as the community children’s nursing team, to develop clearer procedures for referring children for further care or discharging them home is needed.

The following steps should improve compliance with the RCPCH’s ‘Facing the Future Together for Child Health’ standards. It would also help children get the care they need, closer to home, and reduce the demand for hospital assessment and admissions:
• Configuration arrangements of inpatient and SSPAU sites must be supported by networked services, with more care delivered closer to home through community children’s nursing teams and better paediatric provision in primary care.

• Review the scope of on-call activity and maximise the role of nurses to help reduce pressure on doctors, including development of a criteria led nurse discharge programme.

• Ensure that there is sufficient outpatient capacity for all local children to be seen in clinics locally as appropriate. This would be for general paediatric and also subspecialty clinics.

• Services need to be available in the community at peak times of activity so that patients receive the right care, at the right time, in the right place. This will require clarifying the governance, decision making and pathway arrangements for paediatric attenders out of hours, particularly the relationships between paediatrics, ED and the Out of Hours GP service. This will help patients, public and referrers be clear about whom to refer to at different times of day, as well as what telephone support is available to diagnose, treat and discharge locally where safe and appropriate.

• Review and develop the CCN services across the geography to ensure links to primary, hospital and community care are strengthened this will include roles of specialist nurses, for example in epilepsy, asthma/respiratory.

• Look across children’s healthcare pathways at all clinicians working with children in primary and secondary care and ensure that they are working to shared standards and are supported by training programmes for professionals working in all settings.

• Ensure that there are adequately qualified staff with paediatric resuscitation skills available at all times, potentially through a programme of training and skills development for the anaesthetic team with rotation to other units to maintain skills.

• Ensure that all staff who advise members of the public are aware of the correct clinical pathway to access early treatment and safe transfer.
Working Together Programmes
Children’s Acute Care:
Scenario Appraisal
11.10.16

September 2016
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</tr>
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<td>Core Leaders / Programme Executive Group (PEG)/ Senate</td>
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| To be read in conjunction with | Care of the Acutely Unwell Case for Change.  
Best practice guidance for configuration and provision of acute care. |
| File name and path           | Children’s acute care                    |
|                              | M:\Hosted\_RESTRICTED Working Together\PHASE TWO\3. Childrens services\ACUTELY ILL CHILD\1. Major Project Documentation |
| Document History:            |                                          |

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### Approval by:

Joint Committee of Clinical Commissioning Groups and the Acute Federation

### Governance route:

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Contents

1. Executive Summary
2. Evaluating the high level scenarios
3. Scenario Risks/Issues and Benefits
4. Conclusion and Recommendations
Executive Summary

Commissioners need to review and consider the case for change for Children’s Acute Care within the South and Mid Yorkshire, Bassetlaw and North Derbyshire (SMYBND) Working Together footprint and consider if provision commissioned is equitable, safe and sustainable for the future.

The case for change and best practice guidance takes into account the quality of current services, draws on national and regional guidance and clinical best practice, which set out the national standards for Child Health services.

If a transformation scenario is supported, then any consideration on location of services will need to be considered from demographic information and take into account the impact of provision in different locations according to access, local need, deliverability, cost and clinical quality.

The purpose of this document is not to provide the detail of the next phase of work but to add to the case for change and provide commissioners with a number of scenarios to consider in progressing the next phase.

It is acknowledged that at this stage consultation and discussion with patient and public members has not taken place.

The scope is consideration of acute care within 36 hours of presentation; however the interdependencies and links to community pathways of care provide significant challenge when considering scenarios. This is due to the range of models across community and hospital care pathways and the need to consider demand management on acute services to release pressure from acute setting and manage care through alternative models. This appears to have made this project challenging from the outset as the scope within community services of provision that is an integral part of the pathway is large and varied across geographical areas.

The options to be considered by commissioners are:

<table>
<thead>
<tr>
<th>Scenario 1.</th>
<th>Do nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 2.</td>
<td>Continue to deliver the services within the current form and from the current sites across the working together footprint, with a focus on improving performance and quality against standards</td>
</tr>
<tr>
<td>Scenario 3.</td>
<td>Transform children’s acute care provision in the wider context of Working Together footprint and change the service model and pathways to improve performance and quality</td>
</tr>
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</table>

1.1 Preferred option
Members of the project team have reviewed high level options and considered the application of them in line with best practice and national models of configuration of Children’s Acute Care Services, taking on board feedback from the clinical community and sub groups within the Working Together programmes.

It is the recommendation to the Programme Executive Group to consider option 3 and provide wider transformational change in the context of the vision for this programme of work *Equitable, Safe and Sustainable Services* and the vision for Children’s and Maternity Services expressed in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP).

### 2. Evaluating the high level scenarios

For the purpose of the high level scenario appraisal, Commissioners Working Together have developed evaluation criteria to use as part of the decision making process - highlighting risks, issues and possible benefits with the various scenarios.

These criteria are shown below:

Table 1 – Commissioners Working Together scenario evaluation criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Impact on premature / avoidable deaths</td>
</tr>
<tr>
<td></td>
<td>Impact on staffing levels</td>
</tr>
<tr>
<td></td>
<td>Patient safety – conforming with best practice/guidelines and standards</td>
</tr>
<tr>
<td></td>
<td>Patient experience including complaints and feedback</td>
</tr>
<tr>
<td>Access</td>
<td>Impact on population weighted average travel time</td>
</tr>
<tr>
<td></td>
<td>Feedback from patients and public – i.e. acceptability, willingness to travel</td>
</tr>
<tr>
<td></td>
<td>Impact of deprived populations of any potential change in access/ further to travel.</td>
</tr>
<tr>
<td>Affordability</td>
<td>Up front capital and other non-recurring costs required to implement reconfiguration</td>
</tr>
<tr>
<td></td>
<td>Assessment of ongoing financial viability of hospital sites</td>
</tr>
<tr>
<td></td>
<td>Assessment of affordability within commissioners allocations</td>
</tr>
<tr>
<td></td>
<td>Total value of each option incorporating future capital and revenue implications</td>
</tr>
<tr>
<td>Deliverability</td>
<td>Workforce experience/quality (attractiveness for employment)</td>
</tr>
<tr>
<td></td>
<td>Site limitation or estates changes</td>
</tr>
<tr>
<td></td>
<td>Workforce deliverability capacity of skilled workforce</td>
</tr>
<tr>
<td></td>
<td>Assessment of ease of delivering option in terms of public and stakeholder acceptability</td>
</tr>
<tr>
<td></td>
<td>Assessment of ease of creating required capacity shifts within timescales (workforce and physical facilities) Degree of integration across acute, primary, and community services</td>
</tr>
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</table>
3.1 The baseline analysis within the case for change has provided evidence of variation in
provision, which can lead to variation in quality, clinical outcomes and performance
against standards. The key messages are as follows:

There is significant inability of acute hospital providers to maintain the service
and on-call rotas at all grades in accordance with RCPCH standards.

The ability of acute providers to improve and meet standards and performance
targets is not likely to improve in the medium term due to clinical workforce
restraints.

There are challenges with maintaining and developing workforce skills and
expertise to meet the needs of children across the primary / secondary care
interface.

Clinicians are identifying that the current service configuration is not consistent,
safe or sustainable in the short, medium or long term, and that there are
significant variations in the services. This has been raised by Medical Directors
and supported by managers of trusts.

The provision of children’s services is dependent on the provision of other acute
services and vice versa. These interdependencies are complex as changes in one
service can impact upon the overall portfolio of services offered by a Trust.

The demand on acute services is also impacted upon by the configuration,
quality and capability of community services in meeting need and managing
demand.

There is a clear lack of system-wide joined up planning and activity between
acute primary / secondary / community services resulting in variation in
provider’s ability to meet core standards to ensure good quality and sustainable
provision of services in future.

There is a need for managerial leadership and clinical leadership across
organisations as implementation of standards requires cross-organisational
working.

The economic case for change is demonstrated by the flat growth rate in resource and
cost pressure within the NHS. It is also demonstrated by the increase in demand on
urgent care provision. There is not an option to look to additional investment as a
solution. There must be a focus on sustainability of safe care pathways and quality of
provision.

We also know that:
• RCPCH workforce census (2016) indicates current workforce trends and shortages will impact upon future service planning and provision
• Primary care are also experiencing considerable challenges due to:
  o Undersupply of GPs and Practice Nurses
  o Ageing GP/Practice Nurse/Admin workforce
  o Shift of work from secondary care into the community driven by policy, finance and technology
  o Increased demand driven by population demography: age and morbidity and need
• Configuration arrangements of inpatient and Short Stay Paediatric Assessment Unit (SSPAU) sites must be supported by networked services, with more care delivered closer to home through community children’s nursing teams and better paediatric provision in primary care.
• Development of Children’s Community Nursing (CCN) services across the geography will strengthen links between primary, secondary, tertiary and community care.
• Services need to be available in the community at peak times of activity so that patients receive the right care, at the right time, in the right place. This will require clarifying governance, decision making and pathway arrangements for paediatrics, ED, and out of hours GP services, so patients and referrers are clear whom to refer to at different times of day, as well as telephone support available to diagnose, treat and discharge.

**Risks and Issues - Scenario 1- Do nothing**

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk/Issue</th>
<th>RAG</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Non Compliance with RCPCH standards evident at primary and hospital care levels</td>
<td></td>
<td>None identified - challenges given the changes in workforce, and the national shortage of specialised staff undergoing training.</td>
</tr>
<tr>
<td>Performance Standards Set Out National Could Pose a Risk to Infant Mortality.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>If no planned alternative models of care are implemented, there is likely to be an increase in demand on hospital care services. We know that there are capacity issues in the current acute services due to workforce and site limitation. If alternative provision is not planned access could therefore be negatively affected. There would be a potential increase in demand and flow to the specialist site. This would obviously also mean increased transfers of patients away from local communities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordability</td>
<td>Current cost pressures from the use of agency / locum staff. Growth in demand on acute services.</td>
<td>None identified</td>
<td></td>
</tr>
</tbody>
</table>
Deliverability | Staffing shortages will mean that ability to respond to clinical need reduces impacting upon local and health community wide systems resilience | None identified

**Benefits** - Scenario 1- Do nothing

- This would leave provision working in silo and minimal links and joint working
- There would be an anticipated increase in demand on secondary care as community and public health services within community settings become challenged, as the public health grant and Healthy Child Programme Universal offer struggles to be maintained.

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefit</th>
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<tbody>
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<td>None identified</td>
</tr>
<tr>
<td>Access</td>
<td>There would be expected change in flows of patients moving to other sites where paediatric skills are available, so the viability of the local service and the local acute hospital trusts would change. Centralisation of provision is not seen as a viable or affordable option.</td>
</tr>
<tr>
<td>Affordability</td>
<td>Increase in demand would mean more centralised care in acute settings which is not affordable.</td>
</tr>
<tr>
<td>Deliverability</td>
<td>Local hospital services in other areas may be affected if performance and quality is not addressed. This would mean transport services would be affected if pathways changed, more patients could potentially require transfer. Therefore no benefits</td>
</tr>
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</table>

**Risks and Issues** - Scenario 2- Continue to deliver the provision within the current form and with the current providers from existing locations, but develop a network approach and improve quality with a focus on improving performance against standards and strengthening the interface between primary and secondary care.
<table>
<thead>
<tr>
<th>Category</th>
<th>Risk/Issue</th>
<th>RAG</th>
<th>Mitigation</th>
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</thead>
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<tr>
<td>Quality</td>
<td>Staffing shortages and change in staff skills and expertise</td>
<td></td>
<td>Investment in services — Investment into a Clinical Network and investment into workforce planning and skills development across the primary / secondary interface</td>
</tr>
<tr>
<td>Access</td>
<td>This could potentially ensure there are planned thresholds to access care across sites. It would however mean without full transformation that some local areas have variable offer and inconsistencies in access to community support may exist on a local level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordability</td>
<td>Currently commissioners and providers are required to deliver significant cost savings, and this investment in existing services coupled with the cost pressures associated with locum and agency staff may prove to be prohibitive. To release demand on acute care community services need to be in place and stabilised. Increase in demand on acute care is not</td>
<td></td>
<td>None identified</td>
</tr>
</tbody>
</table>
affordable.

| Deliverability | Staffing shortages within the provision may continue to be challenging. Variation would still exist locally which could impact on flow/demand to acute and effect deliverability. | None identified. Even with investment, the workforce development and primary care skills development timeframe will not respond sufficiently to meet growth in need. |

**Benefits** – Scenario 2 - Continue to deliver within the current form and with the current providers but develop a managed clinical network to:

- Agree guidelines and protocols are in place across the primary/secondary care interface for referring and managing the full patient pathway and address unwarranted clinical variation.
- Improve access to/from services at the right time.
- Provide a forum and clinical leadership for training and education, sharing best practice and development of the service.
- Ensure processes are in place to identify and monitor network risks and critical incidents.
- Address strategic issues by monitoring and predicting trends in patient flows, matching capacity to demand, workforce and succession planning.

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>The impact on people from low incomes and deprived areas is assumed to be minimal with this option as it would not involve major changes to their current healthcare provision.</td>
</tr>
<tr>
<td>Access</td>
<td>May be variable dependant on location, but should be able to be managed through a network for acute presentation.</td>
</tr>
<tr>
<td>Affordability</td>
<td>No major investment requirements</td>
</tr>
<tr>
<td>Deliverability</td>
<td>Secondary care staff would not have to move to another site – they could continue to work at their local hospital site. Primary care staff would continue to work in their current environment. Maintaining rota could still be challenging.</td>
</tr>
</tbody>
</table>

**Risks and Issues** - Scenario 3 – Transform children’s acute care provision across South
and Mid Yorkshire, Bassetlaw and North Derbyshire, changing the service model and pathways to improve performance and quality. This could mean re-configuring arrangements for children’s inpatient and SSPAU sites through a hub and spoke model supported by networked services with more care delivered through community children’s nursing teams and strengthened paediatric provision in primary care.

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk/Issue</th>
<th>RAG</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Ability to skill up staff and develop skills across sites, providing lead skills development from a hub would enhance quality but be challenging. Development of consistent service models, alternative care models outside of hospital, or with an alternative skill mix and consistent standards of care would improve quality</td>
<td></td>
<td>Consider the development of a clinical network for acute care. Consider implementation of new models of care to manage demand differently Ensure collaborative agreements are embedded within contractual arrangements</td>
</tr>
<tr>
<td>Access</td>
<td>If services were to be reconfigured, there would be a proportion of patients who may have to travel further. Including possibly longer patient journeys or longer ambulance travel times</td>
<td></td>
<td>This needs to be investigated further as part of the next phase of work looking at possible options. Patients and the public would need to be reassured that travel times by embrace, blue light ambulance are fully understood and planned for.</td>
</tr>
<tr>
<td>Affordability</td>
<td>If evidence based consistent model of care is developed and supported across providers as an</td>
<td></td>
<td>The business case to support this assumption needs further development</td>
</tr>
</tbody>
</table>


alternative to acute hospital care this will manage demand and provide efficiencies.

| Deliverability | There would be a need for extensive patient and public engagement as this would mean a change in where services are delivered but with overall benefits to patients | Overall outcomes will need to be worked on and the impact of changes should demonstrate overall acceptability even though there is significant change |

**Benefits - Scenario 3 - Transform acute care provision across South and Mid Yorkshire, Bassetlaw and North Derbyshire, changing the service model and pathways to improve performance, quality and sustainability**

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Reconfiguration of in patient and SSPAU services, to a more hub and spoke model has the potential to deliver improvements to quality and safety to the service. Implementation of new models of care throughout a patient pathway from community to acute settings would ensure consistency of patient pathway and quality across geography. Planning across a larger footprint will also support resilience.</td>
</tr>
<tr>
<td>Access</td>
<td>A more specialist site as a hub or several hub configurations fits with the national evidence base for best practice services, which should improve quality and outcomes. This should also contribute to a much improved assessment against standards. Consistent models of care across community to acute hospital care would ensure equitable access is planned across providers.</td>
</tr>
<tr>
<td>Affordability</td>
<td>There are economies of scale to be sought from this transformation/reconfiguration. The dependence on agency /locum staff to sustain staff rotas may reduce expenditure, however it should be noted that a full cost benefit analysis should be made available as part of the option appraisal phase of the project.</td>
</tr>
</tbody>
</table>
Planning across a larger geographical footprint for workforce and developing consensus on models that reduce impact on demand could provide efficiencies

| Deliverability | Taking a planned approach to provision of acute care pathways across a larger geographical footprint would support sustained deliverability of acute care. Providing alternative models of care including nursing care and healthcare assistants within community settings as an alternative model supports consistent delivery across. |

5. **Conclusion and recommendations**

This high level options appraisal sets out the options, risks and benefits for Children’s acute care services within the Working Together footprint. The project team are reviewing this work, and have undertaken a high level criteria assessment to form a preferred option for phase 2 of the project.

Through consideration of these criteria, and careful review of the benefits and risks associated with service delivery, the project team recommend that Option 3 (Transform children’s acute care provision South and Mid Yorkshire, Bassetlaw and North Derbyshire - changing the service model and pathways to improve performance and quality), should be considered by the Children’s Core Leaders group and then by the Programme Executive Group (PEG) as the preferred option.

The PEG will be asked to review and endorse the proposal that Option 3 be considered by the Clinical Senate to enable the work to progress.

There is an acknowledgement that further scoping of other services such as neonatal and maternity care would need consideration alongside discussions on proposals for change around acute care.
## Key Stakeholder Engagement

### Children’s services Core Leaders

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
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<tbody>
<tr>
<td>Derek Burke</td>
<td>Clinical Lead</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Des Breen</td>
<td>Medical Director</td>
<td>Providers Working Together Programme</td>
</tr>
<tr>
<td>Fiona Campbell</td>
<td>Clinical Lead – Children and Young People</td>
<td>Strategic Clinical Network</td>
</tr>
<tr>
<td>Gail Collins</td>
<td>Medical Director</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Chris Cotton</td>
<td>Senior Finance Manager</td>
<td>NHS Sheffield CCG</td>
</tr>
<tr>
<td>Will Cleary-Gray</td>
<td>Programme Director</td>
<td>Commissioners Working Together Programme</td>
</tr>
<tr>
<td>Linda Daniel</td>
<td>Project Lead</td>
<td>Commissioners Working Together Programme</td>
</tr>
<tr>
<td>Chris Edwards</td>
<td>Accountable Officer</td>
<td>NHS Rotherham CCG</td>
</tr>
<tr>
<td>Stephen Hancock</td>
<td>Lead Consultant (Paediatrics)</td>
<td>Embrace Transport Service</td>
</tr>
<tr>
<td>Helen Kay</td>
<td>Associate Director – Strategy and Transformation</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
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<tr>
<td>Kate Laurance</td>
<td>Senior Commissioning Support</td>
<td>Commissioners Working Together Programme</td>
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<tr>
<td>Phil Mettam</td>
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<tr>
<td>Tim Moorhead</td>
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<td>Jeff Perring</td>
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<td>Yorkshire and the Humber PIC ODN</td>
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<td>Mandy Philbin</td>
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<tr>
<td>James Scott</td>
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<tr>
<td>John Somers</td>
<td>Chief Executive</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Helen Stevens</td>
<td>Communications and Engagement Lead</td>
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<tr>
<td>Janette Watkins</td>
<td>Programme Director</td>
<td>Provider Working Together Programme</td>
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### Working together SMT

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<thead>
<tr>
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<tr>
<td>Jayne Sivakumar</td>
<td>Head of Service Development</td>
<td>NHS Barnsley CCG</td>
</tr>
<tr>
<td>Name</td>
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</tr>
<tr>
<td>Katie Roebuck</td>
<td>Acting Head of Commissioning and Transformation</td>
<td>NHS Barnsley CCG</td>
</tr>
<tr>
<td>Rachel Gillott</td>
<td>Deputy Chief Operating Officer</td>
<td>NHS Sheffield CCG</td>
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<tr>
<td>Jacqui Tuffnell</td>
<td>Head of Commissioning</td>
<td>NHS Rotherham CCG</td>
</tr>
<tr>
<td>Laura Sherburn</td>
<td>Chief of Partnerships and Primary Care</td>
<td>NHS Doncaster CCG</td>
</tr>
<tr>
<td>Lisa Bromley</td>
<td>Executive Lead</td>
<td>NHS Bassetlaw CCG</td>
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<tr>
<td>Gareth Harry</td>
<td>Chief Commissioning Officer</td>
<td>NHS Hardwick CCG</td>
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<tr>
<td>Mark Smith</td>
<td>Director of Finance</td>
<td>NHS North Derbyshire CCG</td>
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<tr>
<td>Esther Ashman</td>
<td>Head of Strategic Planning</td>
<td>NHS Wakefield CCG</td>
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<tr>
<td>Mike Edmondson</td>
<td>Secondary Care Dental Lead</td>
<td>NHS England</td>
</tr>
<tr>
<td>Matthew Groom</td>
<td>Assistant Director of Specialised Commissioning</td>
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**Joint Committee of Clinical Commissioning Groups**

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<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Steve Allinson</td>
<td>Accountable Officer</td>
<td>NHS North Derbyshire CCG</td>
</tr>
<tr>
<td>Nick Balac</td>
<td>Clinical Chair</td>
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<td>John Boyington</td>
<td>Lay Member</td>
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<tr>
<td>David Crichton</td>
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<td>NHS Doncaster CCG</td>
</tr>
<tr>
<td>Moira Dumma</td>
<td>Director of Commissioning Operations</td>
<td>NHS England</td>
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<tr>
<td>Philip Earnshaw</td>
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<td>Chris Edwards</td>
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<tr>
<td>Andy Gregory</td>
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<td>NHS Hardwick CCG</td>
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<tr>
<td>Idris Griffiths</td>
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<tr>
<td>Steve Hardy</td>
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<tr>
<td>Debbie Hilditch</td>
<td>Director</td>
<td>Healthwatch Doncaster</td>
</tr>
<tr>
<td>Julie Kitlowski</td>
<td>Clinical Chair</td>
<td>NHS Rotherham CCG</td>
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<tr>
<td>Alison Knowles</td>
<td>Locality Director</td>
<td>NHS England</td>
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<tr>
<td>Jackie Pederson</td>
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<td>Andrew Perkins</td>
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<tr>
<td>Maddy Ruff</td>
<td>Accountable Officer</td>
<td>NHS Sheffield CCG</td>
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<tr>
<td>Lesley Smith</td>
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</tr>
<tr>
<td>Jo Webster</td>
<td>Accountable Officer</td>
<td>NHS Wakefield CCG</td>
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**Acute Federation Board**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Martin Barkley</td>
<td>Chief Executive</td>
<td>The Mid Yorkshire Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Louise Barnett</td>
<td>Chief Executive</td>
<td>The Rotherham NHS Foundation Trust</td>
</tr>
<tr>
<td>Des Breen</td>
<td>Medical Director</td>
<td>Provider Working Together Programme</td>
</tr>
<tr>
<td>Andrew Cash</td>
<td>Chief Executive</td>
<td>Sheffield Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Richard Jenkins</td>
<td>Medical Director</td>
<td>Barnsley Hospital NHS Foundation Trust</td>
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<tr>
<td>Mike Pinkerton</td>
<td>Chief Executive</td>
<td>Doncaster and Bassetlaw Hospitals NHS Foundation Trust</td>
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<tr>
<td>Simon Morritt</td>
<td>Chief Executive</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
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<tr>
<td>John Somers</td>
<td>Chief Executive</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
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<tr>
<td>Janette Watkins</td>
<td>Programme Director</td>
<td>Provider Working Together Programme</td>
</tr>
<tr>
<td>Diane Wake</td>
<td>Chief Executive</td>
<td>Barnsley Hospital NHS Foundation Trust</td>
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**Clinical Senate**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Lisa Daniels</td>
<td>Consultant Paediatric Anaesthetist</td>
<td>The Great North Children’s Hospital</td>
</tr>
<tr>
<td>Dr Pnt Laloë</td>
<td>Consultant Anaesthetist</td>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Geoff Lawson</td>
<td>Consultant Paediatrician and Clinical Director Children’s Services</td>
<td>City Hospitals, Sunderland</td>
</tr>
<tr>
<td>Dr Andrew Simpson</td>
<td>Consultant in Emergency Medicine</td>
<td>North Tees and Hartlepool Foundation Trust</td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
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<tr>
<td>Dr Ben Wyatt</td>
<td>GP</td>
<td>Brig Royd Surgery</td>
</tr>
<tr>
<td>Dr Mark Anderson</td>
<td>Consultant Paediatrician and Head of Department – Paediatric Medicine</td>
<td>Royal Victoria Infirmary &amp; The Great North Children’s Hospital</td>
</tr>
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</table>

### 2016 Clinical Workshops

<table>
<thead>
<tr>
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<th>Title/Role</th>
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<tr>
<td>Margaret Ainger</td>
<td>Clinical Director</td>
<td>NHS Sheffield CCG</td>
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<td>Emma Andrews</td>
<td>Quality Improvement Manager</td>
<td>Strategic Clinical Network</td>
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<tr>
<td>Tracey Armstrong</td>
<td>Deputy Head of Nursing</td>
<td>The Rotherham NHS Foundation Trust</td>
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<tr>
<td>Lucy Ashall</td>
<td>Commissioning Manager</td>
<td>NHS Sheffield CCG</td>
</tr>
<tr>
<td>Pat Barbour</td>
<td>Governing Body GP</td>
<td>NHS Doncaster CCG</td>
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<tr>
<td>Tracy Barker</td>
<td>Senior Matron Children’s Services</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
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<tr>
<td>Nikki Bates</td>
<td>Elected Member</td>
<td>NHS Sheffield CCG</td>
</tr>
<tr>
<td>Chris Beattie</td>
<td>Lead Nurse</td>
<td>The Doncaster and Bassetlaw Hospitals NHS Foundation Trust</td>
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<tr>
<td>Sunil Bhimsaria</td>
<td>Consultant Paediatrician</td>
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<td>Anne Brady</td>
<td>Group Manager</td>
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<td>Medical Director</td>
<td>Provider Working Together Programme</td>
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<tr>
<td>Derek Burke</td>
<td>Medical Director</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
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<tr>
<td>Tracy Burton</td>
<td>Children’s Commissioners</td>
<td>NHS Bassetlaw CCG</td>
</tr>
<tr>
<td>Fiona Campbell</td>
<td>Chair Consultant Paediatrician</td>
<td>Leeds Teaching Hospital Trust</td>
</tr>
<tr>
<td>David Clitheroe</td>
<td>Consultant Lead – Unscheduled Care and Emergency Centre</td>
<td>NHS Rotherham CCG</td>
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<tr>
<td>Gail Collins</td>
<td>Medical Director</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
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<tr>
<td>Sarah Cooper</td>
<td>Clinical Strategy and Transformation Lead</td>
<td>The Rotherham NHS Foundation Trust</td>
</tr>
<tr>
<td>Sian Cooper</td>
<td>Consultant Paediatric Intensivist</td>
<td>Leeds Teaching Hospital Trust</td>
</tr>
<tr>
<td>Naomi Compton</td>
<td>Senior Commissioning Manager</td>
<td>NHS Derbyshire CCG</td>
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<tr>
<td>Linda Daniel</td>
<td>Project Lead</td>
<td>Commissioner Working Together Programme</td>
</tr>
<tr>
<td>Ben Dockerill</td>
<td>Nurse Advisor Children and Young Peoples Care/Matron</td>
<td>Barnsley Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>David Gibson</td>
<td>Consultant Paediatrician</td>
<td>The Mid Yorkshire Hospitals NHS Trust</td>
</tr>
<tr>
<td>Lee Golze</td>
<td>Head of Strategy</td>
<td>NHS Doncaster CCG</td>
</tr>
<tr>
<td>Alison Grove</td>
<td>Consultant Paediatrician – Head of Service</td>
<td>The Mid Yorkshire Hospitals NHS Trust</td>
</tr>
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<tr>
<td>Stephen Hancock</td>
<td>Lead Consultant</td>
<td>Embrace Transport Service</td>
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<tr>
<td>Isabel Hemmings</td>
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<tr>
<td>Stjohm Livesey</td>
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<tr>
<td>Tim Moorhead</td>
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<td>NHS Sheffield CCG</td>
</tr>
<tr>
<td>Denise Nightingale</td>
<td>Clinical Lead</td>
<td>NHS Bassetlaw CCG</td>
</tr>
<tr>
<td>Daksha Patel</td>
<td>Divisional Director for Family Health</td>
<td>The Rotherham Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Jeff Perring</td>
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<td>Doncaster and Bassetlaw Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Mary Ryan</td>
<td>Consultant in A&amp;E</td>
<td>Alderhay Children’s Hospital NHS Foundation Trust</td>
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<tr>
<td>Matthew Roby</td>
<td>Consultant Paediatrician and Clinical Lead</td>
<td>Chesterfield Royal Hospital NHS Foundation Trust</td>
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<td>Emma Royal</td>
<td>Commissioning Manager</td>
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<td>James Scott</td>
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<tr>
<td>Sally Shearer</td>
<td>Director of Nursing</td>
<td>Sheffield Childrens Hospital Foundation Trust</td>
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<tr>
<td>Rajiv Singh</td>
<td>Consultant Paediatrician</td>
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<td>Head of Nursing Children’s Services</td>
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<tr>
<td>Sanjay Suri</td>
<td>Clinical Director for Child Health</td>
<td>The Rotherham Hospital NHS Foundation Trust</td>
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<tr>
<td>Conrad Wareham</td>
<td>Medical Director</td>
<td>The Rotherham Hospital NHS Foundation Trust</td>
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Item 9

Continuing Healthcare Hosted Services
Purpose of Paper - Executive Summary

The purpose of this paper is to update the Governing Body in relation to the hosted services for Previously Un-assessed Periods of Care (PUPoC) and Continuing Health Care (CHC).

The paper includes information relating to:-

- Background to hosting the service
- Background to the service
- Current position
- Planned future model

Recommendation(s)

The Governing Body are asked to note the contents of this paper and the on-going progress in relation to the hosted services.
<table>
<thead>
<tr>
<th>Impact analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality impact</td>
<td>Provision of Quality Service for Appellants</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>Neutral</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Financial Impact of shared cost for service</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>No Conflicts of Interest Identified</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong></td>
<td>Service Design and Delivery through Finance and Quality Team</td>
</tr>
<tr>
<td>(internal departments, clinical, stakeholder &amp; public/patient)</td>
<td></td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>Previous Option Paper presented to Governing Body.</td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>No Additional Risks</td>
</tr>
<tr>
<td><strong>Assurance Framework</strong></td>
<td>Nil</td>
</tr>
</tbody>
</table>
Hosted Functions for Previously Unassessed Periods of Care and Continuing Health Care
March 16th 2017

1. Introduction

1.1 The purpose of this paper is to update the Governing Body in relation to the
hosted services for Previously Un-assessed Periods of Care (PUPoC) and
Continuing Health Care (CHC).

2. Background

2.1 In 2015 Yorkshire & Humber Commissioning Support Unit were unsuccessful
for gaining approval to enable them to be accepted onto the Lead Provider
Framework for all services apart from Continuing Health Care. This led to the
demise of Yorkshire & Humber Commissioning Support Unit. A transition
board was established with various work streams. NHS Doncaster CCG led
the work stream looking at options for the future of Continuing Health Care
(CHC) and Previously Un-assessed Periods of Care (PUPoC).

2.2 NHS Doncaster CCG agreed to host the PUPoC service (PUPoC Shared
Service) on behalf of 12 CCGs (including NHS Doncaster CCG). 9 of these
were within Yorkshire and Humber with a further 3 in Leicester.

2.3 NHS Doncaster CCG also agreed to host a shared service for Continuing
Healthcare (CHC Shared Service) across 5 CCGs that managed:
• Appeals
• Complaints coordination
• Performance reporting
• Education/Professional Development

2.4 Responsibility for managing current requests for assessment and funding
through CHC returned to the individual CCGs.

2.5 The CHC Shared Service continues to manage appeals relating to current
patients from those CCGs covered and coordinates data reporting and
complaints in line with the agreed service requirements.

3. Activity and Performance

3.1 NHS England required all claims within the current PUPoC period to be
completed by March 2017 with an aspiration to complete them sooner if
possible. NHS Doncaster CCG, on behalf of the collaborative, committed to complete all cases by the end of January 2017. Additional resources were identified to support this commitment and with the exception of three cases, this was achieved. This was a significant achievement for the team and the collaborative.

3.2 The PUPoC guidance allows for appeals within the process. The team will continue to manage this process when appeals are requested and the guidance allows for appeals to be made up to 6 months after the original decision.

4. **Future Service**

4.1 NHS England have indicated that there will be a further scheme opened for appellants to requests reviews for previously un assessed periods of care. As such there is a need to maintain a team with sufficient capacity to undertake this. The formal guidance for this period is expected imminently from NHS England but it expected to cover the period from 2012 onwards.

4.2 The Governing Body previously approved in principle the option for NHS Doncaster CCG to continue to host the PUPoC Shared service on behalf of the collaborative. The collaborative now includes 9 CCGs within Yorkshire and Humber. There was a mutual decision for the Leicester CCGs to withdraw from the collaborative at the end of March 2017.

4.3 The CHC Shared Service was reviewed and the 5 CCGs committed to continue with the current model albeit with some alteration in relation to some of the Professional leadership and education functions.

4.4 Both shared services will continue to operate out of their current Base at 722 Prince of Wales Road, Sheffield which is the NHS Sheffield CCG headquarters.

5. **Memorandum of Understanding**

5.1 A new Memorandum of Understanding (MOU) will need to be agreed across the collaborative for all parts of the shared services. CCGs have agreed in principle to the staffing model and final finance modelling is underway to finalise the detail within the MOU.

5.2 The costs of the service are shared by all CCGs within the collaborative and it has been agreed that the methodology for determining the cost split is to use CCG population size.

6. **Recommendations**

6.1 The Governing Body are asked to note the contents of this paper and the ongoing progress in relation to the hosted services.
Item 10

Quality & Performance Report
## 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 5 main sections this month:

- Provider Performance - main local healthcare providers
- Other services commissioned by NHS Doncaster CCG
- NHS Constitution measures
- Items for escalation regarding Local Delivery Plan in year delivery
- Health Overview Paper Corporate Parenting Board

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 and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT)
- There were no falls resulting in serious harm during January 2017.
- 18 week Referral to Treatment Times - The position for incomplete pathways in January rose slightly to 90.3% but remained below standard (92% of patients waiting under 18 weeks).
- Performance for the 6 weeks to diagnostic tests measure fell below the 99% target at 98.1% during January 2017.
- There was one breach of the 52 week incomplete waits measure for an NHS Doncaster patient during January 2017 in ENT.
- February 2017 A&E performance was 88.7% against the NHS Improvement trajectory and national standard of 95%.
- Handovers over 60 minutes rose to 12 during December 2016.

### Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH)
- IAPT Recovery Rate achieved target at 54.5% for the 6th consecutive month during January 2017.
- The amount of Section 117 reviews completed within 12 months fell during...
January 2017 to 93.0% against a target of 95%.

**Other Commissioned Services**
- N/A

**Local Delivery Plans**
- None applicable

### 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></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality impact</strong></td>
<td>As identified in the report</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>Neutral</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>As identified in the report</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>The report is for information – no conflicts of interest identified. It should be noted that some Governing Body members may be employed in secondary employment by organisations referenced in this report: please see Register of Interests for details.</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong> (internal departments, clinical, stakeholder &amp; public/patient)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>Risks are captured in the Executive Summary</td>
</tr>
<tr>
<td><strong>Assurance Framework</strong></td>
<td>2.1, 2.2, 2.4</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 January data unless noted. The report covers 5 main sections this month:

- Provider Performance - main local healthcare providers
- Other services commissioned by NHS Doncaster CCG
- NHS Constitution measures
- Items for escalation regarding Local Delivery Plan in year delivery
- Health Overview Paper Corporate Parenting Board

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 DBTHFT and RDASH. Performance is across a range of quality and more traditional “performance” measures. As such the report includes performance as a whole for DBTHFT and Doncaster sites for RDASH, and does not simply relate to services commissioned by NHS Doncaster CCG.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Governance

<table>
<thead>
<tr>
<th>Time Period</th>
<th>November 2016</th>
<th>December 2016</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes to the Board</strong></td>
<td>None applicable</td>
<td>The Chair of Doncaster and Bassetlaw Hospitals (DBH), Chris Scholey, stepped down from his position on 31 December 2016. Suzy Brain England, started in post as Trust Chair on 1 January 2017.</td>
<td>None applicable</td>
</tr>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Trust's rolling 12 month HSMR performance further improved during November and remains better than expected at 93.0. Crude mortality has risen in December and January in a pattern similar to previous years. DBTHFT are reviewing deaths within this period to ensure that care has been of high quality.</td>
<td></td>
</tr>
<tr>
<td><strong>Contractual actions</strong></td>
<td>2016/17</td>
<td>Contract Queries: No further contract queries were issued during January 2017. The Trust has provided the CCG with regular updates against the open Contract Query regarding data quality and the action plan continues to be monitored.</td>
<td></td>
</tr>
</tbody>
</table>
Performance Notices: zero.

<table>
<thead>
<tr>
<th>Number of serious incidents reported (CCG)</th>
<th>Q2 2016/17 – 10</th>
<th>Q3 2016/17 – 3</th>
<th>Jan 2017 – 5</th>
<th>Feb 2017 - 5</th>
</tr>
</thead>
</table>

Please note that the above figures include incidents which may be subsequently de-logged as a SI.

Patient Experience

<table>
<thead>
<tr>
<th>Time Period</th>
<th>October 2016</th>
<th>November 2016</th>
<th>December 2016</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints/concerns Opened</td>
<td>95</td>
<td>104</td>
<td>87</td>
<td>109</td>
</tr>
</tbody>
</table>

The number of complaints increased in January compared to the seasonal drop in December, however they remain below the median for 2016/17. Work continues to improve response rates which fell slightly to 30%.

Friends & Family Test

Inpatients

A&E

Outpatients

During December DBTHFT had a higher percentage of outpatients, inpatients and A&E attenders recommending services than the England average. Response rates for each were below the England average.
Friends & Family test

Antenatal

Birth

Postnatal

The percentage of Doncaster patients recommending antenatal services achieved a higher percentage than the England average for the first time since September.

Workforce

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017</td>
<td>From 01 May 2016, Care Hours Per Patient Day (CHPPD) has become the principle measure of nursing and healthcare support worker deployment. The CHPPD data has been consistent. The model ward portal will allow the Trust to benchmark CHPPD with other providers by specialty and ward to identify how staff deployment and productivity can be improved. DBHFT have been requested to be part of a national pilot for this work. Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for January 2017 are;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>123</td>
<td>456</td>
<td>789</td>
</tr>
<tr>
<td>Site 2</td>
<td>345</td>
<td>678</td>
<td>901</td>
</tr>
<tr>
<td>Site 3</td>
<td>567</td>
<td>890</td>
<td>123</td>
</tr>
<tr>
<td></td>
<td>Bassetlaw</td>
<td>Doncaster Royal Infirmary</td>
<td>Montagu</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
<td>---------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>4.3</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td>7.6</td>
<td>7.2</td>
<td>4.8</td>
</tr>
</tbody>
</table>

### Safety

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Jun 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Never Events (cumulative during financial year)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

There was a new Never Event in December 2016 in relation to a retained wire. Initial meetings around this event have taken place within Commissioners being involved. The RCA investigation is currently taking place and the report is due to be received during March 2017.

| MRSA (cumulative during financial year) | 1      | 1      | 1      | 1      | 1      | 2      | 2      | 2      |

There have been a total of 2 cases of MRSA for the year to date.

| C-Diff Actual Trajectory (NHSE cum. target 40) | 7      | 10     | 11     | 14     | 16     | 20     | 22     | 24     |

| Hospital Acquired Pressure Ulcers (category 3, 4 and ungradeable, target of less than 60 in 2016/17) | Q2 2016/17 - 6 | Q3 2016/17 - 10 | January 2017 - 9 |

Performance in January was higher than the same month in 2015/16. Current year to date performance was 12% better than at the same point last year.

The position is prior to the Root Cause Analysis process being completed.

| Serious Falls (target of less than 29 during 2016/17) | Q2 2016/17 - 2 | Q3 2016/17 - 2 | January 2017 - 0 |

There were no falls resulting in significant harm in January. Year to date performance since April 2016 is 33.33% better than the same period 2015/16.

The Q3 position is prior to the Root Cause Analysis process being completed.
## Operational Effectiveness

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18 week Referral to Treatment Times Incomplete Waits (target 92%)</strong></td>
<td>92.8%</td>
<td>92.6%</td>
<td>92.0%</td>
<td>92.1%</td>
<td>91.7%</td>
<td>91.3%</td>
<td>90.1%</td>
<td>90.3%</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td>91.5%</td>
<td>91.3%</td>
<td>90.9%</td>
<td>90.8%</td>
<td>90.4%</td>
<td>90.6%</td>
<td>89.8%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The position for Incomplete pathways in January rose slightly from December but remained below standard (92% of patients waiting under 18 weeks). The latest England benchmark is for December where on average 89.8% of patients were treated within 18 weeks.

Eight specialties failed to meet 92% in January:
- General Surgery
- Urology
- General Medicine
- Dermatology
- Trauma and Orthopaedics
- ENT
- Ophthalmology
- Rheumatology

January’s recovery trajectory was 90.5% and the Trust performed just under this at 90.3%. An increase in cancellations based on previous months and ongoing staff sickness has been an issue across some specialty areas. Based on delivery plans and increased capacity an improvement to performance is predicted from April onwards. However, the Trust position has improved from December and certain specialties such as Dermatology are demonstrating initiatives to increase capacity. Respiratory continues to show improvement while changes to the sleep studies pathway has increased capacity to meet increased demand.

Care Groups are actively attempting to secure capacity supported by the Chief Operating Officer (COO) and Deputy COO. The DCOO has been through the full RTT Delivery Plan with Commissioners to discuss position and opportunities for support from primary care. This work will continue and be delivered through the new Joint Planned Care Programme Board.

DBTHFT have provided the CCG with a RTT Recovery Plan which sets out the following:

The key issues remain having sufficient workforce to meet demand, utilisation of clinic capacity and theatre slots, cancellations due to bed availability due to non-elective admissions, waiting list management practice and lack of pathway management support in Care Groups for validation, tracking and utilisation.

There are a number of actions underway which have been previously reported including:
- Secure additional capacity both internally and externally through outsourcing
- Turnaround sessions planned with each Care Group commencing 18/01/17
- To ensure chronological booking of patients to support RTT delivery
- Collaboration with CCG on referral management and support in reducing demand
- Workforce Business Case/Requests by specialty
- To provide a situation report of Care Group Review Lists and identify risks and issues
- Increase Pre-Assessment capacity to support recovery plans
- Interim service line management in place
- Dedicated Pathway Co-ordinators in Care Groups to manage specialty level pathways to improve planning and performance
- Validation process between Care Group and DQ Team agreed with weekly monitoring in place on completion
- Identify best practice PTL management to enhance Trust reporting and information
- Exploration of external support; Consultant Resources, PTL management; cleanliness, validation, knowledge and skills
- Clean PTL completed by w/e 03/02/17
- Enhance Business Intelligence to support performance conversations at Accountability meetings - new Care Group Dashboard with planned care metrics

![Graph showing 6 week referral to Diagnostic test times](image)

### 6 week referral to Diagnostic test times (target 99%)

<table>
<thead>
<tr>
<th></th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>99.6%</td>
<td>99.2%</td>
<td>98.96%</td>
<td>98.94%</td>
<td>99.2%</td>
<td>99.4%</td>
<td>99.3%</td>
<td>98.1%</td>
</tr>
<tr>
<td></td>
<td>98.5%</td>
<td>98.6%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>98.3%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Diagnostic waits failed to meet the standard during January at 98.1% against the target of 99%.

The Diagnostic measure failed due to demand pressures and availability of staff and equipment in Audiology and Sleep Studies.

Additional weekend sessions for Endoscopies has been authorised to manage demand with a long term plan to be determined. The Audiology department have new staff in post from March onwards and additional sessions requested. Further information regarding pressures in Sleep Studies is awaited.

### 52 Week Waits – Incomplete Pathway

<table>
<thead>
<tr>
<th></th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCCG</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
There was one 52 week breach in January which occurred in ENT. The patient has been scheduled an appointment in March 2017. A Breach report will be completed and shared with commissioners.

The ENT department has received targeted training and has appointed a position to look specifically at pathway management in ENT.

<table>
<thead>
<tr>
<th>4 Hour access - total time in the A&amp;E department (target 95%)</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
<th>Feb 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>92.8%</td>
<td>91.9%</td>
<td>93.9%</td>
<td>92.6%</td>
<td>90.7%</td>
<td>86.6%</td>
<td>85.0%</td>
<td>88.7%</td>
</tr>
<tr>
<td>FCMS – Urgent Care Centre (UCC) Performance contributing to Total A&amp;E Performance above</td>
<td>90.3%</td>
<td>91.0%</td>
<td>90.6%</td>
<td>89.1%</td>
<td>88.4%</td>
<td>86.2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>DBTHFT’s February position rose by 3.7% to 88.7%, though remained below the 95% standard of patients being admitted, transferred or discharged within 4 hours.</td>
<td>99.9%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Pressures have continued with internal waits in both EDs due to the shortage of medical staff. This has been made worse by last minute cancellations of agency staff. Bed capacity has been an issue at DRI due to emergency demand and Flu continued to cause some issues with closed beds early in the month.

A Doncaster Urgent Care Improvement Plan has been developed and shared with System Resilience Group and the A&E Delivery Board. This includes a recovery trajectory for A&E 4 hour performance and actions aligned to national initiatives and the CCG Delivery Plan, spanning attendance avoidance, patient flow in the ED, Admission avoidance, patient flow in hospital and the discharge process.

<table>
<thead>
<tr>
<th>Handovers – numbers waiting over 60 min</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11</td>
<td>4</td>
<td>15</td>
<td>28</td>
<td>5</td>
<td>8</td>
<td>12</td>
</tr>
</tbody>
</table>

December’s handovers over 1 hour increased from 8 to 12 in December. Due to the continued pressure in January further handover delays are expected to be seen in January data once available, however YAS have since reported that demand has eased during February.

<table>
<thead>
<tr>
<th>Cancelled Operations (target &lt;0.8%)</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.4%</td>
<td>1.2%</td>
<td>1.1%</td>
<td>1.4%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.8%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Cancelled operations (on the day of operation) remained at 1.8% in January 2017.

Theatre cancellations were impacted by a bed capacity of 9 with 4 High Dependency Unit bed cancellations.
**Cancelled Operations - 28 Day Standard**

<table>
<thead>
<tr>
<th>Month</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 16</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

There was 1 breach of the 28 day standard during January which is an improvement of 5 from December. All patients cancelled last minute in December and not re-booked within 28 days have now had their operations.

**Two week wait from referral to date first seen: symptomatic breast patients (target 93%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>95.8%</td>
<td>93.8%</td>
<td>92.5%</td>
<td>97.9%</td>
<td>100%</td>
<td>93.5%</td>
<td>100%</td>
<td>93.2%</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>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>93.1%</td>
<td>94.0%</td>
<td>94.5%</td>
<td>94.4%</td>
<td>94.4%</td>
<td>95.3%</td>
<td>94.3%</td>
<td>94.6%</td>
</tr>
</tbody>
</table>

**31 day wait from diagnosis to first definitive treatment (target 96%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>99.4%</td>
<td>98.6%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.1%</td>
<td>99.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**31 day wait for subsequent treatment – surgery (target 94%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>97.6%</td>
<td>97.6%</td>
<td>97.7%</td>
<td>97.3%</td>
<td>97.3%</td>
<td>97.3%</td>
<td>97.2%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

**31 day wait for subsequent treatment – anti cancer drug regimen (target 98%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</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>
</tr>
</tbody>
</table>

**31 day wait for subsequent treatment – Radiotherapy (target 94%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>99.5%</td>
<td>99.4%</td>
<td>99.3%</td>
<td>99.4%</td>
<td>99.2%</td>
<td>99.3%</td>
<td>99.5%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>
The 62 day wait for first treatment from urgent GP referral to treatment was the only cancer target to fail to meet target during December 2016.

Key pathways were lower and upper GI and Head and Neck. These pathways continue to be reviewed to ensure early access to diagnostics.

Work is ongoing to improve 62 day waiting times standards including:
- Monitoring via flagging at days 28, 30 and 50
- Individual breach reports discussed with MDT to embed learning, and also analysed with the CCG and Clinical Lead
- Capacity and Demand modelling both within Care Groups and in conjunction with the CCG
- Trust and CCG joint involvement in the Cancer Alliance and workstreams

### Outliers (Daily averages)

<table>
<thead>
<tr>
<th>Medicine to Orthopaedics</th>
<th>Most Outliers</th>
<th>Least Outliers</th>
<th>Average Outliers</th>
<th>Medicine to S12</th>
<th>Most Outliers</th>
<th>Least Outliers</th>
<th>Average Outliers</th>
<th>Medicine to surgery</th>
<th>Most Outliers</th>
<th>Least Outliers</th>
<th>Average Outliers</th>
<th>Medicine to gynaecology</th>
<th>Most Outliers</th>
<th>Least Outliers</th>
<th>Average Outliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2016</td>
<td></td>
<td></td>
<td></td>
<td>December 2016</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></td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>26</td>
<td>16</td>
<td>4</td>
<td>10</td>
<td>11</td>
<td>6</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
The number of outliers is monitored and is raised through appropriate joint Trust and CCG Groups as necessary. The amount of outliers has risen during December 2016.

CQUINs

2016/17

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>The quarter 1 evidence was received and a breakdown of achievement was provided in the October 2016 Governing Body Report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 2</td>
<td>The quarter 2 evidence was received and a breakdown of achievement was provided in the January 2017 Governing Body Report.</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>The quarter 3 evidence has now been received and a meeting has been arranged to review and agreed attainment.</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>The quarter 4 evidence is due to be received from the Trust during March 2017. An update on the year end attainment will be provided in the next report.</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: Proportion of patients scanned under 1 hour of clock start (target 48%)</td>
<td>53.8%</td>
<td>55.1%</td>
<td>52.2%</td>
<td>47.8%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Stroke: Proportion of patients directly admitted to a stroke unit under 4 hours (target 90%)</td>
<td>71.2%</td>
<td>67.3%</td>
<td>71.1%</td>
<td>60.9%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Stroke: Proportion of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (target 90%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Stroke: Proportion of applicable patients receiving a joint health and social care plan on discharge (target 90%)

<table>
<thead>
<tr>
<th></th>
<th>90.0%</th>
<th>97.7%</th>
<th>92.3%</th>
<th>94.4%</th>
<th>85.0%</th>
</tr>
</thead>
</table>

### Stroke: Percentage of patients treated by a stroke skilled early supported discharge team (target 40%)

<table>
<thead>
<tr>
<th></th>
<th>66.7%</th>
<th>70.5%</th>
<th>60.0%</th>
<th>78.4%</th>
<th>71.1%</th>
</tr>
</thead>
</table>

### Stroke: Percentage of applicable patients who are discharged who were given a named person to contact after discharge (target 95%)

<table>
<thead>
<tr>
<th></th>
<th>75.0%</th>
<th>95.5%</th>
<th>95.0%</th>
<th>97.2%</th>
<th>82.2%</th>
</tr>
</thead>
</table>

### Stroke: TIA patients assessed and treated within 24 hours (target 60%)

<table>
<thead>
<tr>
<th></th>
<th>82.4%</th>
<th>80.0%</th>
<th>77.3%</th>
<th>77.8%</th>
<th>85.7%</th>
</tr>
</thead>
</table>

### Stroke Summary

Three measures failed to achieve target in November; the Proportion of patients directly admitted to a stroke unit under 4 hours, the Proportion of applicable patients receiving a joint health and social care plan and Percentage of applicable patients who are discharged who were given a named person to contact after discharge

This month’s performance levels are based on 50 discharges in the month. 33 patients were directly transferred within 4 hours. 8 patients were delayed due to their clinical needs and 9 due to the correct pathway not being followed.

The stroke pathway process has been reviewed to improve direct access for CT Angiography and a new assessment area in the Emergency Department for stroke assessment is being identified. The number of direct access beds for hyper acute stroke is being increased across the stroke unit.

Pathways for the stroke service out of the hospital to Mexborough Montagu Hospital and early supported discharge are being reviewed to ensure adequate bed capacity.
Rotherham, Doncaster & South Humber NHS Foundation Trust

Governance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of serious incidents reported</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Contractual Actions</td>
<td>No contractual actions were undertaken during February 2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Experience

Friends and Family Test Mental Health

The percentage of patients who recommended mental health services in RDASH was 92% in December, above the England average. Detailed comments for all FFT areas are shared with DCCG’s Patient Experience Manager and the Trust share learning across their service teams.

Friends and Family Test Community

The percentage of people recommending community services fell during December and remained below the national average. As above these results are shared with DCCG’s Patient Experience Manager and the Trust share learning across their service teams.
## Workforce

<table>
<thead>
<tr>
<th>Time Period</th>
<th>December 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview by exception</td>
<td><strong>Skellbrooke</strong> – One red rating on day shift for qualified staff in January 2017.</td>
</tr>
<tr>
<td></td>
<td><strong>Coral</strong> – One red rating on day shift for qualified staff in January 2017, due to annual leave and long term sickness. Shortfall was made up by non-professionally qualified.</td>
</tr>
<tr>
<td></td>
<td><strong>Hawthorne</strong> - Red ratings for qualified staff in January 2017.</td>
</tr>
<tr>
<td></td>
<td><strong>Jubilee</strong> – One red rating for the month of January 2017 on night shift for non-professionally qualified as a result of last minute sickness.</td>
</tr>
</tbody>
</table>

## Safety

<table>
<thead>
<tr>
<th>Time Period</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Never Events</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>MRSA (cumulative during financial year)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Both were classed as unavoidable to RDASH with no lapses in care identified.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-diff Actual (cumulative during financial year)</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

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.

## Operational Effectiveness

<table>
<thead>
<tr>
<th>Time Period</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</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>46.6%</td>
<td>52.4%</td>
<td>53.7%</td>
<td>58.5%</td>
<td>50.0%</td>
<td>50.6%</td>
<td>54.5%</td>
</tr>
</tbody>
</table>

The December figure for recovery has been revised to 50.6% following validation of the recording system. Assurance has been received that no other figures have been affected.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Access to Psychological</td>
<td>6.8%</td>
<td>8.6%</td>
<td>10.2%</td>
<td>12.0%</td>
<td>13.8%</td>
<td>15.2%</td>
<td>17.0%</td>
</tr>
<tr>
<td><strong>Therapies (IAPT), cumulative – Access</strong> (Target 4.38% per quarter, 17.5% annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
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<td></td>
</tr>
</tbody>
</table>

| **IAPT – Reliable Improvement (no target)** | 66.0% | 69.1% | 73.7% | 72.3% | 72.0% | 68.8% | 73.5% |
|---|---|---|---|---|---|---|

| **Percentage of referrals to IAPT who have received 1st treatment within 6 weeks (target 75%)** | 81.5% | 78.7% | 87.7% | 87.6% | 87.6% | 90.2% | 87.0% |
|---|---|---|---|---|---|---|

| **Percentage of referrals to IAPT who have received 1st treatment within 18 weeks (target 95%)** | 99.3% | 99.5% | 99.4% | 99.3% | 99.1% | 99.6% | 99.7% |
|---|---|---|---|---|---|---|

Both waiting times target definitions have been altered to capture people leaving the service to match national definitions. Figures for these have now been revised.

| **IAPT DNAs** | 12.2% | 13.5% | 12.5% | 11.4% | 11.2% | 11.7% | 11.9% |
|---|---|---|---|---|---|---|

| **Adults receiving a 12 month S117 review compliance (Target 95%)** | 94.2% | 94.1% | 94.9% | 94.6% | 94.2% | 95.1% | 93.0% |
|---|---|---|---|---|---|---|

There are a total of 40 patients currently awaiting a review, a number of which are not actively engaging in mental health services. This measure is being reviewed at the joint meeting between commissioners and providers monthly to ensure that reviews are completed where possibly in a timely manner.

| **The percentage of older people requiring non urgent treatment (mental health) who receive treatment within 6 weeks of assessment (8 week pathway) (Target 85%)** | 82.2% | 82.6% | 72.3% | 85.8% | 77.2% | 86.3% | 86.9% |
|---|---|---|---|---|---|---|

| **The percentage of new patient waits for podiatry within 18 weeks incomplete waits (target 95%)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
|---|---|---|---|---|---|---|

<p>| <strong>The percentage of patients seen within 18 weeks of referral to Evergreen Falls Prevention Service incomplete waits</strong> | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
|---|---|---|---|---|---|---|</p>
<table>
<thead>
<tr>
<th>(target 95%)</th>
<th>95.7%</th>
<th>96.1%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients seen within 18 weeks of referral to Dietician incomplete waits (target 95%)</td>
<td>95.7%</td>
<td>96.1%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of urgent referrals to CAMHS triaged within 24 hours of receipt (target 95%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.2%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of urgent referrals to CAMHS assessed within 24 hours of receipt (target 98%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of non-urgent CAMHS referrals assessed within 4 weeks (target 95%)</td>
<td>66.0%</td>
<td>81.0%</td>
<td>94.1%</td>
<td>86.0%</td>
<td>90.6%</td>
<td>96.1%</td>
<td>90.0%</td>
</tr>
<tr>
<td>(New local measure) Percentage of CAMHS patients classed as an emergency who are assessed within a maximum of 4 hours (target =&gt;98%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of assessed CAMHS patients starting their treatment plan within 8 weeks of referral (target 98% for 2016/17)</td>
<td>97.5%</td>
<td>92.6%</td>
<td>94.7%</td>
<td>85.3%</td>
<td>93.9%</td>
<td>92.3%</td>
<td>94.7%</td>
</tr>
</tbody>
</table>

There were 2 breaches in January both of which were due to capacity issues. The service is currently extending the weekend sessions as required. Staff are being transferred between clinical pathways and the service is exploring the use of appropriate agency staff to provide additional support with the current referral demands.

**CQUINs**

**Quarter 3 - 2016/17**

<table>
<thead>
<tr>
<th>CQUINs</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Holistic Patient Care</td>
<td>During quarter 1 intelligence and information was been gathered on patients on multiple care pathways which included inpatients and patients in transition between services for adults and children.</td>
</tr>
</tbody>
</table>
### Achieved Q3

Using the intelligence two cohorts from multiple care pathways and transition pathways have been established and leads have been identified to take this work forward.

Patient experience measures have been conducted and were tailored to meet the needs of the patients identified in the co-horts. The outcomes of these are being used to drive forward the transformation work.

An options appraisal was undertaken and the agreed way forward is a 4 locality neighbourhood structure coterminous with the Local Authority boundaries, locating community nursing and all age mental health services in these teams.

The Trust moved to the Care Group Structure at the beginning of October 2016. The Doncaster Transformation Group has commenced implementation of agreed changes as follows to provide Holistic Care to all RDASH patients:
- Move to an All Age service.
- Move to a Single Point of Access approach that the majority of services will use across Doncaster.
- Move to Geographical Model with 4 Localities which mirror the Local Authorities and GP Locations.
- Improvements in Information to commence with the implementation of one clinical system across the Trust. The Unity programme has agreed the provider to be on TPP SystmOne which will allow consistency and access across all services.

The transformation programme encompass the following principles
- Holistic Integrated Care
- All Age
- Patient Focused/Needs Led
- Recovery and Wellbeing Focused
- Maintain Care Pathways

Staff education, training and skill mix reviews and development is underway and a skills set audit is due to take place during January 2017.

### 2 End Of Life

**Achieved Q3**

Joint MDT reviews continue to be undertaken on a monthly basis and has a wide membership. The MDT form has been reviewed to capture whether patients have accessed acute and either Dementia, Children’s Community, Mental Health or LD services.

The joint MDT meetings continue to be beneficial on other areas as joint working such as:
- Improving general communication and professional working relationships
- Raising awareness of services between professionals and providers
- Raising awareness of the skill set in each part of the pathway
- Informing the service review process

Action logs continue to be developed, reviewed and moved forward. Themes identified form quarter 1 are as follows:
- Communication
- Documentation
- Systems
- Patient Transfers
- Staff Education
- Medication

### 3 Discharge Pathways

The CQUIN has continued from last year where a Community Nursing form was developed and implemented. The process for information sharing was agreed.
Achieved Q3

between providers and the interface between organisational patient record systems is being discussed as part of the local digital roadmap work stream.

The review of audit/case note review tool continues to be undertaken where themes and trends have been identified and fed through to an action log which is taken forward by the multi-disciplinary team. In quarter one the Older Peoples Mental Health and Learning Disability business divisions have inputted into the group and are currently reviewing the documentation to ensure their patients are fully considered as part of the MDT process.

The Q3 priorities for the discharge group are (evidenced within the action-log):
- Pharmacy input into A&E and CDU - DBHFT Pharmacist attending November 2016
- MDT – Completed in Q3 and Action Log updated
- Discharge Checklist – awaiting update finalisation from DBHFT – Ongoing and update expected in Q4 (February 2017 meeting)
- Establish named responsibilities in Discharge governance and assurance processes (feedback/learning loop) – Completed in Q3 and Action Log updated

The priority for Q4 is to ensure the Discharge Checklist is introduced, assure Pharmacy to A&E and CDU is embedded and clarify with Doncaster CCG with regard to stakeholder feedback (GP/Primary Care) on the discharge process.

The group have continued to update the directory of services (includes referral information) which provides staff with information on where to signpost patients, carers and relevant services. This includes voluntary sectors and is being broadened to include Learning Disability and Older Peoples Services. The dissemination of this to Primary Care is currently on hold whilst the Trust are going through transformation and will be provided at a more appropriate time once staffing and teams have been finalised.

RDASH in conjunction with DBHFT have developed an education plan and training pack which is delivered by the Discharge Planning Team Sister. Staff have attended sessions and work is starting on developing an e-learning package.

The patient and carer’s feedback is being captured as part of a IR1 learning loop. Due to current RDASH transformation and the Intermediate Care Review, which gathers all stakeholder views, a decision has been made not to undertake a discreet CQUIN GP survey gathering views on the discharge process. Instead, the results from the Intermediate Care. The review will be used to inform future service development.

4 Cardiac Rehab

Achieved Q3

This CQUIN is to evaluate the impact of the dedicated Psychological Wellbeing Practitioners on cardiac patient outcomes and establish experience measures. The rationale for inclusion is to determine what the outcomes are for the PWP compared to other service outcomes. The trust has established baseline outcome measures for service users who have had contact with the service. These measures have been able to identify outcomes for the PWP pathway. They are also using experience measures to support the outcomes measure tool for this pathway. Experience measures will be used for other service users who do not meet the threshold for the PWP pathway to understand how psychological support helps with physical recovery/outcomes.

The team have identified that patients with high physical needs to not always have the ability to undertake some of the PWP interventions and the service continues to respond to this and learning how to modify interventions to accommodate physical restrictions. As part of this the Cardiac nurses are trying
to include as much physical limitations the patient has into the referral process so these can be considered at the beginning of the pathway of care. The service is evaluating well from a patients perspective with positive feedback results.

The number of patients screened in Q3 is as follows:

- **October** – 132
- **November** – 140
- **December** – 120

Total = 392

21 Patients were deemed suitable to work with a Psychological Well-being Practitioner, of these, 1 patient declined this offer of support.

The trust have gleaned a lot of learning and report the following:

It is clear that the IAPT therapeutic pathway involves the addressing of patients Physiological issues through the use of exercise and activity, which indicates the need to review the level of mental health service intervention, would best support this cohort of patients. This is further reinforced by the patient feedback around the Cardiac physical health teams approach to physiological support is very positive and suggests that at this lower level of anxiety and depression that the physical health workers are meeting the emotional needs of the patients.

Cardiac patients are generally anxious and/or depressed because of physical health condition and their potential loss of their life style prior to their condition. Any physiological input needs to ensure we are not compounding the patients loss of their ability to carry out their usual activity. The trust will be reviewing how this work can be delivered by further skilling up the Cardiac rehab team.

It has been invaluable learning of the mental health aspect of patients with Long term conditions which can be applied to other conditions and pathways. They are already looking at how IAPT services can link to the Diabetes service, where an exercise based intervention would work perfectly in addressing the life style changes needed to give better diabetic control and improved long term outcomes for patients with diabetes.

Developments in the service are as follows

- Integrated team/ pathway of care for Cardiac Rehabilitation patients. This involves internal tasked handovers to physical and mental health staff and joint group clinics where patient’s holistic needs are assessed and joint care plans established to meet individual patient needs.
- A flowchart to ensure there is a clear pathway to access IAPT and Cardiac Physiotherapy support at an appropriate point in the patient’s Cardiac Rehabilitation journey with view to achieving the best possible patient outcomes.
- Physiotherapy programme offers advice and education around relaxation and stress management but it is important that patients who then needed further psychological support and input from the IAPT team are identified and referred on.
- The Cardiac Rehabilitation Nurses always have initial contact with the patient and therefore screen and identify a need for Physiotherapy and/or IAPT
- Where a patient is identified as needing psychological support before they have completed their physio programme the can be referred early with the IAPT team being aware that they are still mid programme in the physical recovery stage so they can provide ‘nonphysical’ aspects of care.
Wider learning and developments
RDASH is exploring how the lessons learnt from the implementation of the Cardiac CQUIN and the resulting integrated holistic care can be used to inform the development of broader delivery of integrated holistic care. The development event in March 2017 will be delivered to representation from both specialist generalist nurses dealing with LTC.

Pathway development meetings for Diabetes Specialist nursing and Respiratory nursing services with IAPT, are being established to explore how we can develop pathways of care based on the lessons learnt from the Cardiac CQUIN.

5 NATIONAL Health and Wellbeing
Achieved Q3

The trust have provided a plan to promote 3 main initiatives
- Introducing a range of physical activity schemes for staff
- Improving physiotherapy services for staff
- Introducing a range of mental health initiatives for staff.

The CCG provided some feedback on this plan which included the need for set trajectories in year. This feedback is being worked through by a new in post member of staff.

Progress through the action plan is well underway and the trust locally has ‘zoned the food and café at Tickhill Rd Hospital and are including health vending machines for use in and out of hours. Colour coding health and less health food can be easily identified. Price promotions have been removed and foods high in fat sugar and salt have been removed from the checkout area.

The trust provided a national data return to UNIFY which provided information on a number of areas in relation to food provided to patients, staff and visitors this included:
- Franchises
- Suppliers of vendors
- Type of sales outlet
- Supplier contract dates, values and finance information
- Profit share agreements
- Volume of sugar sweetened beverages

Moving forward and in order In order to sustain this element of the CQUIN target, they are already thinking about ways to continue, build upon and develop further ideas to promote healthy eating.
- The catering manager is looking to change the menus in the Food and Drink café, once this is achieved, our nutritionist will provide nutritional and calorific information which will be on display for all our cooked food to allow customers to make informed choices.
- The Change4Life ‘plate swap’ will promote choice of portion size with smaller plates being available.
- A short film will be made to promote the catering department and give key messages to staff across the Trust. This could be placed on You Tube for wider promotion.
- Social media and the Trust intranet will be used to send out key messages.
- The communications department have been involved in developing marketing ideas and will communicate upon progress and develop further ideas.
- We will continue to share information and gather feedback from our staff, patients and visitors. Those visiting the Food and Drink café will be surveyed to gain feedback about the changes and to get further information about what they would like to see in the future.
- There are opportunities to generate discussions around menus for specific groups of patients.
The trust have worked hard on their flu vaccination programme and have exceeded the target set Nationally.

<table>
<thead>
<tr>
<th></th>
<th>Total Frontline Staff Vaccinated</th>
<th>To Frontline Staff (- Exclusions)</th>
<th>% Compliance</th>
<th>Staff declared No to wanting the flu jab due to choice</th>
<th>% compliance (excluding staff who declared 'no')</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doncaster CCG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doncaster Care Group</td>
<td>1003</td>
<td>1610</td>
<td>62%</td>
<td>344</td>
<td>79%</td>
</tr>
<tr>
<td>Children’s Care Group (Donc Staff)</td>
<td>214</td>
<td>368</td>
<td>58%</td>
<td>43</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Total Doncaster CCG</strong></td>
<td>1217</td>
<td>1978</td>
<td>62%</td>
<td>387</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Total RDaSH Trust</strong></td>
<td>1835</td>
<td>2989</td>
<td>61%</td>
<td>622</td>
<td>78%</td>
</tr>
</tbody>
</table>

6 NATIONAL Improving Physical Healthcare

Achieved Q3

This continues from previous years and has been expanded to include Community Mental Health Teams for the first time.

A trust wide physical health implementation and action plan has been updated for Inpatient wards and Early Intervention Psychosis Services and patients on a Care Programme Approach (Community Mental Health Services) to ensure all elements of the indicator and training needs of staff are met. This action plan continues to be progressed and monitored against the timelines.

The revised National audit guidance and audit proforma have has been provided which has revised the inclusion criteria, data sampling and collection process. Data will be collected and submitted across January and February 2017 with publication Nationally in May 2017.

Physical health clinics became operational in December 2016 and operate on a daily basis and screen 8 patients per day to undertake cardio metabolic/physical health screening and appropriate tests.

The communication with GP was undertaken during Q2 observations from this are as follows:

- The 90% target has been achieved for each of the criterion.
- 3 criterion achieved 100%, which is classed as OUTSTANDING.
- 1 criterion achieved 90%, which is classed as GOOD.
- Work will be undertaken with Adult Inpatient Wards and the Early Interventions team to increase performance of letters being sent within 4 weeks of discharge / review.
- All patients received a letter; however, 3 fell outside the 4 week timescale we set for the audit criteria as being ’up to date.
# SECTION 2: OTHER COMMISSIONED SERVICES

## 2.1 FCMS

**Urgent Care Centre**

<table>
<thead>
<tr>
<th></th>
<th>May 16</th>
<th>June 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCMS – Urgent Care Centre (UCC) Performance against 4 hour A&amp;E target</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Out of Hours**

<table>
<thead>
<tr>
<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>Telephone clinical assessment - &lt;20 min (target 95%)</td>
<td>98.87%</td>
<td>98.32%</td>
<td>97.34%</td>
<td>99.00%</td>
<td>98.27%</td>
<td>98.59%</td>
<td>98.04%</td>
<td>97.05%</td>
<td>96.67%</td>
</tr>
<tr>
<td>Telephone clinical assessment - &lt;60 min (target 95%)</td>
<td>97.10%</td>
<td>96.50%</td>
<td>89.40%</td>
<td>98.83%</td>
<td>99.25%</td>
<td>98.49%</td>
<td>94.29%</td>
<td>94.64%</td>
<td>92.71%</td>
</tr>
</tbody>
</table>

**Surgery**

<table>
<thead>
<tr>
<th></th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face assessment (base) – triaged as emergency in &lt;1 hour (target 95%)</td>
<td>100.0% (5/5)</td>
<td>100.0% (5/5)</td>
<td>81.82% (9/11)</td>
<td>75.00% (6/8)</td>
<td>28.57% (2/7)</td>
<td>75.00% (3/4)</td>
<td>100% (2/2)</td>
<td>84.62% (11/13)</td>
<td>82.35% (14/17)</td>
</tr>
<tr>
<td>Face to face assessment (base) – triaged as urgent in &lt;2 hours (target 95%)</td>
<td>85.71% (168/196)</td>
<td>89.03% (138/155)</td>
<td>71.50% (143/200)</td>
<td>90.27% (167/185)</td>
<td>86.76% (118/136)</td>
<td>89.69% (173/194)</td>
<td>80.33% (196/244)</td>
<td>81.76% (241/296)</td>
<td>88.86% (311/350)</td>
</tr>
<tr>
<td>Face to face assessment (base) – triaged as urgent in &lt;6 hours (target 95%)</td>
<td>97.71%</td>
<td>97.72%</td>
<td>97.35%</td>
<td>98.16%</td>
<td>97.88%</td>
<td>98.10%</td>
<td>98.32%</td>
<td>98.01%</td>
<td>98.56%</td>
</tr>
</tbody>
</table>
Face to face assessment within 1 hour:

Of the 3 cases not seen within time: 1 was seen within timeframe however was reported incorrectly, with the remaining breaches due to the appointment times being scheduled over the target time.

Face to face assessment urgent 2 hour cases:

Thirty nine cases were not seen within time, details of these below;

- Two cases were seen within time but each case was locked by the clinician and the time the clinician returns to the case is used rather than the time the cases are locked.
- Seven cases were due to the patient arriving late for the appointment.
- One patient was advised to go to A&E but refused the advice and insisted to be seen at UCC and one patient left without being seen but the case was not finished correctly to reflect this.
- In 11 cases the patient caused the delay.
- 18 cases could have been delayed due to patient choice (as the appointment was booked outside of the 2 hour criteria) but the service is not able to confirm at present.

<table>
<thead>
<tr>
<th>Visits</th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face assessment (visit) – triaged as emergency in &lt;1 hour (target 95%)</td>
<td>100.0% (2/2)</td>
<td>50.0% (2/4)</td>
<td>60.0% (3/5)</td>
<td>83.3% (5/6)</td>
<td>100% (3/3)</td>
<td>60.0% (3/5)</td>
<td>100% (2/2)</td>
<td>83.33% (5/6)</td>
<td>36.36% (4/11)</td>
</tr>
<tr>
<td>Face to face assessment (visit) – triaged as urgent in &lt;2 hours (target 95%)</td>
<td>78.5% (51/65)</td>
<td>72.0% (36/50)</td>
<td>89.2% (56/65)</td>
<td>92.7% (38/41)</td>
<td>75.8% (47/62)</td>
<td>81.4% (48/59)</td>
<td>87.5% (35/40)</td>
<td>69.49% (41/59)</td>
<td>85.33% (64/75)</td>
</tr>
<tr>
<td>Face to face assessment (visit) – triaged as urgent in &lt;6 hours (target 95%)</td>
<td>98.9%</td>
<td>96.6%</td>
<td>96.3%</td>
<td>98.7%</td>
<td>99.0%</td>
<td>98.8%</td>
<td>99.4%</td>
<td>92.75% (243/262)</td>
<td>97.12%</td>
</tr>
</tbody>
</table>
Face to face 1 hour visit:

Seven cases were seen outside timeframe, between 1 hour 4 seconds & 1 hour 41 minutes.

Face to face 2 hour visit:

11 cases were not seen within timeframe. The longest wait was 3 hours 59 minutes.

Initial analysis suggests that some of the delays could be due to capacity and demand. Measures are being taken to assist with clarification of the visit consultation start and end times. FCMS are introducing a log sheet for the drivers to manually complete and capture the times of arrival and departure for each visit. These sheets will be checked against the timings entered on the system to identify any inaccuracies.

From a non-clinical review it appears that no harm came to any of the patients as a result of the delays.

Same Day Health Centre

<table>
<thead>
<tr>
<th></th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face appointment – triaged as emergency seen in &lt;1 hour (target 95%)</td>
<td>39.39% (13/33)</td>
<td>32.00% (8/25)</td>
<td>66.67% (20/30)</td>
<td>58.33% (14/24)</td>
<td>50.00% (12/24)</td>
<td>66.67% (10/15)</td>
<td>56.00% (14/25)</td>
<td>81.25% (13/16)</td>
<td>85.00% (17/20)</td>
</tr>
<tr>
<td>Face to face appointment – triaged as emergency seen in &lt;2 hours (target 95%)</td>
<td>68.54% (122/178)</td>
<td>74.09% (143/193)</td>
<td>72.56% (119/164)</td>
<td>69.87% (109/156)</td>
<td>71.19% (126/177)</td>
<td>85.63% (143/168)</td>
<td>79.47% (151/190)</td>
<td>82.32% (163/198)</td>
<td>85.20% (167/196)</td>
</tr>
<tr>
<td>Face to face appointment – triaged as emergency seen in &lt;24 hours (target 95%)</td>
<td>99.57%</td>
<td>99.21%</td>
<td>99.69%</td>
<td>99.62%</td>
<td>99.66%</td>
<td>99.40%</td>
<td>100%</td>
<td>99.75%</td>
<td>99.68%</td>
</tr>
</tbody>
</table>
Face to face 1 hour:

From the 3 breaches one has been attributed to patient choice, with the other breaches unclear as to whether this was due to patient choice or the first available appointment.

Face to face seen within 2 hours:

- 29 cases were not seen within time, details of these below;
- Six cases had appointments made in excess of 3 hours therefore appears to be due to patient choice of appointment time.
- 11 cases had appointments made between 2 hours 20 minutes & 2 hours 52 minutes and may also be due to patient choice of appointment time but cannot be confirmed.
- 7 cases had appointments made between 2 hour 1 min and 2 hours 13 minutes and this is likely to be due to the first available appointments.

From a non-clinical perspective it appears that no harm came to any of the patients as a result of the delays

2.2. Yorkshire Ambulance Service (YAS)

Performance during Ambulance Response Programme Pilot

<table>
<thead>
<tr>
<th>Category</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October 1&lt;sup&gt;st&lt;/sup&gt; to 19th</th>
<th>YTD at Sept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red &lt; 8 min</td>
<td>62.5%</td>
<td>63.2%</td>
<td>66.8%</td>
<td>65.4%</td>
<td>68.3%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Amber R &lt; 19 min</td>
<td>89.4%</td>
<td>58.8%</td>
<td>83.4%</td>
<td>76.8%</td>
<td>74.3%</td>
<td>78.6%</td>
</tr>
<tr>
<td>Amber T &lt; 19 min</td>
<td>66.7%</td>
<td>53.4%</td>
<td>73.6%</td>
<td>63.5%</td>
<td>63.6%</td>
<td>67.2%</td>
</tr>
<tr>
<td>Amber F &lt; 19 min</td>
<td>62.5%</td>
<td>55.7%</td>
<td>74.1%</td>
<td>69.6%</td>
<td>67.4%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Green F &lt;60 min</td>
<td>100%</td>
<td>76.0%</td>
<td>82.5%</td>
<td>90.8%</td>
<td>96.1%</td>
<td>77.1%</td>
</tr>
<tr>
<td>Green T &lt;60 min</td>
<td>78.9%</td>
<td>68.1%</td>
<td>74.9%</td>
<td>73.4%</td>
<td>67.4%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Green H &lt;60 min</td>
<td>100%</td>
<td>97.5%</td>
<td>99.2%</td>
<td>100%</td>
<td>100%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

Please note that performance standards for the new categories have not yet been confirmed.

YAS is continuing to participate in NHS England’s Ambulance Response Programme (ARP) pilot. The next stage, Phase 2.2, has been developed by listening to feedback from ambulance staff, GPs, healthcare professionals (HCPs) and patients and was implemented from 20 October 2016.

This revised process will give four main options for ambulance responses:
- Cardiac arrest or peri-arrest (Purple response standard - within 8 minutes)
- Life-threatening emergency (Amber response standard - within 19 minutes)
- Serious but not life-threatening emergency (Yellow response standard - within 40 minutes)
- Non-emergency (Green response standard - 1 to 4 hours)

<table>
<thead>
<tr>
<th>Category</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 &lt; 8min</td>
<td>59.3%</td>
<td>58.4%</td>
<td>59.5%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Category 2T &lt; 19 min</td>
<td>72.9%</td>
<td>67.4%</td>
<td>66.7%</td>
<td>70.7%</td>
</tr>
<tr>
<td>Category 2R &lt; 19 min</td>
<td>78.9%</td>
<td>81.4%</td>
<td>83.3%</td>
<td>82.1%</td>
</tr>
<tr>
<td>Category 3T &lt; 40 min</td>
<td>69.4%</td>
<td>64.5%</td>
<td>63.8%</td>
<td>65.5%</td>
</tr>
<tr>
<td>Category 3R &lt; 40 min</td>
<td>79.2%</td>
<td>64.9%</td>
<td>74.9%</td>
<td>77.1%</td>
</tr>
<tr>
<td>Category 4 &lt; 90 min</td>
<td>76.4%</td>
<td>64.8%</td>
<td>72.8%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Category 4H (triage) &lt; 90 min</td>
<td>96.6%</td>
<td>94.6%</td>
<td>98.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 2.3 Nursing / Care Homes / Domiciliary Care Providers

The information provided within this section is taken up to 28th February 2017. Since the last Governing body meeting there has been 0 new embargo’s against admissions / new care packages placed.

At present there is 1 provider within Doncaster with an embargo in place and 1 provider with a restriction in place.

### 2.4 Serious Case Reviews / Lesson Learnt Reviews

There have been no new Serious Case Reviews / Lessons Learnt Reviews commissioned during February 2017.

### 2.5 Domestic Homicide Reviews

There was a Domestic Homicide Review commissioned during November 2016. The initial meeting for this review has been held and an independent chair has been commissioned. The next meeting is due to take place at the end of March 2017. The GP records for this review have now been obtained from Capita.
SECTION 3: NHS Constitution measures

The following section shows Doncaster CCG performance against the NHS Constitution standards and benchmarks against the England average and also the CCG's RightCare Peer Group where possible. These are the 10 CCGs most demographically similar to Doncaster.

They are:
Hartlepool and Stockton-on-Tees CCG
Barnsley CCG
Durham Dales, Easington and Sedgefield CCG
Wigan Borough CCG
Rotherham CCG
Wakefield CCG
Mansfield and Ashfield CCG
North East Lincolnshire CCG
Darlington CCG
Tameside and Glossop CCG
Referral to Treatment

Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Dec-15</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster CCG</td>
<td>92.27%</td>
<td>92.76%</td>
<td>92.74%</td>
<td>92.62%</td>
<td>93.59%</td>
<td>93.68%</td>
<td>93.21%</td>
<td>93.01%</td>
<td>92.41%</td>
<td>92.20%</td>
<td>91.87%</td>
<td>91.45%</td>
<td>90.43%</td>
</tr>
<tr>
<td>Rightcare Peer Group</td>
<td>92.19%</td>
<td>92.49%</td>
<td>92.55%</td>
<td>92.27%</td>
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![Patients on incomplete non-emergency pathways who have been waiting no more than 18 weeks](chart.png)
### Diagnostic Waiting Times

**Patients waiting less than 6 weeks for a diagnostic test**

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### Graph

**Patients waiting less than 6 weeks for a diagnostic test**

- **Doncaster CCG**
- **Rightcare Peer Group**
- **England**
- **Standard**

*Graph shows trends from Dec-15 to Dec-16 with percentages ranging from 95% to 100%.*
### A&E

#### A&E attendances under 4 hours from arrival to admission, transfer or discharge

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#### A&E attendances under 4 hours from arrival to admission, transfer or discharge

![Graph showing A&E attendances over time](graph.png)
Cancer Waiting Times

2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP

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Target: 93%
2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)

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![Graph](https://via.placeholder.com/150)
31-day wait from diagnosis to first definitive treatment for all cancers

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![Graph showing the 31-day wait from diagnosis to first definitive treatment for all cancers for Doncaster CCG, Rightcare Peer Group, England, and Target.](image-url)
### 31 day wait for subsequent treatment where that treatment is surgery

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![Graph showing the 31 day wait for subsequent treatment where that treatment is surgery for Doncaster CCG, Rightcare Peer Group, England, and Target from Dec-15 to Dec-16.]
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31 day wait for subsequent treatment where that treatment is drug regimen

![Graph showing the percentage of patients who had a 31-day wait for subsequent treatment, categorized by different providers and compared against targets.](image_url)
### 31 day wait for subsequent treatment where that treatment is radiotherapy

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![Graph showing 31 day wait for subsequent treatment where that treatment is radiotherapy]
62-day wait from urgent GP referral to first definitive treatment for cancer

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![Graph showing 62-day wait from urgent GP referral to first definitive treatment for cancer]
62-day wait from referral from an NHS screening service to first definitive treatment for all cancers

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### 62-day wait from referral from consultant upgrade to first definitive treatment for all cancers

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#### Chart:

- **Doncaster CCG**: Blue line
- **Rightcare Peer Group**: Red line
- **England**: Green line

**Graph Note**: The chart illustrates the percentage of patients who received their first definitive treatment within 62 days from referral to consultant, from December 2015 to December 2016. The data shows variations across different groups and time periods.
Mixed Sex Accommodation

Breaches of Mixed Sex Accommodation

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Mental Health Targets

People under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period

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People waiting 6 weeks or less from referral to entering a course of IAPT treatment (Completed)

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People under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period

![Graph showing percentage of people followed up within 7 days of discharge from psychiatric inpatient care during different periods for Doncaster CCG, England, and Target.](image-url)
Although nationally published data shows underperformance within the timeframes of access to the IAPT service, locally performance has been shown to be meeting targets. Work is underway to fully understand this difference and to ensure that patients are being seen within the target time.

### People waiting 18 weeks or less from referral to entering a course of IAPT treatment (Completed)

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### IAPT Recovery Rate

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**People waiting 18 weeks or less from referral to entering a course of IAPT treatment - Completed**

- **Commissioner**: Doncaster CCG, England, Target
- **Target**: 50%

---

- **Doncaster CCG**:
  - Nov-15: 47.41%
  - Dec-15: 48.15%
  - Jan-16: 48.91%
  - Feb-16: 49.30%
  - Mar-16: 46.58%
  - Apr-16: 45.45%
  - May-16: 44.83%
  - Jun-16: 44.74%
  - Jul-16: 41.99%
  - Aug-16: 42.16%
  - Sep-16: 43.92%
  - Oct-16: 56.00%
  - Nov-16: 47%

- **England**:
  - Nov-15: 45.59%
  - Dec-15: 46.32%
  - Jan-16: 47.95%
  - Feb-16: 47.70%
  - Mar-16: 48.19%
  - Apr-16: 48.53%
  - May-16: 48.59%
  - Jun-16: 48.89%
  - Jul-16: 48.72%
  - Aug-16: 48.55%
  - Sep-16: 48.44%
  - Oct-16: 49.00%
  - Nov-16: 48.90%

- **Target**: 50%
IAPT Recovery Rate

IAPT Reliable Recovery Rate

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Patients starting treatment for Early Intervention in Psychosis within 2 weeks of referral

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Healthcare Acquired Infections

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Doncaster CCG responsible cases of MRSA

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Doncaster CCG responsible cases of Clostridium Difficile (C-Diff)

- Target
- Actual
SECTION 4: NHS Doncaster CCG Local Delivery Plans- Items to note

There were no items of escalation this month.

SECTION 5: Health Overview Paper Corporate Parenting Board February 2017

1. CONTEXT

This paper has been prepared by the Designated Nurse and Designated Doctor for Looked After Children (LAC) with the appropriate contribution from the LAC Health Commissioner and the LAC Teams in provider services. It intends to provide the Corporate Parenting Board with current performance information, challenges across the system and the strategic planning in place to achieve a robust service for our children.

2. INTRODUCTION

As commissioners of high quality, safe healthcare, Doncaster Clinical Commissioning Group (DCCG) has responsibility for ensuring the timely and effective delivery of health services to Looked After Children and Young People; this is through effective commissioning arrangements and partnership working. Under the Children Act 2004 health provider organisations have a duty to comply with requests from Local Authorities (for Doncaster this is with Doncaster Children’s Services Trust, DCST) to help them to provide support and services to children in need.

Promoting the Health and Well-being of Looked After Children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England (2015) identifies a statutory requirement to have a Designated Doctor and Nurse to take a strategic, professional lead on all aspects of the health service contribution for Children who are Looked After, which includes all providers. Designated Professionals are a vital source of professional advice to the CCG, health professionals, and work closely with the Specialist Nurse for LAC and the LAC Health Team, Local Authority Children’s Services, the Doncaster Safeguarding Children Board and Corporate Parenting Board.

Doncaster CCG has all the necessary Designate Professional roles in place with the capacity to deliver the required function. In addition to the Designated Roles, the CCG has a children’s commissioner who all work closely with NHS England and South Yorkshire and Bassetlaw colleagues to progress the service regionally.

NHS England North supported the development of a benchmarking tool to assess and Peer Review the level of compliance of CCGs with the statutory guidance relating to commissioning services for children in care. The aim of the tool was to support the relevant CCG Designated Professionals for LAC to:

- Benchmark CCGs regarding levels of compliance with commissioning requirements for LAC
- Understand further the role; position and challenges of Designated Professionals for LAC
• Doncaster CCG complied with this review and identified 2 standards that required further work and an action plan is in place to progress this, these were particularly in relation to health needs analysis and themes and trends for the JSNA and informing commissioning intentions.

3. HEALTH COMMISSIONING RESPONSIBILITIES

It is essential that meeting LAC health needs is at forefront of commissioning decisions. The CCG has recognised and prioritised children who are in care, as part of the priority Delivery Plans and have developed success indicators to support commissioning intentions and planning arrangements with the aim of improving services and ensuring all LAC get timely, good quality assessments by competent professionals.

The models of commissioning services to meet these responsibilities have recently been revised due to a lack of medical capacity to undertake the initial health assessment and are as follows:

3.1 Initial Health Assessments (IHA’s)

Over the last 2 years a mixed model of DBHFT (children aged 0-5ys) and GPs (children aged 5-18yrs) have been completing the IHA, due to changes in staffing and vacancies this model has resulted in a decline of IHA completed in 20 working days.

The CCG is in the final stages of a procurement process for a new service to provide Initial Health Assessments for all LAC. At the time of writing this paper the new service is due to commence January 1st 2017. To enhance this service the LAC Nursing Team from RDASH will be offering a holistic assessment to all children over the age of 11 to capture the voice of the child and provide the opportunity to explore sexual health, risk taking behaviours. This model should provide us with a robust service going forward.

3.2 Review Health Assessments

The LAC Specialist Health Team provides these services in partnership with Health Visitors and School Nurses. There are service specifications for both elements with clear quality and performance frameworks. Data is routinely captured via the RDaSH Performance Dashboard.

4. THE HEALTH LAC TEAM

4.1 Designated Professionals

Designated Doctor, Consultant Community Paediatrician based at DBHFT
Designated Nurse, Deputy Chief Nurse for Doncaster CCG.

The Designated Doctor and Nurse take a strategic and professional lead to assist Doncaster CCG in fulfilling its responsibilities as a commissioning organisation, to
improve the health of Looked After Children. They support the Trust in its clinical governance role and work collaboratively with partner agencies to improve outcomes for children in care. They provide advice and support to health staff and promote good professional practice.

4.2 Named Doctor Role

Since the implementation of the statutory guidance in 2009 there has been no Named Doctor. This role has been undertaken through a GP Local Enhanced Service. The administration and coordination of the initial health assessment is provided by the LAC Team within RDaSH. This will change with the new service and a Named Doctor will be identified.

4.3 Specialist LAC Health Team

The concept of a Specialist LAC Health Team was initially established in 2011 following an inspection by CQC deeming health as inadequate for LAC. The team now consists of a Named Nurse, 1.6 WTE school nurses, 1 WTE HV, 1.8 WTE specialist LAC nurses, a part time nurse practitioner and administrative support.

4.4 Formation of a Dedicated 0-19 Lac Team

RDaSH are undertaking a transformation in the form of restructuring services. In line with this the LAC Health Team have formed a dedicated 0-19 service. This has involved two school nurses and two health visitors joining our already established team. This will enable the team to have a clear focus on improving the quality and continuity of health services delivered to Looked After Children / Young People (LACYP) and their families; reducing problems previously encountered at transition points.

Performance Indicators are currently collated monthly in detail by RDaSH from the datasets that have been established furthermore; the Local Authority publishes information booklets and has bi monthly meetings involving provider services to scrutinise the datasets. This provides data for the Children’s Annual Performance Assessment as required by Central Government. This activity based reporting identified the number of Initial Health Care Assessments, timescales for completion, dental checks, immunisations and reviews completed for children who have been in care.

The Looked After Children Health Team works closely with universal services for children and families which are commissioned by Public Health within the Local Authority. Each area has a Looked After Children Champion to raise the profile and the needs of Looked After Children within locality areas. The Named Nurse for Looked After Children and team provide regular training to remind health professionals of their professional responsibilities in relation to review assessment and on-going care of LAC in line with the Looked After Children: Knowledge, Skills and Competences Framework (March 2015).
5. **EMOTIONAL WELLBEING AND CAMHS**

Following the CQC inspection in September 2014 one of the actions was to ensure that the Strengths and Difficulties Questionnaire (SDQ) was available to inform Review Health Assessments. There is now a system in place to enable the exportation of SDQ’s from Doncaster Children’s Trust records to health records prior to Review Health Assessments. If there is no SDQ available in social care records the health practitioner undertaking the health assessment will indicate this as an action for the social worker in the health assessment action plan. This in now reported through the DSCT data set.

DSCT have employed a Social Worker that is seconded into CAMHs to help embed the system.

6. **ACCESSING PRIMARY AND COMMUNITY CARE**

There is a requirement for Looked After Children to be registered with a GP Practice. This is normally the foster carer’s practice however; with moves of placement it is inevitable that the GP will change from time to time. The whole concept of having a key health practitioner as the Specialist Nurse avoids young people having to repeat their story many times and for one person / department to hold the health information for the individual. This is facilitated by SystmOne, the electronic care record which can be accessed with permission by primary and secondary care. Health Care Plans are always shared with the GP and updated when required.

Looked After Children aged 0-5 will have an allocated Health Visitor from the LAC Team who will follow the child anywhere across the borough to develop a therapeutic relationship with the child and their carer and maintain continuity of care.

Children and Young People from 5-18 have a School Nurse / Looked After Children Nurse allocated and will follow the child anywhere across the Borough to encourage the development of a therapeutic relationship and maintain continuity of care.

7. **DENTAL CARE**

There is a requirement for Looked After Children to be registered with a Dentist. It is the responsibility or the carer, supported by the Social Worker to ensure the child is registered and attends for regular dental checks. This is reviewed by the specialist nursing team at each health assessment and identified as an action in the health plan if outstanding. The health plan is overseen and reviewed by the Independent Reviewing Officer to ensure identified health needs are addressed. There is capacity in Doncaster for all children have access to a registered dentist.

8. **LEAVING CARE HEALTH SERVICE**

The Specialist Looked After Children Team now provide support to children up to the age of 19 years and beyond where necessary, supporting transition into adulthood and promoting independence in accessing health care. This bespoke care leaver health service was established following a recommendation made from the Ofsted /
CQC Inspection in July 2011. The team have developed excellent links with DCST18+ team providing advice and support for care leavers and staff where required.

9. HEALTH ASSESSMENT ACTIVITY FOR CHILDREN WHO ARE GOING THROUGH ADOPTION

Paediatricians at Doncaster Royal Infirmary receive requests from Doncaster Local Authority Adoption Team to complete pre-adoption medical assessments on children who are going through the process of adoption. This service is functioning well, with the appropriate capacity being commissioned to meet timescales for panel. The service has been enhanced with increased capacity to provide an opportunity to prospective adopters to meet with the consultant to discuss any health concerns regarding a child they may have.

10. ENGAGEMENT WITH LOOKED AFTER CHILDREN AND YOUNG PEOPLE

One of RDASH LAC Team’s priorities for development over the past year has been the on-going development of the Leaving Care Health Summary. Through consultation with Looked After Children, Young People and Care Leavers this has now been updated and revised in a format that is more user friendly and informative.

The RDASH LAC Health Team undertakes on-going consultation with children and young people in care to ask them how best to obtain their feedback on the services provided.

Looked After Children were involved in the design of their own unique Your Opinion Counts feedback questionnaire which is issued to them following their Review Health Assessment. This enables us to gauge how useful children and young people found talking to a nurse about their health.

The responses were measured among children aged 11+ using a sliding scale 0 -10, 10 being high.

“How useful do you feel it is to be able to discuss your health?”
The average response to this question was 7.8

How likely are you to contact the nurse if you want to discuss something at a later date?
The average response to this question was 6.5

Some of the comments received from Looked After Children on the feedback form include:
The questionnaire response rate during 2015/16 is provided below:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Completed Questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1, March - May 2015</td>
<td>41%</td>
</tr>
<tr>
<td>Quarter 2, June – August 2015</td>
<td>64%</td>
</tr>
<tr>
<td>Quarter 3, September – November 2015</td>
<td>60%</td>
</tr>
<tr>
<td>Quarter 4, December – February 2016</td>
<td>58%</td>
</tr>
<tr>
<td>Total for the year</td>
<td>56%</td>
</tr>
</tbody>
</table>

Through 2016 the LAC Health Team continue to canvass feedback from our services users to provide improved targeted service provision. Following review health assessments we have asked Looked After Children, Young People and their carers for their feedback on the care provided.

We asked for thoughts about their Looked After Children’s Health Assessments, these are the comments we received:

- ‘She helped me and it was in the right place, she made me laugh’
- ‘It was alright and I’m glad I’m bigger’
- ‘It was ok you can come again’
- ‘It was very useful information and helped me understand my Health’
- ‘I thought it was great and I have grown much taller’
- ‘Lovely the nurse was easy to talk to’
- ‘I’m glad the nurse came to see me today she helped me with my worries’

We asked foster carers for their thoughts about their Looked after Children’s Health assessments. These are the comments we received:
## 11. PERFORMANCE

### Initial Health Assessment April – October 2016

<table>
<thead>
<tr>
<th>IHA Required</th>
<th>Number of notifications received from DCST within 5 working days</th>
<th>IHA’s completed within 20 working days</th>
<th>IHA’s completed out of the 20 working day</th>
<th>IHA still to be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children placed in Authority</td>
<td>87</td>
<td>17 (32%) 5-18 only</td>
<td>21 (24%)</td>
<td>33 (38%)</td>
</tr>
<tr>
<td>IHA Required</td>
<td>Number of notifications received from DCST within 5 working days</td>
<td>IHA’s completed within 20 working days</td>
<td>IHA’s completed out of the 20 working day</td>
<td>IHA still to be completed</td>
</tr>
<tr>
<td>Children placed OOA</td>
<td>17</td>
<td>8 (47%)</td>
<td>4 (24%)</td>
<td>7 (41%)</td>
</tr>
</tbody>
</table>

**Narrative:** On receipt of the request / consent from DCST, the IHA is requested from the Host Authority where the child is placed. RDASH LAC team have a recall system in place to follow up IHA’s requested from other authorities, however we have no influence on how soon they are completed.
**Review Health Assessment April – October 2016**

<table>
<thead>
<tr>
<th></th>
<th>IHA Required</th>
<th>Number completed in timescale</th>
<th>Number completed out of timescale</th>
<th>Number not completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children placed In Authority</td>
<td>139 At 15.11.16</td>
<td>129 (93%)</td>
<td>9 (6%) 7 of these were exception reported due to DNA / patient choice</td>
<td>1 (1%) refusal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>IHA Required</th>
<th>Number of requests received from DCST 8 weeks prior to RHA due date</th>
<th>Number completed in timescale</th>
<th>Number completed out of timescale</th>
<th>Number not completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children placed out of Authority</td>
<td>94</td>
<td>19 (20%)</td>
<td>24 (26%)</td>
<td>37 (39%)</td>
<td>33 (35%)</td>
</tr>
</tbody>
</table>

**Narrative:** It is a statutory requirement that LAC aged 0-5 have a RHA every 6 months and LAC aged 5-18 have an RHA every 12 months, to review their health and development and formulate a health action plan to address any identified health needs.

For LAC placed out of authority a formal request is required from DCST 8 weeks prior to the review date, in order to ensure that statutory timescales are met and Looked After Children’s health needs are reviewed in a timely manner.

RDASH LAC team are working closely with DCST to try to improve the timeliness of RHA requests. Reminders are issued to DCST administrators prior to the agreed 8 week deadline for all children placed out of area requiring RHA’s. Meetings are on-going between RDASH and DCST to improve DCST administrative processes. RDASH LAC team have a recall system in place to follow up RHA’s requested from other authorities, however we have no influence on how soon they are completed.

12. **OUT OF AREA PLACED CHILDREN**

Local Authorities have a duty to place children near to their home, unless not reasonably practicable or consistent with child’s welfare. If the Local Authority places the child out of area the Health Commissioner should ensure appropriate health services can be secured. Latest data from DCST suggests that one third of children are still placed out of area. This potentially has an impact on the performance of achieving IHA and RHA completion timescales since they will be completed by out of area professionals, this creates challenges for Doncaster health commissioners to influence as there is no responsibility for out of area health services.
13. **AUDITS**

13.1 **Quality Review of Initial Health Assessments by Designated Doctor 2016**

This was a review of 40 reports from September 2015 to October 2016. It considered key quality standards to be included in an assessment. Findings established:

- Overall the vast majority of the reports included the important criteria.
- There are different formats for different reports.
- Having a table for recommendations makes them clearer and prompts a timescale and person responsible.
- Aspects we are used to in a “normal” history such as physical health, immunisations, past medical history and family history were all done well.
- The deficiencies are in the “extra” areas such as hearing, vision, emotional/mental health.
- Noted from the audit, there is a difference in the quality of reports from different practitioners.

An action has been developed in response to the audit findings.

13.2 **Strengths and Difficulties Questionnaire audit (SDQ)**

The CQC inspection in 2014 found that there was no evidence that SDQ’s were being used to inform review health assessments. Following this the LAC Health Team were given access to DCST recording systems to directly export the SDQ if available to health records prior to the Review Health Assessments taking place. A dip sample audit of 50 records in June 2015 indicated that 62% of review health assessments contained evidence of the SDQ and when the dip sample was repeated in October 2016 this had increased to 80%.

14. **ACHIEVEMENTS**

14.1 **Joint Initial Health Assessment Pilot**

The Specialist LAC team identified a gap in quality service provision for LAC aged 11 years and above on entry into care. It was evident within the GP led IHA’s that when discussion on risk taking behaviours was offered it was rarely taken up. This was seen as a missed opportunity to provide early assessment, support and referral around their holistic health needs including emotional health and wellbeing, sexual health, sexual exploitation and substance misuse. The Specialist LAC team piloted a nurse led home visit prior to their GP appointment to contribute to a holistic, young person centred assessment. Following successful evaluation of the pilot this joint model will now be implemented from January 2017, this will greatly improve the quality of service that we offer and young people on entry into care.

14.2 **Looked after Children’s Youth Club**

The Specialist LAC Team provide health promotional information and advice on a monthly basis at the Looked after Children’s Clubs which run in Bentley and Stainforth. A health topic is chosen each month in consultation with LACYP in order to promote and encourage healthy lifestyles for LACYP and their carers. This also
enables Looked after Children and their carers to have access to LAC Nurses in a more informal setting, promoting positive relationships and improving access to the LAC Nursing team.

A recent session was provided on healthy teeth which evidence indicates is a particular health inequality for LACYP. Here are some of the comments we received from Looked after Children:

Foster carers were interested in particular re teenagers consuming fizzy sugar and energy drinks and were surprised about the levels of caffeine and the level of tooth decay they can cause. Here is some feedback from the Doncaster Foster Carer Association secretary:

14.3 Mockingbird Family Model

The Named Nurse for Looked After Children has been involved with the implementation of the Mockingbird Family Model. This is an alternative method of delivering Foster care with the potential to improve placement stability and permanency for children and young people in care, and to improve the support for and retention of Foster Carers. The model is based on the idea of an extended family. Two ‘Hub’ foster cares have been specifically recruited and trained to offer
respite care, peer support, regular joint planning and social activities. It uses the concept of 'constellations' with 10 'spoke' fostering families being linked to each hub foster carer. Like an extended family, the hub empowers families to support each other, overcome problems before they escalate and offer children a more positive experience of care. The Named Nurse for LAC provides health advice and support to the two Hub foster carers and their constellations to promote and improve health outcomes for Looked after Children.

'I just wanted to say a big thank you for all your help at our support meetings. We had many lovely comments about the support you can give and our carers found this really useful' Janice Jinks Hub Foster Carer.

14.4 Foster Carer Training – “Let’s talk about sex”

The LAC health team continues to facilitate and deliver sex and relationships education (SRE) training for Foster Carers in Doncaster. This enables Foster Carers to fully understand the importance of their role in supporting Looked After Children in relation to SRE. This increases carer confidence in talking to young people about sensitive issues preventing them from escalating and improving Foster Carers awareness of services provision.

We asked foster carers:

Has the training made a difference to how you will support foster children in the future, and these were their responses?

“I have a greater awareness and understanding of the issues”

“You will be more open and honest with my foster children about sex and relationships in the future. I have learnt how easy it is for children to be exploited”

“Being able to talk to my children about different situations”

“I have a greater understanding and awareness of the issues”

“Help my child to learn about bodies, sex etc. How to see the signs of CSE and how to contact the relevant agencies”

14.5 Fostering Family Fun Day Saturday 11th June 2016

RDASH Looked After Children’s health team attended the third annual Fostering Family Fun day on Saturday 11.6.16 at Bentley High Street Primary School. This was as usual a great day with lots of fun activities for Looked after Children and their Carers to participate in. The Looked after Children’s Health Team provided a fun fruit and veg tasting stall to entice and encourage Looked after Children and their carers to try a variety of different fruit and vegetables, promoting and encouraging 5 a day.
This was also a great opportunity to meet with fostering families in a fun, informal setting and raise awareness of the support that the Looked after Children’s Health Team can offer. Lots of positive feedback was received, here are some of the comments

I think it’s a great job because it gets children to try new things” – Looked After Child

“I loved trying all of the fruits and vegetables, it was fun” – Looked after Child

“My daughter really enjoyed trying everything” – Foster Carer

Excellent way to involve children in healthy food tasting, great fun to do as a family

15. CHALLENGES

1. Improving the capacity to complete Initial Health Assessments within statutory timescales.

2. There are several themes that effect outcomes on a number of performance indicators. These include challenges for children placed out of area.
   - Improving the timeliness of Review Health Assessments for children placed out of authority.
   - Timely and accurate notification regarding LAC from DCST.

3. Responding to the unknown demand and health needs of Unaccompanied Asylum Seeking Children UASC.

16. RECOMMENDATIONS AND OBJECTIVES FOR 2017 – 2018

1. CAMHS Looked After Children analysis deep dive March 2017, this will inform future commissioning decision making
2. DCST to improve timely communication of notifications and consent for children coming into care by 5 working days
3. Embed new IHA providers and holistic team working to achieve timely IHA that are of good quality
4. The voice of LAC and their carers needs to continue to be at the forefront of commissioning decisions and service development, as a commissioning organisations
5. CCG to hear the voice of the Looked After Child during patient stories in Governing Body
6. CCG to consider opportunities for work experience for LAC.
## Doncaster CCG 2016/17 Performance Report

### A&E

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Pass Condition</th>
<th>Fail Condition</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
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<td>Equal to or greater than 95%</td>
<td>Less than 95%</td>
<td>95.1%</td>
<td>93.1%</td>
<td>92.2%</td>
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<td>A&amp;E Attendances (Type1) DBHFT</td>
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<td>11834</td>
<td>12165</td>
<td>11798</td>
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<td>% of patients seen within 4 hours at DRI</td>
<td>Equal to or greater than 95%</td>
<td>93.3%</td>
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<td>76.3%</td>
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<tr>
<td>A&amp;E Attendances (Bassetlaw)</td>
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</tr>
<tr>
<td></td>
<td>% of patients seen within 4 hours (Bassetlaw)</td>
<td>Equal to or greater than 95%</td>
<td>96.3%</td>
<td>96.1%</td>
<td>94.7%</td>
<td>94.9%</td>
<td>95.9%</td>
<td>96.7%</td>
<td>97.0%</td>
<td>91.1%</td>
<td>91.5%</td>
<td>91.3%</td>
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<tr>
<td></td>
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<td>Less than 95%</td>
<td>93.7%</td>
<td>93.9%</td>
<td>95.1%</td>
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<td>Trolley waits in A&amp;E</td>
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### Ambulance

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<td>75</td>
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<td>68.5%</td>
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<tr>
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<td>86.8%</td>
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<td>89.4%</td>
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<td>Amber F- 19 minute response time DONC</td>
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<tr>
<td>Green F- 60 minute response time DONC</td>
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<tr>
<td>Red Under 8- 8 minute response time YAS</td>
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<td>Amber R- 19 minute response time YAS</td>
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## Doncaster CCG 2016/17 Performance Report

### Amber T: 19 minute response time YAS

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<th>Q2 May-16</th>
<th>Q2 Jun-16</th>
<th>Q2 Jul-16</th>
<th>Q2 Aug-16</th>
<th>Q2 Sep-16</th>
<th>Q2 Oct-16</th>
<th>Q2 Nov-16</th>
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<th>Q2 Jan-17</th>
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**Key:**
- **T** = Trust Targets
- **C** = CCG related Targets
- **ND** = No Data Available
- **DDHFT**
- **RDaSH**
- **Misc**
- **Delivery Plans**
## Doncaster CCG 2016/17 Performance Report

### Key:
- **CCG**
- **DBHFT**
- **RDaSH**
- **Misc**
- **No Data Available**
- **Delivery Plans**

- **T** = Trust Targets
- **C** = CCG related Targets

### Data Provided
- Prior to signoff via YAS
- Subject to change

### Indicators

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<th>Jun-16</th>
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* 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 2016/17 Performance Report

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- **Misc**
- **Delivery Plans**

### Indicators and Performance

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<tr>
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<th>Fail Condition</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
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<tr>
<td>All cancer two week wait</td>
<td>Equal to or greater</td>
<td>Less than 88%</td>
<td>93.7%</td>
<td>94.0%</td>
<td>93.5%</td>
<td>95.6%</td>
<td>95.7%</td>
<td>96.2%</td>
<td>95.6%</td>
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<tr>
<td>Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>Equal to or greater</td>
<td>Less than 88%</td>
<td>92.1%</td>
<td>97.0%</td>
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<td>97.6%</td>
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<tr>
<td>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis</td>
<td>Equal to or greater</td>
<td>Less than 91%</td>
<td>93.0%</td>
<td>98.1%</td>
<td>97.2%</td>
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<td>97.8%</td>
<td>98.5%</td>
<td>99.2%</td>
</tr>
<tr>
<td>11-day standard for subsequent cancer treatment - anti cancer drug regimens</td>
<td>Equal to or greater</td>
<td>Less than 87%</td>
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<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>11-day standard for subsequent cancer treatments - radiotherapy</td>
<td>Equal to or greater</td>
<td>Less than 89%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>95.6%</td>
<td>97.3%</td>
<td>96.2%</td>
<td>97.4%</td>
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<tr>
<td>11-day standard for subsequent cancer treatments - surgery</td>
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<td>Less than 89%</td>
<td>88.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>92.9%</td>
<td>100.0%</td>
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<tr>
<td>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</td>
<td>Less than 80%</td>
<td>81.1%</td>
<td>82.8%</td>
<td>81.5%</td>
<td>80.6%</td>
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<td>74.5%</td>
<td>71.9%</td>
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<tr>
<td>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</td>
<td>Less than 85%</td>
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<td>81.8%</td>
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<td>75.0%</td>
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<td>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</td>
<td>Less than 85%</td>
<td>86.4%</td>
<td>70.6%</td>
<td>69.2%</td>
<td>76.2%</td>
<td>76.9%</td>
<td>92.3%</td>
<td>82.4%</td>
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</table>
### Doncaster CCG 2016/17 Performance Report

**Indicator** | **Pass Condition** | **Fail Condition** | **Q1** | **Q2** | **Q3** | **Q4**
--- | --- | --- | --- | --- | --- | ---
**T** All cancer two week wait. | Equal to or greater than 93% | Less than 88% | 93.1% | 93.1% | 94.0% | 94.5% | 94.4% | 94.4% | 95.3% | 94.3% | 94.6% |
**T** Two week wait for breast symptoms (where cancer was not initially suspected) | Equal to or greater than 93% | Less than 88% | 93.4% | 95.8% | 93.8% | 96.0% | 95.0% | 96.0% | 99.1% | 99.2% | 100.0% |
**T** Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis | Equal to or greater than 96% | Less than 91% | 99.3% | 99.4% | 98.6% | 100.0% | 100.0% | 100.0% | 99.1% | 100.0% | 100.0% |
**T** 11-day standard for subsequent cancer treatments-anti cancer drug regimens | Equal to or greater than 98% | Less than 87% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
**T** 11-day standard for subsequent cancer treatments-surgery | Equal to or greater than 94% | Less than 89% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
**T** Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer | Equal to or greater than 85% | Less than 82% | 86.0% | 89.7% | 86.0% | 86.2% | 84.7% | 81.0% | 85.8% | 85.8% |
**T** Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service | Equal to or greater than 85% | Less than 82% | 93.3% | 100.0% | 100.0% | 100.0% | 87.0% | 94.7% | 90.9% | 83.3% | 100.0% |

**Children**

| **C** | **Pass Condition** | **Fail Condition** | **Q1** | **Q2** | **Q3** | **Q4**
--- | --- | --- | --- | --- | --- | ---
**C** 5% Reduction in emergency admissions for upper respiratory tract infections by April 2015 | Equal to or less than 5% | Greater than | 230 | 92 |
**C** Emergency admissions for children with lower respiratory tract infections (LRTIs) | Equal to or less than 382 per annum | Greater than | 27 | 20 |

**Infection Control**

| **C** | **Pass Condition** | **Fail Condition** | **Q1** | **Q2** | **Q3** | **Q4**
--- | --- | --- | --- | --- | --- | ---
**C** Incidence of healthcare associated infection: MRSA bacteraemia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
**T** Incidence of healthcare associated infection: MRSA bacteraemia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
**C** Incidence of healthcare associated infection: MRSA bacteraemia | 0 | Greater than 0 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
**T** Incidence of healthcare associated infection: MRSA bacteraemia | 0 | Greater than 0 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
**C** Incidence of healthcare associated infection: C. difficile | Equal to or less than 66 | Greater than 66 | 3 | 4 | 10 | 11 | 18 | 28 | 39 | 45 | 50 | 55 | 58 |
**T** Incidence of healthcare associated infection: C. difficile | Equal to or less than 66 | Greater than 66 | 3 | 6 | 9 | 12 | 15 | 18 | 20 | 23 | 26 | 29 |
### Doncaster CCG 2016/17 Performance Report

#### Indicator Table

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<th>Q2</th>
<th>Q3</th>
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<tbody>
<tr>
<td>Mental Health - 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>Equal to or less than 24</td>
<td>Greater than 24</td>
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<td>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>Equal to or greater than 95%</td>
<td>Less than 90.25%</td>
<td>100%</td>
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<tr>
<td>Mental Health Measure - 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 75%</td>
<td>Less than 77.25%</td>
<td>1.7%</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Sex Accommodation (MSA) Breaches (DBHFT)</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed Sex Accommodation (MSA) Breaches (RDASH)</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CANCELLED OPERATIONS - All patients who operations cancelled for non clinical reasons to be offered another binding date within 26 days</td>
<td>Greater than 0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Stroke &amp; TIA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>69.6%</td>
<td>70.0%</td>
<td>67.4%</td>
<td>71.2%</td>
</tr>
<tr>
<td>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>92.9%</td>
<td>92.5%</td>
<td>90.0%</td>
<td>93.8%</td>
</tr>
<tr>
<td>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>66.7%</td>
<td>60.5%</td>
<td>71.8%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Stroke: Proportion of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis</td>
<td>Equal to or greater than 90%</td>
<td>Less than 89.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Stroke: Proportion of applicable patients receiving a joint health and social care plan on discharge</td>
<td>Equal to or greater than 90%</td>
<td>Less than 89.9%</td>
<td>87.6%</td>
<td>97.1%</td>
<td>90.1%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>
## Doncaster CCG 2016/17 Performance Report

### Indicator: Stroke: Percentage of patients treated by a stroke skilled early supported discharge team

- **Pass Condition**: Equal to or greater than 40%
- **Fail Condition**: Less than 39.9%

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>73.6%</td>
<td>67.6%</td>
<td>82.5%</td>
<td>66.7%</td>
<td>70.5%</td>
<td>80.0%</td>
<td>78.4%</td>
<td>71.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2</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>Q3</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>Q4</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>

### Indicator: Stroke: Percentage of applicable patients who are discharged who were given a named person to contact after discharge

- **Pass Condition**: Equal to or greater than 95%
- **Fail Condition**: Less than 94.9%

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>79.2%</td>
<td>73.0%</td>
<td>82.5%</td>
<td>75.0%</td>
<td>95.5%</td>
<td>95.0%</td>
<td>97.2%</td>
<td>82.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2</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>Q3</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>Q4</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>
### Doncaster CCG 2016/17 Performance Report

#### Waiting Times

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Pass Condition</th>
<th>Fail Condition</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C</strong> 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>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>C</strong> 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>1</td>
</tr>
<tr>
<td><strong>C</strong> 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>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>T</strong> Diagnostic test waiting times</td>
<td>Equal to or greater than 99%</td>
<td>Less than 99%</td>
<td>99.2%</td>
<td>99.5%</td>
<td>99.6%</td>
<td>99.2%</td>
</tr>
<tr>
<td><strong>C</strong> Diagnostic test waiting times</td>
<td>Equal to or greater than 99%</td>
<td>Less than 99%</td>
<td>99.0%</td>
<td>99.5%</td>
<td>99.6%</td>
<td>99.4%</td>
</tr>
<tr>
<td><strong>T</strong> 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>92.9%</td>
<td>93.1%</td>
<td>92.8%</td>
<td>92.6%</td>
</tr>
<tr>
<td><strong>C</strong> 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>93.7%</td>
<td>93.2%</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

**Key:**
- **T** = Trust Targets
- **C** = CCG related Targets
- **ND** = No Data Available
- **CCG** = Delivery Plans
- **DBHT**
- **RDaSH**
- **Misc**
Enc F

Item 11

Finance Report
This report sets out the financial position as at the end of January 2017 and outlines the final budgets for 2017/18 for approval.

The CCG is currently forecasting to achieve all of its financial targets for 2016/17.

The report also outlines:

- The key risk areas identified in 2016/17 planning and any current issues
- A summary of the CCG Efficiency Savings plan for 2016/17 (Appendix 2)
- A summary of the CCG’s Resource Allocation (Appendix 3)
- A summary of the CCG’s Reserve position (Appendix 4)
- A final summary of the 2017/18 plan including a high level Budget Book summary for approval (Appendix 5)

Members are asked to:

- RECEIVE the report and NOTE the financial position for 2016/17 and
- APPROVE the high level budget book summary for 2017/18
<table>
<thead>
<tr>
<th>Impact analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality impact</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>As highlighted within the report</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>None Identified</td>
</tr>
<tr>
<td><strong>Consultation / Engagement (internal departments, clinical, stakeholder &amp; public/patient)</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**Risk analysis**

The CCG identified a number of risks as part of the Financial planning for 2016/17. These included:

- Prescribing and High Cost Drugs Expenditure
- Over performance against the main acute contracts
- Individual Placements
- Non delivery of parts of the Efficiency Savings programme

A small contingency fund which equates to 0.5% of the CCG’s allocation was set aside to mitigate against these risks as required by the business rules. It has not been possible to flex investment reserves due to the national ring fencing of the 1% headroom and therefore should the contingency fund not be sufficient the CCG will have to increase efficiencies, seek to risk share with other organisations or seek additional support from NHS England.

**Assurance Framework**

1.2, 1.4, 2.4, 3.1, 3.2, 6.2
1. Introduction

This report provides the financial position for NHS Doncaster CCG for 2016/17 as at the end of January (Month 10). The CCG is forecasting to achieve all of its financial targets for 2016/17.

2. Current Position

The year to date position reflects a surplus of £6,504k which is consistent with the year to date target of £6,435k. The annual target is a surplus of £7,722 which the CCG is forecasting to achieve. The year to date and forecast 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 Prescribing and High Cost Drugs. Work to address the variations in both outcomes and costs will be taken forward as part of the Primary Care Strategy, specifically the medicine optimisation work. A prior approval process has been initiated with the Acute Trust and implemented from 1st April 2016; this will address any non-compliance with NICE guidance and correct charging through the PbR tariff mechanism. This is having a positive impact on costs.

Other risks identified include the over performance on acute contracts, increased Individual placements (including Continuing Healthcare, Specialist Placement and Section 117 packages) and the non-delivery of parts of the efficiency savings. If the efficiency savings fail to deliver there will be increased pressure on the CCGs statutory duty to breakeven.

The pressures around Emergency and A&E activity are continuing within the DBH NHS FT contract. The contract is forecast to overspend by £1.8m. Some of the smaller contracts are also forecast to over perform including Sheffield Teaching Hospitals, Sheffield Children’s and Barnsley NHS FT.

There are also some pressures in relation to S117 and Specialist Placement activity due to increased activity levels and cases being stepped down from NHS England, however some of this is offset by a reduction in Continuing Healthcare costs. This is being be closely monitored in year.

An additional risk has arisen in year in relation to the nationally agreed rates for Funded Nursing Care (FNC) which has caused an additional cost pressure of approximately £600k. Following a national review, the rate has increased by 39% from £112 per week to £156.25 per week; the CCG has had no choice but to implement this rate. NHS England have now advised that the further national review on the agency element of the FNC is now highly unlikely to have any impact on the...
rates for 2016/17 but will impact on 2017/18. The outcome of the review has not yet been published.

To help manage and offset these risks a small contingency fund of £2.2m has been established. This equates to 0.5% of the CCG’s allocation and is in line with planning guidance. If this is insufficient the following actions would need to be considered:

- Seeking further efficiencies and decommissioning opportunities
- Risk sharing with other CCGs
- Seeking repayable financial assistance from other NHS organisations
- Seeking further support from NHS England

In previous years flexing of investment funds have supported mitigation to manage unexpected risks however this is not an option 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 schemes, current progress and forecast are shown in Appendix 2.

The Prescribing LES scheme was launched earlier in the year and all practices signed up to the scheme which started in August. The scheme aims to reduce overall spend across several areas of prescribing and rewards practices with a percentage of the savings made. Information is now available for the period August to October and overall costs have increased by £464k on the same period last year after adjusting for prices and population changes. Despite the overall increase a small number of practices have reduced spend and this has resulted in an estimated gain share payment of £18k. Further updates will be provided as more information becomes available from the BSA.

Savings have materialised overall in the prescribing budget as it was set net of a £5.1m efficiency target and is only forecasting an overspend of £1.7m as at Month 10. However most of these savings are fortuitous and are linked to the nationally determined Cat M prices.

Savings have also materialised in the DBH contract in relation to High Cost Drugs due to the impact of transferring patients onto bio-similars and the prior approval processes. There are also some savings against other elements of the contract due to activity being lower than expected in some areas, mainly outpatients, audiology and critical care. This equates to approximately £1.2m so far this year and a forecast of £1.6m.

The continuation of the rigorous controls around CHC following the review in 2015/16, are continuing to have a positive impact on the financial position with estimated savings this year of £3.5m.

The total savings achieved so far across all areas are approximately £6.5m with a forecast achievement of £8.5m against an original target of £8.8m.
5. **1% Non Recurrent Headroom**

The CCG set aside £4.8m, (1% of the CCG’s recurrent allocation) as per the business rules, for non-recurrent investment. However, the CCG had to ring-fence this funding to provide funds to insulate the wider health economy from financial risk. It has now been confirmed that this funding will not be released to CCG’s for utilisation due to the wider NHS England financial position.

6. **Further Allocations**

The CCG has received two new allocations in relation to pass through payments for the STH Vanguard project (£306k and £13k), the second instalment of the Children and Young Peoples Transformation Plan funding £72k, funding for Perinatal/IAPT services, £25k and funding for the changes to Market Rent charging for Property Services buildings £176k.

7. **Capital Resource**

The CCG has not received any capital funding in 2016/17.

8. **Other Key Financial Targets**

Below is a summary table outlining all the key financial targets for the CCG, the current performance and the forecast, there are no areas of concern to be noted.

<table>
<thead>
<tr>
<th>Key Duty</th>
<th>Target</th>
<th>Actual</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>Achieve annual target of £7,722k, YTD £6,435k</td>
<td>£6,504</td>
<td>£7,722k</td>
</tr>
<tr>
<td>BPPC</td>
<td>95% + invoices paid within 30 days (NHS)</td>
<td>98.10%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoices paid within 30 days (non NHS)</td>
<td>98.71%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoice values paid within 30 days (NHS)</td>
<td>99.93%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoice values paid within 30 days (Non NHS)</td>
<td>98.71%</td>
<td>98%</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>1.25% of monthly drawdown remaining at period end</td>
<td>1.07%</td>
<td>1.25%</td>
</tr>
<tr>
<td>Running Costs</td>
<td>Maintain spend within annual target of £6,806k, YTD £4,672k</td>
<td>£4,124k</td>
<td>£6,278k</td>
</tr>
<tr>
<td>Capital Resources</td>
<td>Expenditure not to exceed allocation (N/A)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
9. **Better Care Fund**

The Better Care Fund is governed via the signed Section 75 Framework Agreement with Doncaster Council, the total pooled budget is £23,907k. Both the CCG’s £14.9m and the DMBC’s £7m are funded via the CCG’s allocation. The £14.9m is made up of historical CCG contracts which are linked to common priorities with the local authority. The £7m DMBC element is used jointly for shared priorities such as Intermediate Care. The Q3 position and forecast are summarised in Table 1 below, both are in line with budget. A summary of the overall budget by theme is also shown in Table 2 for information.

**Table 1 – Summary of budget by commissioner**

<table>
<thead>
<tr>
<th></th>
<th>Budget £000’s</th>
<th>Spend to Q3 £000’s</th>
<th>Forecast £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>14,902</td>
<td>11,178</td>
<td>14,902</td>
</tr>
<tr>
<td>DMBC</td>
<td>7,040</td>
<td>4,847</td>
<td>7,040</td>
</tr>
<tr>
<td>DFG</td>
<td>1,965</td>
<td>1,531</td>
<td>1,965</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>23,907</strong></td>
<td><strong>17,556</strong></td>
<td><strong>23,907</strong></td>
</tr>
</tbody>
</table>

**Table 2 – Summary of the budget by theme**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Budget £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are independent with good health and wellbeing</td>
<td>4,572</td>
</tr>
<tr>
<td>When in need of care / or support it is personalised flexible &amp; appropriate</td>
<td>4,322</td>
</tr>
<tr>
<td>Where people are in urgent need of care or crisis, there will be responsive services that meet their needs</td>
<td>14,722</td>
</tr>
<tr>
<td>Enablers</td>
<td>79</td>
</tr>
<tr>
<td>Programme Management</td>
<td>212</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23,907</strong></td>
</tr>
</tbody>
</table>

The plans for 2017/18 are currently being developed; however as part of the Intermediate Care project providers will need time to take capacity and costs out of the system whilst transitioning to the new delivery models, therefore services will need a period of ‘double running’ to ensure safe and effective implementation to the
new models of care. This period of ‘double running’ whilst new services are properly established and appropriately staffed is critical to the success of the transformation programme and the BCF will be used to support this.

10. Primary Medical Care Delegated Commissioning

The CCG assumed devolved responsibility for Primary Medical Care commissioning with effect from April 2016. The total allocation devolved from NHS England was £41m and expenditure is currently forecast to be contained within this budget. The financial position will be discussed regularly at the Primary Care Committee including developments for 2017/18 and implementation of the Primary Care Forward View. The CCG is currently developing an offer of a non-financial support package for vulnerable practices to enable them to become sustainable for the future. This will be taken forward through the Primary Care Committee.

11. Financial Planning 2017/18

The final financial plans were submitted to NHS England on 27th February 2017 and it is expected that NHS Doncaster CCG’s plan will be approved in the next few weeks. As outlined previously the plans for 2017/18 are very challenging with the CCG facing unprecedented pressures and an £11.6m QIPP target.

The culmination of the above has resulted in the preparation of a detailed budget book which sets the budgets at an individual provider level for the main contracts split between the key areas of Acute, Mental Health, Community, Primary Care, Continuing Healthcare and Corporate budgets. A High Level Summary of the Budget Book is attached at Appendix 1 and requires approval by the Governing Body. A more detailed version is available on request.

Once approved, the detailed Budget Book will be formally issued to Budget Managers for in year management. The budgets will be monitored at a detailed level and reported to the Governing Body on a monthly basis.

It should be noted that NHS England are changing their reporting in 2017/18 to in year monitoring i.e. movement from the previous year. The CCG therefore does not have a surplus target in 2017/18 but instead will be monitored against any movement from the prior year's position.

12. Conclusion and Recommendations

Members are asked to:

- RECEIVE and NOTE the Finance Report for December 2016 (Month 9).
- APPROVE the high level budget book for 2017/18
## OPERATING COST STATEMENT

<table>
<thead>
<tr>
<th>Recurrent Budget</th>
<th>Non Recurrent Budget</th>
<th>Total Budget</th>
<th>Recurrent Budget</th>
<th>Non Recurrent Budget</th>
<th>Total Budget</th>
<th>Variance Over 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Assurance</strong></td>
<td>614</td>
<td>614</td>
<td>614</td>
<td>614</td>
<td>614</td>
<td>614</td>
</tr>
<tr>
<td><strong>1% Non Recurrent Headroom Reserve</strong></td>
<td>4,799</td>
<td>4,799</td>
<td>4,799</td>
<td>4,799</td>
<td>4,799</td>
<td>4,799</td>
</tr>
<tr>
<td><strong>Total Corporate Costs</strong></td>
<td>9,988</td>
<td>-171</td>
<td>9,816</td>
<td>9,927</td>
<td>414</td>
<td>10,341</td>
</tr>
<tr>
<td><strong>Governing Body</strong></td>
<td>1,493</td>
<td>0</td>
<td>1,493</td>
<td>1,493</td>
<td>0</td>
<td>1,493</td>
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<tr>
<td><strong>Primary Care Support</strong></td>
<td>208</td>
<td>0</td>
<td>208</td>
<td>208</td>
<td>0</td>
<td>208</td>
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<tr>
<td><strong>Performance</strong></td>
<td>823</td>
<td>0</td>
<td>823</td>
<td>823</td>
<td>0</td>
<td>823</td>
</tr>
<tr>
<td><strong>Communications &amp; PR</strong></td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>5</td>
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<tr>
<td><strong>Corporate Costs &amp; Services</strong></td>
<td>397</td>
<td>0</td>
<td>397</td>
<td>397</td>
<td>0</td>
<td>397</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>792</td>
<td>0</td>
<td>792</td>
<td>792</td>
<td>0</td>
<td>792</td>
</tr>
<tr>
<td><strong>TOTAL APPLICATION OF FUNDS</strong></td>
<td>479,686</td>
<td>8,983</td>
<td>488,669</td>
<td>481,385</td>
<td>9,335</td>
<td>490,720</td>
</tr>
</tbody>
</table>

| **TOTAL RESERVES** | 2,482                 | 4,799         | 7,281             | 2,482                 | 4,799         | 7,281             |

*As directed by NHS England - All CCGs are required to make a surplus of at least 1%*
<table>
<thead>
<tr>
<th>Project</th>
<th>2016/17 Target £000's</th>
<th>Achieved YTD £000's</th>
<th>Forecast £000's</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>2434</td>
<td>3407</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>DBH - move to biosimilars and prior approval</td>
<td>511</td>
<td>689</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DBH outpatients and audiology</td>
<td>512</td>
<td>684</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>DBH Critical Care non recurrent underspend</td>
<td>139</td>
<td>191</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Continuing Healthcare - continuation of rigorous</td>
<td>2917</td>
<td>3500</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>controls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other schemes as part of Working Together and STP</td>
<td>0</td>
<td>0</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>2016/17 TOTAL</td>
<td>8,882</td>
<td>6,513</td>
<td>8,471</td>
<td></td>
</tr>
</tbody>
</table>

Note: Risk assessed on the basis of management experience

A summary of the progress in each year is summarised below -

The prescribing LES has been launched and all practices have signed up to the scheme which started in August. Information is now available for August to October and costs have increased by £464k overall, however a small number of practices have made some savings and therefore an estimated payment of £18k will need to be made. It should also be noted that prescribing budgets were reduced by £5.1m this year and the budgets are only forecast to overspend by £1.4m, the majority of this saving is linked to the nationally determined Cat M prices.

DBH Contract - savings in relation to High Cost Drugs are due to the move to Bio-similars and the prior approval processes. Other savings in relation to outpatients and audiology are also materialising due to reduced activity in these areas together with a non recurrent underspend against critical care activity.

Continuing Healthcare - the continuation of the rigorous controls following the review of criteria is continuing to have an impact with an expected underspend of £3.5m this year.
### SUMMARY OF RESOURCE ALLOCATIONS AS AT MONTH 10 JANUARY 2016

<table>
<thead>
<tr>
<th>Recurrent</th>
<th>Recurrent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>£000's</td>
<td>£000's</td>
</tr>
<tr>
<td>-438,097</td>
<td>-438,097</td>
<td></td>
</tr>
<tr>
<td>Primary Care Delegation</td>
<td>-500,000</td>
<td>-500,000</td>
</tr>
<tr>
<td>Non Recurrent Surplus from prior years</td>
<td>-9,722</td>
<td>-9,722</td>
</tr>
<tr>
<td>Running Cost Allowance</td>
<td>-6,806</td>
<td>-6,806</td>
</tr>
<tr>
<td><strong>Total Resources Available at Plan Stage</strong></td>
<td>-496,391</td>
<td>-496,391</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjustments to the Resource Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month 01 April</strong></td>
</tr>
<tr>
<td>No adjustments</td>
</tr>
<tr>
<td><strong>Month 02 May</strong></td>
</tr>
<tr>
<td>No adjustments</td>
</tr>
<tr>
<td><strong>Month 03 June</strong></td>
</tr>
<tr>
<td>Vanguard Q1 Sheffield Teaching Hospitals</td>
</tr>
<tr>
<td>Q1 Eating Disorder Service</td>
</tr>
<tr>
<td>PYE Transfer of One Health July-March 2017</td>
</tr>
<tr>
<td>PYE Transfer of Claremont July-March 2017</td>
</tr>
<tr>
<td>Colposcopy Contract transfer from NHS England</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 04 July</strong></td>
</tr>
<tr>
<td>Transfer of NHSE support re Embed and Third Party Contracts</td>
</tr>
<tr>
<td>Learning Disability Transformation Funding to TCPs</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 05 August</strong></td>
</tr>
<tr>
<td>PYE Transfer of One Health April - June 2017</td>
</tr>
<tr>
<td>PYE Transfer of Claremont April - June 2017</td>
</tr>
<tr>
<td><strong>GP Development Programme - Reception and Clerical training</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 06 September</strong></td>
</tr>
<tr>
<td>Suspended Doctors Budget Transfer back to NHSE</td>
</tr>
<tr>
<td>Vanguard Q2 Sheffield Teaching Hospitals</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 07 October</strong></td>
</tr>
<tr>
<td>CYP Local Transformation Mental Health M7 - NHS</td>
</tr>
<tr>
<td>Doncaster CCG</td>
</tr>
<tr>
<td>Q1 &amp; 2 Local Evaluation Funding - Working Together Partnership ACC</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 08 November</strong></td>
</tr>
<tr>
<td>CEOV Adjustment</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 09 December</strong></td>
</tr>
<tr>
<td>Quality Premium</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 10 January</strong></td>
</tr>
<tr>
<td>Q4 Vanguard Funding - Working Together Partnership ACC</td>
</tr>
<tr>
<td>Q3 Local Evaluation Funding - Working Together Partnership ACC</td>
</tr>
<tr>
<td>Perinatal / IAPT underspend allocation M10</td>
</tr>
<tr>
<td>CYP WL &amp; WT Reduction: 2nd tranche</td>
</tr>
<tr>
<td>Mitigate impact of NHS PS move to market rents (Programme)</td>
</tr>
<tr>
<td>Mitigate impact of NHS PS move to market rents (Admin)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Month 11 February</strong></td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td><strong>Month 12 March</strong></td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

**Revised Resources available as at Month 10 January 2017**

-486,738 | -11,704 | -498,442
### SUMMARY OF RESERVES AS AT MONTH 10 JANUARY 2017

#### RESERVES

<table>
<thead>
<tr>
<th></th>
<th>Recurrent £000's</th>
<th>Non Recurrent £000's</th>
<th>Total £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RISK RESERVES AND CONTINGENCIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% Non Recurrent Headroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Plan</td>
<td>0</td>
<td>4,799</td>
<td>4,799</td>
</tr>
<tr>
<td>Budget Transfers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No transfers as at Month 10 - funding uncommitted and ringfenced as per NHSE Guidance</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5% Contingency</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Initial Plan</td>
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<td>0</td>
<td>2,482</td>
</tr>
<tr>
<td>Budget Transfers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No transfers as at Month 10</td>
<td>2,482</td>
<td>0</td>
<td>2,482</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,482</td>
<td>4,799</td>
<td>7,281</td>
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<tr>
<td>Cross Check to Operating Cost Statement</td>
<td>2,482</td>
<td>4,799</td>
<td>7,281</td>
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### 2017/18 Budget Book Summary

<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>Baseline Allocation - Recurrent (Incl PC Co-Commissioning)</td>
<td>-487,673</td>
<td>-487,673</td>
<td></td>
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<tr>
<td>Running Cost allocation</td>
<td>-6,773</td>
<td>-6,773</td>
<td></td>
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<tr>
<td>Baseline Allocation - Non recurrent</td>
<td>-3,662</td>
<td>-3,662</td>
<td></td>
</tr>
<tr>
<td>Use of Drawdown</td>
<td>-436</td>
<td>-436</td>
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<tr>
<td><strong>Total Initial Allocation</strong></td>
<td><strong>-494,446</strong></td>
<td><strong>3,224</strong></td>
<td><strong>-491,222</strong></td>
</tr>
<tr>
<td>Acute Contracts - Doncaster &amp; Bassetlaw NHS FT</td>
<td>186,163</td>
<td>1,186</td>
<td>187,349</td>
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<tr>
<td>Acute Contracts - Other NHS</td>
<td>34632</td>
<td>-2643</td>
<td>31,989</td>
</tr>
<tr>
<td>Aucte Contracts - Other Providers Non NHS</td>
<td>4544</td>
<td>-140</td>
<td>4,404</td>
</tr>
<tr>
<td>Acute - Non Contract Activity</td>
<td>2627</td>
<td>-53</td>
<td>2,574</td>
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<tr>
<td>Urgent Care</td>
<td>5843</td>
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<td>5,843</td>
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<tr>
<td>Other acute</td>
<td>422</td>
<td>1,378</td>
<td>1,800</td>
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<td><strong>Total Acute Services</strong></td>
<td><strong>234,231</strong></td>
<td><strong>-272</strong></td>
<td><strong>233,959</strong></td>
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<tr>
<td>NHS Community Services</td>
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<td>Non NHS Community Services</td>
<td>2,814</td>
<td>438</td>
<td>3,252</td>
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<tr>
<td>Better Care Fund</td>
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<tr>
<td>Intermediate Care CAP Beds</td>
<td>861</td>
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<td>861</td>
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<td><strong>Total Community Services</strong></td>
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<td><strong>438</strong></td>
<td><strong>42,667</strong></td>
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<tr>
<td>Mental Health Contracts - Rotherham, Doncaster &amp; South Hum</td>
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<td>34,864</td>
</tr>
<tr>
<td>Mental Health Contracts - Other NHS</td>
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<td>0</td>
<td>1,094</td>
</tr>
<tr>
<td>Mental Health Contracts - Non NHS</td>
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<td>17,435</td>
</tr>
<tr>
<td>NCA’s</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total Mental Health &amp; Learning Disabilities</strong></td>
<td><strong>53,399</strong></td>
<td>0</td>
<td><strong>53,399</strong></td>
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<tr>
<td>Prescribing</td>
<td>64,829</td>
<td>0</td>
<td>64,829</td>
</tr>
<tr>
<td>Oxygen Services</td>
<td>614</td>
<td>0</td>
<td>614</td>
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<tr>
<td>Primary Care Co-Commissioning</td>
<td>41,992</td>
<td>0</td>
<td>41,992</td>
</tr>
<tr>
<td>GPIT</td>
<td>802</td>
<td>0</td>
<td>802</td>
</tr>
<tr>
<td>Other Primary Care Services</td>
<td>4,176</td>
<td>944</td>
<td>5,120</td>
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<tr>
<td><strong>Primary Care Services</strong></td>
<td><strong>112,413</strong></td>
<td><strong>944</strong></td>
<td><strong>113,357</strong></td>
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<tr>
<td>Continuing Healthcare</td>
<td>29,665</td>
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<td>29,665</td>
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<tr>
<td>Continuing Healthcare Services</td>
<td>29,665</td>
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<td>29,665</td>
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<tr>
<td><strong>Total Healthcare Services</strong></td>
<td><strong>471,937</strong></td>
<td><strong>1,110</strong></td>
<td><strong>473,047</strong></td>
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<tr>
<td>Admin Costs</td>
<td>6,773</td>
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<td>6,773</td>
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<tr>
<td>Other Corporate Costs including Property Costs</td>
<td>4,065</td>
<td>0</td>
<td>4,065</td>
</tr>
<tr>
<td><strong>Total Corporate Costs</strong></td>
<td><strong>10,838</strong></td>
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<td><strong>10,838</strong></td>
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<tr>
<td>Surplus Target *</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Risk Reserve &amp; Contingencies</td>
<td>2,460</td>
<td>0</td>
<td>2,460</td>
</tr>
<tr>
<td>1% Non Recurrent Headroom Reserve</td>
<td>0</td>
<td>4,877</td>
<td>4,877</td>
</tr>
<tr>
<td><strong>Total Reserves</strong></td>
<td><strong>2,460</strong></td>
<td><strong>4,877</strong></td>
<td><strong>7,337</strong></td>
</tr>
<tr>
<td><strong>Total Application of Funds</strong></td>
<td><strong>485,235</strong></td>
<td><strong>5,987</strong></td>
<td><strong>491,222</strong></td>
</tr>
</tbody>
</table>

**Note**

*NHS England are moving to “in year reporting” in 2017/18 therefore there is no surplus target. The CCG will instead be monitored against its movement from the prior years surplus achievement.*
Enc G

Item 12

Chair & Chief Officer Report
Meeting name: Governing Body  
Meeting date: 16 March 2017  
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:

- Sustainability & Transformation Plan (STP) update  
- Place Plan update  
- Commissioning for Value Decision Making and Prioritisation Framework  
- Proposed change to Constitution  
- NHS England Quarter 3 Assurance Meeting  
- Forward Procurement Schedule  
- Strategy & Organisational Development Forum update

Recommendation(s)

The Governing Body is asked to:

- Note the report.  
- Consider the proposal to remove Committee Terms of Reference from the Constitution, and make any resulting recommendations to our Member Practices for their consideration.
<table>
<thead>
<tr>
<th>Impact analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality impact</td>
<td>Neutral</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>Management of Conflicts of Interest</td>
<td>Paper is for information. No relevant interests.</td>
</tr>
<tr>
<td>Consultation / Engagement</td>
<td>N/A</td>
</tr>
<tr>
<td>(internal departments, clinical, stakeholder &amp; public/patient)</td>
<td></td>
</tr>
<tr>
<td>Report previously presented at</td>
<td>None</td>
</tr>
<tr>
<td>Risk analysis</td>
<td>Nil</td>
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<tr>
<td>Assurance Framework</td>
<td>3.2, 5.1, 6.2</td>
</tr>
</tbody>
</table>
Chair and Chief Officer Report
March 2017

1. Sustainability & Transformation Plan (STP) update

1.1. Strategic Progress

Collaborative partnership work continues across the South Yorkshire & Bassetlaw footprint to bring to life the high-level ambition articulated within the Sustainability & Transformation Plan (STP). A number of meetings of the Chief Executives of the partner organisations have been held to discuss the next steps towards implementation.

In addition, Simon Stevens and Jim Mackey wrote to STP leaders recently and confirmed that in March, a Five Year Forward View Delivery Plan setting out what the NHS will deliver in the next two to three years will be published.

The Delivery Plan will outline the steps that will be taken, including:

- Initiating a formal appointment process for STP leaders.
- Giving STP leaders the right to make recommendations to NHS England / NHS Improvement about local organisational governance, as well as other actions to drive forward and overcome the inertia or organisational vetoes that are preventing improvements.
- Giving the strongest STPs greater control over NHS England staff, together with CCG and trust resources, to enhance their implementation capability.
- Providing a relatively small amount of centrally held transformation funding to areas with strong plans and partnerships to help them make faster progress. This funding will help create exemplars for elective and emergency care, and get the most advanced accountable care systems off the ground. NHS England / NHS Improvement will also provide some additional central funding to support the formation of primary care hubs or networks across the country. STP leaders will oversee this transformation funding.

1.2. Strategic Commissioning

As requested by the STP lead, CCG’s are undertaking a review of Strategic Commissioning across the STP footprint to ensure the model remains fit for purpose as the STP progresses. Recommendations will be considered by all Governing Bodies and initial proposals are expected during April 2017.

There are a number of commissioning organisations across the STP and whilst it makes sense to commission most services locally to ensure that they can be built around the needs of the individual communities, there are benefits in commissioning
some services across the wider STP footprint to enable the best value for services, to improve the consistency and quality of services, and to make the best use of commissioning resources available.

1.3. Communication

The statutory partners in the STP across South Yorkshire and Bassetlaw have asked each local Healthwatch organisation and CVS organisation to commence conversations with and involve communities in conversations about the STP including why it has been developed, what it covers, and how detailed proposals will be developed. In Doncaster, Healthwatch Doncaster will be carrying out this communication together with the local Patient Participation Groups, Health Ambassadors and NHS Doncaster CCG. This is not a consultation exercise at this stage, but a communication and engagement process to assist the public and patients to understand what the STP is. Once the high-level ambition articulated within the STP evolves into more concrete proposed changes to services, formal consultation will follow for significant changes to local services. For example, this is what has happened recently with the Hyper Acute Stroke Unit and Children’s Surgery & Anaesthesia proposals.

2. Place Plan update

The commissioners within the Place Plan (Doncaster Council and NHS Doncaster CCG), have procured for a strategic partner to support the development of the vision contained in the Place Plan into tangible next steps. Following the procurement, EY have been appointed as our Strategic Partner.

EY have commenced a series of interactions with the partners in the Place Plan and are completing a Readiness State Assessment for the ambition described within the Place Plan.

- Doncaster Council and NHS Doncaster CCG, as the Commissioners within the Place Plan, are meeting together to agree the commissioning readiness state and next steps towards the integrated commissioning model described within the Place Plan.

- EY are also facilitating discussions between the Providers of health and social care within the Place Plan to agree the next steps towards an Accountable Care Partnership as described in the Place Plan.

From the Readiness State Assessment, a business case will be built towards the new system operating model described in the Place Plan.

A report highlighting the state of readiness and proposals for place plan implementation will be produced by the end of March. This will be considered by the Governing Body in due course.
3. Commissioning for Value - Decision Making and Prioritisation Framework

The Commissioning for Value Decision Making and Prioritisation Framework was approved at the last Governing Body meeting. Subsequent to this, numerous clinical discussions have taken place both within NHS Doncaster CCG and within Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT) and we are together moving forwards with implementing changes to some referral pathways to align with National Institute for Health and Care Excellence guidance and other relevant national guidance.

A full communication campaign to support any changes is being developed and will launch imminently. To ensure that the operations and treatments we fund are clinically effective and improve our patients’ health and well-being, we’ll be asking patients to discuss these five questions with their doctor or nurse:

- Do I really need this test, treatment or procedure?
- What are the risks or downsides?
- What are the possible side-effects?
- Are there simpler, safer options?
- What will happen if I do nothing?

4. Proposed change to Constitution

Our Constitution currently contains, as appendices, the Terms of Reference for each of the Committees of the Governing Body. As the Terms of Reference are included in the Constitution, any minor updates have to be consulted upon with our Member Practices. This increases the administrative burden placed upon Member Practices because we have to consult them more frequently on minor matters.

A number of CCGs have taken the decision to remove the Terms of Reference of Committees and instead place them on their website so that they can be updated on a more “live” basis.

To reduce the administrative burden upon our Member Practices, it is recommended that the Terms of Reference for each of the Committees of the Governing Body be removed from the Constitution and placed on our website alongside the Constitution.

Any changes to Committee Terms of Reference are already subject to Governing Body approval, on which Member Practices are represented by elected Locality Leads.

The Governing Body is asked to consider this proposal, and make any resulting recommendations to our Member Practices for their consideration.

5. NHS England Quarter 3 Assurance Meeting

Further to the verbal update provided during the presentation of the Chair & Chief Officer Report to Governing Body in February 2017, the formal feedback letter from
our Quarter 3 Assurance Meeting has been received from NHS England and is appended to this report for information.

6. Forward Procurement Schedule

The following tenders have been recently awarded, are in progress, or are to be tendered shortly. A regular update on progress with procurements will be provided to Governing Body through the Chair & Chief Officer Report on a quarterly basis.

<table>
<thead>
<tr>
<th>Recently awarded:</th>
<th>In progress:</th>
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<td>• Integrated Digital Care Record</td>
<td>• Patient Transport Service (GP Urgent and A&amp;E take homes)</td>
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<td>• CAMHS Looked After Children Review</td>
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7. Strategy & Organisational Development Forum update

Our Strategy & Organisational Development Forum met at the beginning of this month to debate a range of topics. The Forum:

- Was updated by representatives from Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT) on their strategic vision as a Trust and the development of their strategic plan.
- Heard from Doncaster Council’s Adult Health & Wellbeing lead about the planned transformation programme.

The Forum also took time out to discuss the importance of including patient stories within the Governing Body agenda and making time for public questions. The Governing Body agreed to:

- Work in partnership with existing engagement forums in Doncaster and our statutory partner, Healthwatch Doncaster, to integrate patient stories within relevant agenda items at the Governing Body meetings.
- Continue to protect time at the beginning of each Governing Body meeting for public questions submitted in advance of the meeting, and to update the public guidance/information about how to submit questions so that it is more accessible. Any changes to the public guidance/information will be shared with Healthwatch Doncaster for their comments prior to publication in April 2017.
8. **Recommendations**

The Governing Body is asked to:

- Note the report.
Dr David Crichton, Chair  
Jackie Pederson, Accountable Officer  
Doncaster CCG

Dear Jackie and David,

RE: Improvement and Assessment Framework Checkpoint Meeting

Thank you for meeting with us on 13 February 2017 for your Quarter 3 CCG checkpoint meeting. The purpose of this letter is to provide a summary of our discussion.

We firstly discussed the CCG’s achievements, and I commended you on these, with particular thanks to the team for securing delivery of the PUPOC trajectories across the patch.

Planning
We discussed the CCG’s operational plan for 17/18 and 18/19 and you articulated your confidence that the level of commissioned activity will maintain national standards and quality of care for patients for general and mental healthcare. We acknowledged the risks in some specialties but that this risk was being mitigated with appropriate elective growth built into the contract with DBH, and you are confident that RTT performance will be maintained at 92% from April 2017.

We discussed the CCG’s £11.7m (2%) QIPP and you felt that this was a challenging, yet manageable ambition. You described your confidence in the deliverability of your QIPP schemes and confirmed that these schemes would not have an adverse impact on patient care. We discussed the partnership approach that you have taken to contracting with all of your providers, and the positive impact this had on negotiations, and finally, we discussed your contingency plans and mitigations.

We agreed that you have a coherent plan, with clear ownership, which is linked to your wider commissioning plan. You have appropriate mitigations in place and your senior team is focussed on delivery, with a clear sense of shared responsibility. It will be important to maintain this focus on delivery throughout 2017/18 in order to secure the required level of savings.

We discussed the process of planning for 17/19 and 18/19, and the process of signing plans off. I explained that NHS England and NHS Improvement would, over the coming weeks undertake a joint exercise to triangulate commissioner and
provider plans to test planning assumptions. We would feedback the result of this in advance of a final submission of plans required on 27 February 2017.

Subsequent to the meeting, we have identified that your A&E planning trajectory does not meet the NHS Constitutional Standards. All CCGs should be planning to deliver the NHS Constitution and therefore we expect your operational plan to be refreshed to deliver A&E performance of 95% through the year.

Subject to this being reflected in the final submission (27 February), we expect to be able to sign off the Doncaster plan in mid-March, ready for implementation on 1 April 2017.

Performance & Delivery
We discussed delivery issues and acknowledged the CCG’s Governing Body role in holding the CCG and system to account.

We discussed the recent RTT performance at DBH, and acknowledged that the Trust has an RTT recovery plan in place, with trajectories indicating recovery of the standard by 31 March 2017. You are engaged in the North East Commissioning Support Unit (NECS) commissioned Demand Management work, being led in Yorkshire & the Humber by Yee Lee Wright, and anticipate that this may present opportunities to further manage referral demand.

We discussed the A&E performance at DBHFT. You described the ED streaming pathway and a continued focus on this. This model is currently consistently deflecting circa 15% of patients away from ED, and the ambition is for this to reach 20% in early 2017/18.

We discussed the executive level focus on urgent and emergency care, achieved through the A&E Delivery Board which spans Bassetlaw and Doncaster and the role of local SRGs which continue, focussing on local system delivery.

General Practice Forward View (GPFV)
We discussed your GPFV plan, and confirmed that the plan had been rated as Amber. We noted the significant national challenge, and acknowledged that further work will be undertaken in Doncaster on:

(i) Estates; and
(ii) The pan-Doncaster primary care entity.

In terms of estates, it is important that your estates plan for general practice supports delivery of your wider strategy. You may want to take the opportunity to review the current developments in the pipeline to ensure this alignment

We discussed the planned transformation of primary care and also the CCG’s approach to delivering resilient General Practice. We noted the importance of ensuring that all your practices are engaged in the transformation agenda in order to build resilient general practice going forward. You described your focus on training and the development of the wider primary care workforce as well as your top priorities in developing sustainable General Practice in the coming year.
Commissioning Reform
We discussed commissioning reform including the on-going discussions within the STP team and between CCGs about the development of accountable care systems, commissioning for place and commissioning across South Yorkshire and Bassetlaw.

You confirmed that your Governing Body has discussed all of these developments, is committed to maximising efficiencies in commissioning, but keen to work through the arrangements in terms of its statutory responsibilities.

It will be important that you continue to engage with your Governing Body and membership so that the CCG is ready to move (collaboratively with the other four CCGs) towards a reformed commissioning system from the beginning of 2017/18.

Thank you for your continued work to secure improvement in health services and outcomes for your population. Please do not hesitate to contact me should you wish to discuss this letter, or require any further information.

Yours sincerely

Alison Knowles
Locality Director – NHS England North (Yorkshire and the Humber)
Verbal

Item 13

Locality Feedback
Item 14

Standing Orders (SOs), Standing Financial Instructions (SFIs) & Scheme of Delegation (SoD)
Review of Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) – March 2017

1. Introduction

As part of its role, the Audit Committee reviews the Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) on an annual basis, making any recommendations for amendments to the Governing Body.

2. Review

The document has been reviewed by the Chief Finance Officer and the Chief of Corporate Services from both a financial and governance perspective.

The following amendments are recommended:

- Change Quality & Safety Committee to Quality & Patient Safety Committee.
- Change Delivery & Performance Committee to Executive Committee and amend the delegated roles.
- Add reference within the Standing Orders and Scheme of Delegation to the Joint Committee of CCGs which has been established for the Working Together programme.
- Remove reference to the obsolete NHS England definition of relevant and material interests, and replace with reference to the CCG’s Standards of Business Conduct & Conflicts of Interest Policy.
- Add reference to the role of the Conflict of Interest Guardian.
- Remove references to the Audit Commission.
- Updating of Section 17 on Tendering and Contracting in line with the latest national guidance.

3. Recommendation

The Audit Committee considered these amendments at its meeting on 9 March 2017 and recommends the amendments to Governing Body for approval. The Governing Body is asked to:

- CONSIDER and APPROVE the recommended amendments.
STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS, AND STANDING FINANCIAL INSTRUCTIONS

FOR

NHS DONCASTER CLINICAL COMMISSIONING GROUP

1st April 2017

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SECTION A - INTERPRETATION AND DEFINITIONS

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Clinical Commissioning Group (CCG) shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Officer or Chief of Corporate Services).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006, Health & Social Care Act 2012, and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 "Accountable Officer" means the NHS Officer responsible and accountable for funds entrusted to the CCG. The Accountable Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For the CCG this shall be the Chief Officer.

1.2.2 "Budget" means a resource, expressed in financial terms, proposed by the Governing Body for the purpose of carrying out, for a specific period, any or all of the functions of the CCG.

1.2.3 "Budget holder" means the manager with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.4 "CCG" means NHS Doncaster Clinical Commissioning Group. A CCG is a body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act).

1.2.5 "Chair of the CCG" is the person appointed to lead the CCG Governing Body and to ensure that it successfully discharges its overall responsibility. The expression "the Chair of the CCG" shall be deemed to include the Deputy Chair of the Governing Body if the Chair is absent from the meeting or is otherwise unavailable.

1.2.6 "Chief Officer" means the CCG Accountable Officer.

1.2.7 "Chief Finance Officer" means the Finance Officer to whom certain functions are delegated in accordance with the scheme of delegation. The individual is a qualified accountant employed by the CCG with responsibility for financial strategy, financial management and financial governance.

1.2.8 "Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the CCG within available resources.

1.2.9 "Committee" means a committee or sub-committee created and appointed by the Governing Body.

1.2.10 "Committee members" means persons formally appointed by the Governing Body to sit on or to chair specific committees.

1.2.11 The "Constitution" describes the governing principles, rules and procedures that are established to ensure probity and accountability in the day to day running of the CCG.
1.2.12 “Contracting and procuring” means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.13 “Corporate Secretary” means a person appointed to act independently of the Governing Body to provide advice on corporate governance issues to the Governing Body and the Chair and to monitor the CCGs’ compliance with the law, Standing Orders, and Department of Health guidance. For the CCG this is the Chief of Corporate Services.

1.2.14 “Deputy Chair” means the non-officer member appointed by the CCG to take on the Chair’s duties in chairing the Governing Body if the Chair is absent for any reason.

1.2.15 “Financial Directions” means any and all Directions made by the Secretary of State from time to time which relate to financial entitlements and or requirements.

1.2.16 “Governing Body” means the members of the CCG Governing Body as listed in the CCG Constitution comprising Chair, Locality Leads, Lay Members, Chief Officer, Chief Finance Officer, Secondary Care Doctor and Registered Nurse. The Governing Body is appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a CCG has made appropriate arrangements for ensuring that it complies with its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and such generally accepted principles of good governance as are relevant to it.

1.2.17 “Group” means Clinical Commissioning Group.

1.2.18 “Lay member / representative” means a non-officer of the Governing Body with responsibilities as defined in the Group’s Constitution.

1.2.19 “LMC” means Doncaster Local Medical Committee which is the statutory representative body of general practice for provider purposes in relation to local primary care medical contracts.

1.2.20 “Locality Lead” means an individual appointed by each Practice within the relevant Locality to represent and act on behalf of the Locality on the Governing Body and relevant Committees.

1.2.21 “Member” means Officer, Non Officer and Locality Lead member as the context permits.

1.2.22 “Member Practice" means general practices as providers of primary medical services to a registered patient list of which the CCG is comprised, as defined within the Group’s Constitution. Each Member Practice is represented by a nominated Practice Representative.

1.2.23 “Nominated officer” means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.24 “Non-officer member” means a member of the Governing Body who is not an officer of the CCG and is not to be treated as an officer. For the CCG this is the Lay Members and the Secondary Care Doctor Member.
1.2.25 "Officer" means employee of the CCG or any other person holding a paid appointment or office with the CCG, but excluding Locality Leads who are defined separately.

1.2.26 "Petition" means a list of signatures from the public urging an authority to do (or not do) something.

1.2.27 "SFIs" means Standing Financial Instructions.

1.2.28 "SOs" means Standing Orders.

1.2.29 "The 2006 Act" means the National Health Service Act 2006.

1.2.30 “The 2012 Act” means the Health & Social Care Act 2012.
SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework and status

1.1.1 NHS Doncaster Clinical Commissioning Group (the CCG) is a statutory body which came into existence from 1st April 2013 under the Health & Social Care Act 2012 (“the 2012 Act”).

1.1.2 The principal place of business of the CCG is per the attached document at Appendix 1.

1.1.3 CCGs are governed by Acts of Parliament, mainly the National Health Service Act 2006 (“the 2006 Act”) and the Health and Social Care Act 2012 (“the 2012 Act”). They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the 2006 Act. The duties of Clinical Commissioning Groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.

1.1.4 These Standing Orders have been drawn up to regulate the proceedings of the CCG so that the Group can fulfill its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related Regulations. They are effective from the date the CCG is established.

1.1.5 The Standing Orders, together with the CCG’s scheme of reservation and delegation and its Prime Financial Policies / Standing Financial Instructions, provide a procedural framework within which the CCG discharges its business. They set out:

   a) the arrangements for conducting the business of the CCG;

   b) the appointment of Member Practice representatives;

   c) the procedure to be followed at meetings of the CCG, the Governing Body and any committees or sub-committees;

   d) the process to delegate powers;

   e) the requirements relating to declaration of interests and standards of conduct. These arrangements comply, and are consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related Regulations and take account as appropriate of any relevant guidance.

1.1.6 The Standing Orders, scheme of reservation and delegation and Prime Financial Policies have effect as if incorporated into the CCG’s Constitution. Member Practices, Officers, Non Officer members, Locality Leads, members, employees and persons working on behalf of the CCG, the Governing Body and committees and sub-committees should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the Standing Orders, scheme of reservation and delegation and Prime Financial Policies // Standing Financial Instructions may be regarded as a disciplinary matter that could result in dismissal.

1.2 Schedule of matters reserved to the CCG and the scheme of reservation and delegation
1.2.1 The 2006 Act (as amended by the 2012 Act) provides the CCG with powers to delegate its functions and those of the Governing Body to certain bodies (such as committees) and certain persons. The CCG has decided that certain decisions may only be exercised in formal session. These decisions and also those delegated are contained in the CCG’s scheme of reservation and delegation (see Section C).

2. OVERLAP WITH OTHER CCG POLICY STATEMENTS / PROCEDURES, REGULATIONS AND THE PRIME FINANCIAL POLICIES

2.1 Policy statements: general principles

2.1.1 The CCG Governing Body will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by CCG. The decisions to approve such policies and procedures will be recorded in an appropriate CCG Governing Body minute and will be deemed where appropriate to be an integral part of the CCG’s Standing Orders and Standing Financial Instructions.

2.2 Specific Policy statements

Notwithstanding the application of Standing Order 2.1.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- The Standards of Business Conduct and Conflicts of Interest Policy for CCG staff;
- Code of Conduct for NHS Managers 2004;
- ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical / external industry;
- CCG staff Expenses Policy.

2.3. Standing Financial Instructions

2.3.1 Standing Financial Instructions adopted by the CCG Governing Body in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

2.4 Specific guidance

2.4.1 Notwithstanding the application of Standing Order 2.1.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following legislation and guidance issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Confidentiality: NHS Code of Practice 2003;
- Human Rights Act 1998;
- Freedom of Information Act 2000; and
3. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

3.1 Eligibility for CCG Membership

3.1.1 Clinical Commissioning Groups are clinically led membership organisations made up of general practices. These providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract will be eligible to apply for membership of this Group. Member Practices are those which pay the statutory levy to their Local Medical Committee.

3.1.2 NHS Doncaster Clinical Commissioning Group comprises all the providers, (as set out in 3.2.1 of the Constitution), based in the geographic area of Doncaster Metropolitan Borough Council. Providers that are based outside of that area but have branch surgeries within it, are not members of the NHS Doncaster Clinical Commissioning Group.

4. THE CCG GOVERNING BODY: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

4.1 Composition of the Governing Body

4.1.1 The Governing Body shall not have less than 18 members and comprises of:

   a) the Chair;
   b) ten representatives of Member Practices otherwise called “Locality Leads”;
   c) three Lay Members:
      i) one to lead on audit, remuneration and conflict of interest matters (and also act as Deputy Chair of the Governing Body),
      ii) one to lead on patient and public participation matters;
      iii) one to lead on primary care commissioning matters;
   d) one Registered Nurse;
   e) one Secondary Care Specialist Doctor;
   f) the Accountable Officer;
   g) the Chief Finance Officer.

4.2 Appointment of Chair and members of the Governing Body

4.2.1 The appointment process for the Chair and members of the Governing Body are set out in the Constitution.

4.3 Terms of Office of the Chair and members of the Governing Body

4.3.1 The Regulations setting out the period of tenure of office of the Chair and members of the Governing Body and for the termination or suspension of office of the Chair and members of the Governing Body are set out in the Constitution.

4.4 Appointment and Powers of Deputy Chair of the Governing Body

4.4.1 The Deputy Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act. The Deputy Chair shall automatically become the Chair of the Governing Body for the interim period where a Chair has been removed from office or during an extended period of sickness absence,
maternity leave or equivalent and another Chair is not immediately appointed. The Lay Member with a lead role in overseeing key elements of financial management and audit functions as the Deputy Chair to the Governing Body.

4.4.2 Where the Chair of the Governing Body has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair of the Governing Body until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

4.5 Joint Members

4.5.1 Where more than one person is appointed jointly to a post, those persons shall count for the purpose of Standing Order 4.1.1 as one person.

4.5.2 Where the office of a Member of the Governing Body is shared jointly by more than one person:

   (a) Either or both of those persons may attend or take part in meetings of the Governing Body;
   (b) If both are present at a meeting they should cast one vote if they agree;
   (c) In the case of disagreements no vote should be cast;
   (d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 5.6 Quorum.

4.6 HealthWatch

4.6.1 Local Authorities are required to make arrangements for public engagement in health and social services delivery via the commissioning of local HealthWatch services. The CCG shall work in partnership with HealthWatch in respect of its involvement duties.

4.7 Role of Governing Body members

4.7.1 The Governing Body will function as a corporate decision-making body. Officer members, Non-Officer members and Locality Leads as laid out in the Constitution will be full and equal members. Their role as members of the Governing Body will be to consider the key strategic and managerial issues facing the CCG in carrying out its statutory and other functions.

4.8 Governing Body Members

4.8.1 Governing Body Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

4.9 Chief Officer

4.9.1 The Chief Officer shall be responsible for the overall performance of the functions of the CCG. He/she is the Accountable Officer for the CCG and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with any national requirements for CCG Chief Officers.

4.10 Chief Finance Officer

4.10.1 The Chief Finance Officer shall be responsible for the provision of financial advice to the
CCG and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with Chief Officer for ensuring the discharge of obligations under relevant Financial Directions.

4.11 Chair

4.11.1 The Chair shall be responsible for the operation of the Governing Body and will chair all Governing Body Meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

4.11.2 The Chair shall work in close harmony with the Chief Officer and shall ensure that key and appropriate issues are discussed by the Governing Body in a timely manner with all the necessary information and advice being made available to the Governing Body to inform the debate and ultimate resolutions.

4.12 Corporate Role of the Governing Body

4.12.1 All business shall be conducted in the name of the CCG.

4.12.2 All funds received on trust shall either be held in the name of the CCG as corporate trustee or another assigned body.

4.12.3 The powers of the CCG established under statute shall be exercised by the Governing Body meeting in public session except as otherwise provided for in Standing Order 5.

4.12.4 The Governing Body shall define and regularly review the functions it exercises on behalf of the NHS Commissioning Board and the Secretary of State.

4.13 Schedule of Matters reserved to the Governing Body and Scheme of Delegation

4.13.1 The Governing Body has resolved that certain powers and decisions may only be exercised by the Governing Body in formal session. These powers and decisions are set out in the ‘Schedule of Matters Reserved to the Governing Body’ and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

5. MEETINGS OF THE CCG

5.1 Calling meetings

5.1.1 Ordinary meetings of the Governing Body shall be held at regular intervals at such times and places as the Governing Body may determine.

5.1.2 Extra-ordinary Governing Body meetings can be called at the request of the Chair of the meeting, the Accountable Officer or the Chief Finance Officer.

5.1.3 A meeting of all nominated Practice Representatives will be called on an annual basis, representing the Group as a whole. Quorum shall be 66% of nominated Practice Representatives or their nominated Deputies. Decision-making shall be based on agreement by 75% or more of meeting attendees and votes by proxy. Additional meetings of all nominated Practice Representatives may be called at the Chair’s discretion. In accordance with the Scheme of Reservation & Delegation this meeting is authorised to:
a) delegate additional functions to the Governing Body;
b) approve changes to the Constitution and associated Standing Orders and Scheme of Reservation & Delegation;
c) approve the arrangements for identifying Practice Representatives to represent Practices in matters concerning the work of the Group and appointing clinical leaders (Locality Leads) to represent the Group’s Member Practices on the Group’s Governing Body;
d) approve arrangements for identifying the Group’s proposed Accountable Officer;
e) agree the vision, values and overall strategic direction of the Group.

5.2 Agenda, supporting papers and the Business to be transacted

5.2.1 Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair of the meeting at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 6 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 3 working days before the date the meeting will take place.

5.2.2 Agendas and certain papers for the Group’s Governing Body – including details about meeting dates, times and venues - will be published on the Group’s website at www.doncasterccg.nhs.uk and also available upon application to our Headquarters.

5.3 Petitions

5.3.1 Where a petition has been received by the CCG the Chair shall include the petition as an item for the agenda of the next meeting of the Governing Body.

5.4 Chair of Meeting

5.4.1. At any meeting of the Group or its Governing Body or of a Committee or Sub-Committee, the Chair of the Group, Governing Body, Committee or Sub-Committee, if any and if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if any and, if present, shall preside.

5.4.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a Chair or Deputy a member of the Group, Governing Body, Committee or Sub-Committee respectively shall be chosen by the members present, or by the majority of them and shall preside.

5.5 Chair's Ruling

5.5.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity and their interpretation of the Constitution, Standing Orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

5.6 Quorum

5.6.1 The full membership of the Group's Governing Body is 18. Quorum is 9 members including at least 5 clinical members. A Deputy is permitted to attend for a member and be included in the quorum if they have formal acting-up status. If quorum is lost due to a member or members being disqualified from taking part in a vote or discussion due to a declared interest, the minimum quorum for decision-making is 5 members including the Accountable Officer or Chair/Deputy Chair and conflicts of interest will be managed in accordance with the Constitution and the policy of the organisation.
5.6.2 For all other of the Group’s Committees and Sub-Committees, including the Governing Body’s Committees and Sub-Committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.

5.7 Decision making

5.7.1 Paragraph 6 of the Group’s Constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the Group’s statutory functions. Generally it is expected that at the Group’s / Governing Body’s meetings decisions will be reached by consensus. Should this not be possible then a vote of governing body members will be required, the process for which is set out below:

a) Eligibility – All Members of the Governing Body as listed in Section 6.6.2 of the Constitution;

b) Majority necessary to confirm a decision – a simple majority (over 50%) of voting members present at the meeting;

c) Casting vote – Chair of the meeting;

d) Dissenting views – Members taking a dissenting view but losing a vote may request to have their dissent recorded in the minutes.

5.7.2 Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

5.7.3 For all other of the Group’s Committees and Sub-Committees, including the Governing Body’s Committees and Sub-Committee, the details of the process for holding a vote are set out in the appropriate terms of reference.

5.8 Emergency powers and urgent decisions

5.8.1 Emergency meetings can be called at the request of the Chair of the meeting, the Accountable Officer or the Chief Finance Officer.

5.8.2 The need for an urgent decision exceeding individuals’ delegated authority can be agreed by the Accountable Officer or their nominated Deputy and the Chair or Deputy Chair. Such decisions must be reported to the next meeting and recorded in the minutes of the meeting.

5.9 Suspension of Standing Orders

5.9.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these standing orders may be suspended at any meeting, provided a simple majority (over 50%) of Group members are in agreement.

5.9.2 A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.9.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body’s Audit Committee for review of the reasonableness of the decision to suspend standing orders.

5.10 Variation and amendment of Standing Orders

5.10.1 These Standing Orders shall not be varied except in the following circumstances:

- Upon a recommendation of the Chair or Chief Officer included on the agenda for
the meeting;
- That two-thirds of the Governing Body members are present at the meeting where the variation or amendment is being discussed, and that at least half of the CCG’s Non-Officer Members vote in favour of the amendment;
- Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

5.11 Record of Attendance

5.11.1 The names of the Chair and Members present at the meeting shall be recorded in the minutes of the Group’s meetings. The names of all members of the Governing Body’s Committees / Sub-Committees present shall be recorded in the minutes of the respective Governing Body Committee / Sub-Committee meetings.

5.12 Minutes

5.12.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting and they shall be signed by the person presiding at it.

5.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

5.12.3 Minutes shall be circulated in accordance with members’ wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by the Freedom of Information Act.

5.13 Admission of Public and the Press

5.13.1 Subject to Standing Order 5.13.2 below, meetings of the CCG Governing Body shall normally be open to the public.

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

5.13.3 In the event the public could be excluded from a meeting of the CCG pursuant to Standing Order 5.13.2 above, the CCG shall consider whether the subject matter of the meeting would in any event be subject to disclosure under the Freedom of Information Act 2000, and if so, whether the public should be excluded in such circumstances.

5.13.4 The Chair (or Deputy Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the CCG’s business shall be conducted without interruption and disruption.

5.13.5 Without prejudice to the power to exclude the public pursuant to Standing Order 5.13.2 above the CCG may resolve (as permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) to exclude the public from a meeting (whether during whole or part of the proceedings) to suppress or prevent disorderly conduct or behaviour.

5.13.6 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into
meetings of the Group or any Committee or Sub-Committee thereof. Such permission shall be granted only upon resolution of the Chair.

5.13.7 The CCG will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the CCG Governing Body’s meetings and may change, alter or vary these terms and conditions as it deems fit.

6. **APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

6.1 **Appointment of Committees and Sub Committees**

6.1.1 The Group may appoint Committees and Sub-Committees of the Group, subject to any regulations made by the Secretary of State and make provision for the appointment of Committees and Sub-Committees of its Governing Body. Where such Committees and Sub-Committees of the Group, or Committees and Sub-Committees of its Governing Body, are appointed they are included in paragraph 6 of the Group’s Constitution.

6.1.2 Other than where there are statutory requirements, such as in relation to the Governing Body’s Audit Committee or Remuneration Committee, the Group shall determine the membership and terms of reference of Committees and Sub-Committees and shall, if it requires, receive and consider reports of such Committees at the next appropriate meeting of the Group.

6.1.3 The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body’s Committees and Sub-Committee and all Committees and Sub-Committees unless stated otherwise in the Committee or Sub-Committee’s terms of reference.

6.2 **Joint Committees**

6.2.1 Joint committees may be appointed by the CCG by joining together with one or more other health service bodies consisting wholly or partly of Officers, Non Officers or Locality Leads of the CCG or other health service bodies, or wholly of persons who are not Officers, Non Officers or Locality Leads of the CCG or other health service bodies in question.

6.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the CCG or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are Officers of the CCG or health bodies in question) or wholly of persons who are not Officers of the CCG or health bodies in question or the committee of the CCG or health bodies in question.

6.3 **Applicability of Standing Orders and Standing Financial Instructions to Committees**

6.3.1 The Standing Orders and Standing Financial Instructions of the CCG, as far as they are applicable, shall as appropriate apply to meetings of the CCG and any committees established by the CCG. In which case the term “Chair” is to be read as a reference to the Chair of the Governing Body, or other committee as the context permits, and the term “member” is to be read as a reference to a member of the Governing Body, or other committee also as the context permits. (There is no requirement to hold meetings of committees established by the CCG in public excepting the Primary Care Commissioning Committee.)

6.4 **Terms of Reference**
6.4.1 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Governing Body), as the Governing Body shall decide and shall be in accordance with any legislation and Regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.5 Delegation of powers by Committees to Sub-Committees

6.5.1 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Governing Body (or CCG in the case of sub-groups established by the CCG).

6.6 Approval of Appointments to Committees

6.6.1 The Group shall approve the appointments to each of the committees which it has formally constituted. Where the Governing Body on behalf of the Group determines, and Regulations permit, that persons, who are not Officers, Non Officers or Locality Leads, shall be appointed to a committee the terms of such appointment shall be within the powers of the Governing Body as defined by the Secretary of State. The Governing Body shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.7 Appointments for Statutory functions

6.7.1 Where the Governing Body is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Governing Body such appointment shall be made in accordance with the Regulations and directions made by the Secretary of State.

6.8 Committees established by the CCG Governing Body

6.8.1 The committees, sub-committees, and joint-committees established by the Governing Body are listed below.

6.9 Audit Committee

6.9.1 In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, an Audit Committee will be established and constituted to provide the Governing Body with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and Regulations governing the NHS. The Terms of Reference will be approved by the Governing Body and reviewed on a periodic basis, and include information on the membership of the Audit Committee.

6.9.2 The chair of the Audit Committee is appointed in line with current approved practice.

6.9.3 In addition the Group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body’s main function, to its Audit Committee:

i) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and assurance across the activities of the Group (both clinical and non clinical) that support the achievement of these objectives.

ii) Overseeing and monitoring the Internal Audit programme of work.
iii) Review the findings of other significant assurance functions both internal and external and consider the implications for governance of the Group.

iv) Ensuring that the Group has appropriate arrangements for countering fraud and review the outcomes of counter fraud work.

v) Monitoring the integrity of the financial statements of the Group and any formal announcements relating to the Group’s financial performance.

vi) Ensuring that the systems for financial reporting to the Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

vii) Reviewing schedules of debtor and creditor balances over 6 months old over £5,000 and consider explanations and action plans.

viii) Establishing Sub-Committees to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

ix) Approving corporate policies and procedures within the functions of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

6.10 Remuneration Committee

6.10.1 In line with the requirements of the NHS Codes of Conduct and Accountability, a Remuneration Committee will be established and constituted.

6.10.2 The Remuneration Committee, which is accountable to the Group’s Governing Body, makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the Remuneration Committee, which includes information on the membership of the Remuneration Committee.

6.10.3 In addition the Group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body’s main function, to its Remuneration Committee:

i) Advising the Governing Body on all aspects of salary (including performance related pay elements, bonuses and allowances), provision for other benefits including pensions and lease cars (where applicable) not covered by Agenda for Change.

ii) Advising the Governing Body on arrangements for termination of employment (including compulsory and voluntary redundancy payments and mutually agreed severance payments) and other contractual terms and conditions.

iii) Advising the Governing Body on the remuneration, allowances and terms of service of senior managers covered by the Very Senior Managers pay framework ensuring that the terms and conditions of service, remuneration and pay awards are in line with nationally agreed guidance.

iv) Monitoring and evaluating the performance of individual Executive Members.

v) Advising and overseeing appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance.
as appropriate.

vi) Advising the Governing Body on the remuneration, allowances and terms of service for the Chairs and Members of the Group.

vii) Reporting to the Governing Body that it has met and performed its function, within recognised national guidelines.

viii) Establishing Sub-Committees to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

ix) Approving human resources policies and procedures within the functions of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

6.11 Quality and Patient Safety Committee

6.11.1 The Quality & Patient Safety Committee is accountable to the Group’s Governing Body for monitoring the quality and safety of all services commissioned by the Group. The Governing Body has approved and keeps under review the terms of reference for the Quality & Safety Committee, which includes information on the membership of the Quality & Safety Committee.

6.11.2 In addition the Group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body’s main function, to its Quality & Safety Committee:

i) Receiving and acting upon reports from regulatory and other competent bodies and ensure action plans are delivered.

ii) Receiving regular reports regarding quality and safety legislative and contractual requirements including patient safety and clinical effectiveness data, and taking mitigating action as necessary.

iii) Ensuring that significant clinical risks are identified and reported on the Risk Register, escalating to the Assurance Framework where necessary.

iv) Establishing Sub-Committees to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

v) Developing and approving clinical policies and procedures within the functions of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

6.12 Engagement & Experience Committee

6.12.1 The Engagement & Experience Committee is accountable to the Group’s Governing Body for ensuring effective engagement with patients and delivering the public sector equality duties. The Governing Body has approved and keeps under review the terms of reference for the Engagement & Experience Committee, which includes information on the membership of the Engagement & Experience Committee.

6.12.2 In addition the Group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body’s main function, to its Engagement & Experience Committee:

i) Developing comprehensive mechanisms to effectively engage with and gather insight from patients and the public, including disadvantaged groups.

ii) Ensuring that patient experience and feedback from patients, carers and other stakeholders is measured and analysed effectively and is used to influence decision making throughout the
commissioning cycle.

iii) Acting as a coordinating group for all patient and public engagement activity and patient experience data.

iv) Developing partnerships with other engagement networks.
v) Developing, implementing and monitoring a Patient Engagement Strategy.

vi) Ensuring that the organisation considers equality and human rights when designing, delivering and reviewing its business priorities.

vii) Establishing Sub-Committees to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

viii) Developing and approving engagement and communication policies and procedures within the functions of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

6.13 Executive Committee

6.13.1 The Executive Committee is accountable to the Group's Governing Body for directing operational aspects of the organisation and overseeing the provider contractual reporting structure. The Governing Body has approved and keeps under review the terms of reference for the Executive Committee, which includes information on the membership of the Executive Committee.

6.13.2 In addition the Group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body's main function, to its Delivery & Performance Committee:

i) Coordinating and directing the operations of the CCG in accordance with the strategic direction set by the Governing Body, ensuring operational delivery on behalf of the Governing Body.

ii) Deploying the resource of the organisation effectively and efficiently to deliver the strategies of the organisation.

iii) Horizon scanning to enable review and discussion of the implications and implementation of key policy documentation issued by NHS England, the Department of Health and other statutory authorities for recommendation to the Governing Body regarding the potential impact on plans and on services commissioned by the CCG.

iv) Overseeing the operational commissioning and contracting of healthcare services for the Doncaster population.

v) Overseeing integration of commissioning functions across the Doncaster health and social care community and a wider footprint.

vi) Approving proposals, business cases, service change, funding requests and procurements where they are in line with the CCG’s strategic plan, financial scheme of delegation and approved budgets.

vii) Ensuring that the organisation has systems in place to obtain appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health.

viii) Taking decisions and action on any other appropriate matter within the delegated authority of its individual members.

ix) Developing and approving policies and procedures relating to CCG operations within the functions of the Committee as set out in its Terms of Reference.

x) Establishing Sub-Groups to assist in discharging delegated responsibilities of the Committee as set out in its Terms of
6.14 **Primary Care Commissioning Committee**

6.14.1 The Primary Care Commissioning Committee is accountable to the Group’s Governing Body. The Committee has been established to enable the members to make collective decisions on the review, planning and procurement of primary care services in Doncaster under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG which will sit alongside the delegation and terms of reference of the Committee.

6.14.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:

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

6.14.3 The CCG will also carry out the following activities:

- To plan, including needs assessment, primary medical care services in Doncaster;
- To undertake reviews of primary medical care services in Doncaster;
- To co-ordinate a common approach to the commissioning of primary care services generally;
- To manage the budget for commissioning of primary medical care services in Doncaster.

6.15 **Other Committees**

6.15.1 The Governing Body has also established some joint committees as required to discharge the CCG’s responsibilities:

- Joint Committee of CCGs: Working Together.

7. **ARRANGEMENTS FOR THE EXERCISE OF CCG FUNCTIONS BY DELEGATION**

7.1 Delegation of Functions to Committees, Officers, Locality Leads or other bodies

7.1.1 Subject to such directions as may be given by the Secretary of State, the Governing Body may make arrangements for the exercise, on behalf of the Governing Body, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 6, or by an Officer or Locality Lead of the CCG, or by another body as defined in Standing Orders, in each case subject to such restrictions and conditions as the CCG thinks fit.

7.2 Emergency Powers and urgent decisions
7.2.1 The powers which the Governing Body has reserved to itself within these Standing Orders (see Standing Order 4) may in emergency or for an urgent decision be exercised by the Chief Officer and the Chair after having consulted at least two non-officer members. The exercise of such powers by the Chief Officer and Chair shall be reported to the next formal meeting of the CCG Governing Body in public session for formal ratification.

7.3 Delegation to Committees

7.3.1 The Governing Body shall agree from time to time to the delegation of executive powers to be exercised by the CCG, other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State or NHS England. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Governing Body or by the CCG in respect of its sub-committees.

7.3.2 When the Governing Body is not meeting as the CCG in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the CCG in public session.

7.4 Delegation to Officers

7.4.1 Those functions of the CCG which have not been retained as reserved by the Governing Body or delegated to the CCG, other committee or sub-committee or joint-committee shall be exercised on behalf of the CCG by the Chief Officer. The Chief Officer shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the CCG.

7.4.2 The Chief Officer shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Governing Body. The Chief Officer may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Governing Body.

7.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Governing Body of the Chief Finance Officer to provide information and advise the Governing Body in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Officer for operational matters.

7.5 Schedule of Matters Reserved to the CCG and Scheme of Delegation of powers

7.5.1 The arrangements made by the Governing Body as set out in the “Schedule of Matters Reserved to the Governing Body” and “Scheme of Delegation” of powers shall have effect as if incorporated in these Standing Orders.

7.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

7.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the CCG and the Governing Body for action or ratification. All members of the CCG Governing Body and CCG and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Officer as soon as possible.
8. DUTIES AND OBLIGATIONS OF GOVERNING BODY MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

8.1 Requirements for Declaring Interests and applicability to Governing Body and Clinical Commissioning Group Members

8.1.1 The NHS Code of Accountability requires CCG Governing Body members and CCG members to declare any personal or business interest which may influence or may be perceived to influence their judgement, including without limitation interests which are “relevant and material” as defined by Standing Order 8.2.1 below. All existing Governing Body members should declare such interests. Any Governing Body members appointed subsequently should do so on appointment. Details are set out in the CCG Standards of Business Conduct and Conflicts of Interest Policy.

8.2 Interests which are relevant and material

8.2.1 Interests which should be regarded as "relevant and material" for the purposes of Standing Order 8.1.1 are those listed in the Standards of Business Conduct & Conflicts of Interest Policy available on the CCG website.

a) Roles and responsibilities held within member practices;

b) Directorships, including non-executive directorships, held in private companies or PLCs;

c) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England;

d) Shareholdings (more than 5%) of companies in the field of health and social care;

e) A position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;

f) Any connection with a voluntary or other organisation (public or private) contracting for NHS services;

g) Research funding/grants that may be received by the individual or any organisation in which they have an interest or role;

h) Any other role or relationship which the public could perceive would impair or otherwise influence the individual’s judgment or actions in their role within the CCG.

8.3 Advice on Interests

8.3.1 If Governing Body members or employees have any doubt about the relevance of an interest, this should be discussed with the Conflict of Interest Guardian Chair of the CCG or the Chief Officer as appropriate, or with the Corporate Secretary.

8.3.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Governing Body) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

8.4 Recording of Interests in CCG Governing Body and Clinical Commissioning Group(s) minutes

8.4.1 At the time Governing Body members’ interests are declared, they should be recorded in the CCG Governing Body minutes or in the case of the CCG’s Committees, in the Committee minutes.
Any changes in interests should be declared at the next CCG Governing Body meeting or CCG meeting following the change occurring and recorded in the minutes of that meeting.

Publication of declared interests in Annual Report

Governing Body members' interests should be published in the CCG's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

Conflicts of interest which arise during the course of a meeting

During the course of a CCG Governing Body meeting or a CCG meeting, if a conflict of interest is established, the Governing Body or CCG member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

Register of Interests

The Chief Officer will ensure that a Register of Interests is established to record formally declarations of interests by Officer members, Non Officer members, Locality Leads and Member Practices that are relevant and material (as defined in Standing Order 8.2.1).

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Governing Body Register will be available to the public and the Chief Officer will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

Exclusion of Chair and Members in proceedings on account of pecuniary interest

For the sake of clarity in interpreting this Standing Order:
(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
(ii) "contract" shall include any proposed contract or other course of dealing;
(iii) subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-
   a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
   b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.
(iv) a person shall not be regarded as having a pecuniary interest in any contract if:-
   a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
   b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
   c) those securities of any company in which he/her (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital,
whichever is the less.

8.8.2 Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 8.2.1.

8.9 Exclusion in proceedings of the CCG Governing Body or Clinical Commissioning Group

8.9.1 Subject to the following provisions of this Standing Order, if the Chair or a member of the CCG Governing Body, or Chair of the CCG or member of the CCG has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the CCG Governing Body or CCG at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.9.2 The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed.

8.9.3 The Governing Body may exclude the Chair or a member of the Governing Body from a meeting of the Governing Body while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

8.9.4 Any remuneration, compensation or allowance payable to the Chair or a member by virtue of paragraph 11 of Schedule 3 to the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.9.5 This Standing Order applies to a committee (including the CCG) or sub-committee and to a joint committee or sub-committee as it applies to the CCG and applies to a member of any such committee or sub-committee (whether or not he is also a member of the CCG) as it applies to a Member of the CCG.

8.10 CCG Policy and National Guidance

8.10.1 All CCG staff and members of the Governing Body must comply with the CCG’s Standards of Business Conduct and Conflicts of Interests Policy and the national guidance contained in HSG (93) 5 on ‘Standards of Business Conduct for NHS staff’, the Code of Conduct for NHS Managers 2004 and the ABPI Code of Professional Conduct relating to hospitality/gifts/sponsorship.

8.11 Interest of Officers in Contracts

8.11.1 Any officer or employee of the CCG who comes to know that the CCG has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 8.2.1) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Officer or Corporate Secretary as soon as practicable.

8.11.2 An Officer should also declare to the Chief Officer any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the CCG.

8.11.3 The CCG will require interests, employment or relationships so declared to be entered in a register of interests of staff.
8.12 **Canvassing of and Recommendations by Members in Relation to Appointments**

8.12.1 Canvassing of members of the CCG or of any Committee of the CCG directly or indirectly for any appointment under the CCG shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.12.2 Members of the CCG shall not solicit for any person any appointment under the CCG or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate’s ability, experience or character for submission to the CCG.

8.12.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.13 **Relatives of Members or Officers**

8.13.1 Candidates for any staff appointment under the CCG shall, when making an application, disclose in writing to the CCG whether they are related to any member or the holder of any office under the CCG. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/herself liable to instant dismissal.

8.13.2 The Chair and every member and officer of the CCG shall disclose to the CCG Governing Body any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Officer to report to the CCG Governing Body any such disclosure made.

8.13.3 On appointment, members (and prior to acceptance of an appointment in the case of Governing Body Members) should disclose to the CCG whether they are related to any other member or holder of any office under the CCG.

8.13.4 Where the relationship to a member of the CCG is disclosed, Standing Order 8 shall apply.

9. **CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS**

9.1 **Custody of Seal**

9.1.1 The common seal of the CCG shall be kept by the Chief Officer or a nominated Manager by him/her in a secure place.

9.2 **Sealing of Documents**

9.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Officer, and not also from the originating department, and shall be attested by them. The following individuals or officers are authorised to authenticate its use by their signature:

- the Accountable Officer or their nominated Deputy;
- the Chair of the Governing Body or their nominated Deputy;
- the Chief Finance Officer or their nominated Deputy.

9.3 **Register of Sealing**
9.3.1 The Chief Officer shall keep a register in which he/she, or another manager of the CCG authorised by him/her, shall enter a record of the sealing of every document.

9.4 Use of Seal – General guide

9.4.1 The Seal shall normally be used in the case of:

- All contracts for capital works exceeding £100,000
- All lease agreements where the annual lease charge exceeds £50,000 per annum and the period of the lease exceeds beyond five years;
- Any other lease agreement where the total payable under the lease exceeds £100,000; and
- Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000.

9.5 Signature of documents

9.5.1 Where any document will be a necessary step in legal proceedings on behalf of the CCG, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Officer. The following individuals are authorised to execute a document on behalf of the Group by their signature.

- the Accountable Officer or their nominated Deputy;
- the Chair of the Governing Body or their nominated Deputy;
- the Chief Finance Officer or their nominated Deputy.

10. MISCELLANEOUS

10.1 Joint Finance Arrangements

10.1.1 The Governing Body may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 256 of the NHS Act 2006. The Governing Body may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 256 of the NHS Act 2006.
**SECTION C - SCHEME OF RESERVATION AND DELEGATION**

The overarching scheme of delegation from the CCG Constitution as approved by Members is replicated here for completeness. There follows the operational scheme of delegation reserved to the Governing Body for approval.

**C1 – OVERARCHING SCHEME OF DELEGATION**

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
<th>Reserved to the Membership</th>
<th>Reserved or delegated to Governing Body</th>
<th>Accountable Officer</th>
<th>Chief Finance Officer</th>
<th>Remuneration Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.1 Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.2 Consideration and approval of applications to the NHS Commissioning Board on any matter concerning changes to the Group’s Constitution, including terms of reference for the Group’s Governing Body, its Committees, membership of Committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
<td>X</td>
<td></td>
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<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.3 Exercise or delegation of those functions of the Group which have not been retained as reserved by the Group, delegated to the Governing Body or other Committee or Sub-Committee or [specified] Member or employee.</td>
<td></td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.4 Prepare the Group’s overarching scheme of reservation and delegation, which sets out those decisions of the Group reserved to the membership and those delegated to the Group’s Governing Body, Committees and Sub-Committees of the Group, or its Members or employees and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the Governing Body’s Committees and Sub-Committees, members of the Governing Body, an individual who is Member of the Group but not the Governing Body or a specified person for inclusion in the Group’s Constitution.</td>
<td></td>
<td></td>
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<td>X</td>
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</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.5 Approval of the Group’s overarching scheme of reservation and delegation.</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.6 Prepare and approve the Group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the Group.</td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.7 Approval of the Group’s operational scheme of delegation that underpins the Group’s ‘overarching scheme of reservation and delegation’ as set out in its Constitution.</td>
<td></td>
<td>X</td>
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<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.8 Prepare detailed financial policies that underpin the Group’s prime financial policies.</td>
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<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.9 Approve detailed financial policies.</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.10 Approve arrangements for managing exceptional funding requests.</td>
<td></td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>1. REGULATION AND CONTROL</td>
<td>1.11 Set out who can execute a document by signature / use of the seal.</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>2. PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>2.1 Approve the arrangements for • identifying Practice Representatives to represent Practices in matters concerning the work of the Group; and • appointing clinical leaders (Locality Leads) to represent the Group’s Members on the Group’s Governing Body.</td>
<td></td>
<td>X</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<tr>
<td>2. PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>2.2 Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.</td>
<td></td>
<td></td>
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<tr>
<td>2. PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
<td>2.3 Approve arrangements for identifying the Group's proposed Accountable Officer.</td>
<td>X</td>
<td></td>
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<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.1 Agree the vision, values and overall strategic direction of the Group.</td>
<td>X</td>
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<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.2 Approval of the Group’s operating structure.</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.3 Approval of the Group’s commissioning plan.</td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.4 Approval of the Group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the Constitution.</td>
<td></td>
<td></td>
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<tr>
<td>3. STRATEGY AND PLANNING</td>
<td>3.5 Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the Group’s ability to achieve its agreed strategic aims.</td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
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<tr>
<td>4. ANNUAL REPORTS AND ACCOUNTS</td>
<td>4.1 Approval of the Group’s annual report and annual accounts.</td>
<td></td>
<td></td>
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<td>X</td>
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<tr>
<td>4. ANNUAL REPORTS AND ACCOUNTS</td>
<td>4.2 Approval of the arrangements for discharging the Group’s statutory financial duties.</td>
<td></td>
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</tr>
<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.1 Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.</td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.2 Approve terms and conditions of employment for all employees of the Group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.3 Approve any other terms and conditions of services for the Group’s employees.</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.4 Determine the terms and conditions of employment for all employees of the Group.</td>
<td></td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.5 Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.</td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.6 Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.</td>
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</tr>
<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.7 Approve disciplinary arrangements for employees, including the Accountable Officer (where he/she is an employee or member of the Group) and for other persons working on behalf of the Group.</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.8 Review disciplinary arrangements where the Accountable Officer is an employee or member of another Clinical Commissioning Group.</td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>5. HUMAN RESOURCES</td>
<td>5.9 Approval of the arrangements for discharging the Group's statutory duties as an employer.</td>
<td></td>
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<td>X</td>
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<tr>
<td>5. HUMAN RESOURCES</td>
<td>5. 10 Approve human resources policies for employees and for other persons working on behalf of the Group</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>6. QUALITY AND SAFETY</td>
<td>6.1 Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.</td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
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<tr>
<td>6. QUALITY AND SAFETY</td>
<td>6.2 Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.</td>
<td></td>
<td>X</td>
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<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.1 Approve the Group’s counter fraud and security management arrangements.</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.2 Approval of the Group’s risk management arrangements.</td>
<td></td>
<td>X</td>
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<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.3 Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
<td></td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.4 Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the Group.</td>
<td></td>
<td>X</td>
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<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.5 Approve proposals for action on litigation against or on behalf of the Group.</td>
<td></td>
<td>X</td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<tr>
<td>7. OPERATIONAL AND RISK MANAGEMENT</td>
<td>7.6 Approve the Group’s arrangements for business continuity and emergency planning.</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>8. INFORMATION GOVERNANCE</td>
<td>8.1 Approve the Group’s arrangements for handling complaints.</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>8. INFORMATION GOVERNANCE</td>
<td>8.2 Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>9. TENDERING AND CONTRACTING</td>
<td>9.1 Approval of the Group’s contracts for any commissioning support.</td>
<td></td>
<td></td>
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<td>X</td>
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<tr>
<td>9. TENDERING AND CONTRACTING</td>
<td>9.2 Approval of the Group’s contracts for corporate support (for example finance provision).</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>10. PARTNERSHIP WORKING</td>
<td>10.1 Approve decisions that individual members or employees of the Group participating in joint arrangements on behalf of the Group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.</td>
<td></td>
<td></td>
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<td>X</td>
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<tr>
<td>10. PARTNERSHIP WORKING</td>
<td>10.2 Approve decisions delegated to joint committees established under section 75 of the 2006 Act.</td>
<td></td>
<td></td>
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<tr>
<td>Policy Area</td>
<td>Decision</td>
<td>Reserved to the Membership</td>
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<tr>
<td>11. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>11.1 Approval of the arrangements for discharging the Group’s statutory duties associated with its commissioning functions.</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>11. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES</td>
<td>11.2 Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies)</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>12. COMMUNICATIONS</td>
<td>12.1 Approving arrangements for handling Freedom of Information requests.</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>12. COMMUNICATIONS</td>
<td>12.2 Determining arrangements for handling Freedom of Information requests.</td>
<td></td>
<td></td>
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</tbody>
</table>
# C2 – Operational Scheme of Delegation

## Reservations to the Governing Body

<table>
<thead>
<tr>
<th>Body / Individual</th>
<th>Delegation</th>
<th>Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Governing Body</strong></td>
<td><strong>General Enabling Provision</strong>&lt;br&gt;The Governing Body may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</td>
<td>Not delegated</td>
</tr>
<tr>
<td><strong>The Governing Body</strong></td>
<td><strong>Functions</strong>&lt;br&gt;The functions that the Group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health’s <em>Functions of Clinical Commissioning Groups</em>. They relate to:&lt;br&gt; a) commissioning certain health services (where the NHS Commissioning Board is not under a duty to do so) that meet the reasonable needs of:&lt;br&gt; i) all people registered with Member GP practices, and&lt;br&gt; ii) people who are usually resident within the area and are not registered with a member of any Clinical Commissioning Group;&lt;br&gt; b) commissioning emergency care for anyone present in the Group’s area;&lt;br&gt; c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group’s employees;&lt;br&gt; d) determining the remuneration and travelling or other allowances of members of its Governing Body.</td>
<td>Not delegated</td>
</tr>
<tr>
<td><strong>The Governing Body</strong></td>
<td><strong>Regulations and Control</strong>&lt;br&gt;1. Approve Standing Orders (SOs), a schedule of matters reserved to the Governing Body and Standing Financial Instructions for the Regulation of its proceedings and business.&lt;br&gt;2. Suspend Standing Orders.&lt;br&gt;3. Vary or amend the Standing Orders.&lt;br&gt;4. Approve a scheme of delegation of powers from the Governing Body to the other committees.&lt;br&gt;5. Require and receive the declaration of Governing Body members’ interests which may conflict with those of the CCG and, taking account of any waiver which the Secretary of State for Health may have made in any case, determining the extent to which that member may remain involved with the matter under consideration.&lt;br&gt;6. Require and receive the declaration of officers’ interests that may conflict with those of the CCG.&lt;br&gt;7. Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the CCG and to agree modifications thereto.&lt;br&gt;8. Receive reports from committees including those that the CCG is required by the Secretary of State for Health</td>
<td>Not delegated</td>
</tr>
</tbody>
</table>
### RESERVATIONS TO THE GOVERNING BODY

<table>
<thead>
<tr>
<th>BODY / INDIVIDUAL</th>
<th>DELEGATION</th>
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<tr>
<td>or other Regulation to establish and to action appropriately.</td>
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<tr>
<td>Confirm the recommendations of the CCG’s committees where the committees do not have executive powers.</td>
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</tr>
<tr>
<td>Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Governing Body.</td>
<td></td>
</tr>
<tr>
<td>Ratify use of the seal.</td>
<td></td>
</tr>
<tr>
<td>Approve any urgent decisions taken by the Chair of the CCG and Chief Officer for ratification by the CCG in public session in accordance with SO 5.2.</td>
<td></td>
</tr>
<tr>
<td>Governing Body members share corporate responsibility for all decisions of the Governing Body.</td>
<td></td>
</tr>
</tbody>
</table>

### THE GOVERNING BODY

<table>
<thead>
<tr>
<th>Strategy and Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the strategic aims and objectives of the CCG.</td>
</tr>
<tr>
<td>Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored.</td>
</tr>
<tr>
<td>Approve proposals for ensuring quality and developing clinical governance in services commissioned by the CCG, having regard to any guidance issued by the Secretary of State for Health.</td>
</tr>
<tr>
<td>Commission health services for all the population in accordance with the requirements of the NHS Operating Framework and all other relevant national policy and guidance.</td>
</tr>
<tr>
<td>Ensure clinicians are engaged in the development and implementation of the strategic plan.</td>
</tr>
<tr>
<td>Assure implementation of the strategic plan</td>
</tr>
<tr>
<td>Ensure contracts with all providers reflect the requirements of the NHS Operating Framework and strategic plan.</td>
</tr>
<tr>
<td>Ensure required performance against all NHS Operating Framework requirements, all strategic plan requirements and all contract requirements is achieved.</td>
</tr>
<tr>
<td>Approve the CCG’s proposed organisational development proposals.</td>
</tr>
<tr>
<td>Decisions relating to service reconfiguration i.e. service changes requiring formal consultation.</td>
</tr>
<tr>
<td>Formal adoption of a commissioning policy which has legal or budget implications e.g. restricted procedures policy.</td>
</tr>
</tbody>
</table>

### THE GOVERNING BODY

<table>
<thead>
<tr>
<th>Finance and Procurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure all financial duties are achieved.</td>
</tr>
<tr>
<td>Ensure all QIPP programme requirements are achieved.</td>
</tr>
<tr>
<td>Approve (with any necessary appropriate modification) the CCG annual Financial Strategy.</td>
</tr>
<tr>
<td>Approve decisions to procure for contracts exceeding or likely to exceed £10,000,000.00 (£10m) over a period of 3 years (or the period of contract if longer) excepting decisions relating to primary care contracts which will be made by the Primary Care Commissioning Committee.</td>
</tr>
</tbody>
</table>

Not delegated

Not delegated
### RESERVATIONS TO THE GOVERNING BODY

<table>
<thead>
<tr>
<th>BODY / INDIVIDUAL</th>
<th>DELEGATION</th>
<th>DELEGATED TO</th>
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</thead>
<tbody>
<tr>
<td><strong>5.</strong></td>
<td>Approve award of Capital or Revenue Healthcare or Non Healthcare contracts exceeding or likely to exceed £10,000,000.00 (£10m) over a period of 3 years (or the period of contract if longer) excepting decisions relating to primary care contracts which will be made by the Primary Care Commissioning Committee.</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Approve annual budgets via the budget book, which will be enacted by budget managers through the separate scheme of budgetary delegation.</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>Approve Outline and Final Business Cases for Capital Investment if this represents a variation from the plan.</td>
<td></td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td>Ratify proposals for acquisition, disposal or change of use of land and/or buildings.</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>Approve the opening of bank accounts.</td>
<td></td>
</tr>
<tr>
<td><strong>10.</strong></td>
<td>Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Audit Committee.</td>
<td></td>
</tr>
<tr>
<td><strong>11.</strong></td>
<td>Approve individual compensation payments.</td>
<td></td>
</tr>
<tr>
<td><strong>12.</strong></td>
<td>Receipt and approval of the CCG’s Annual Report and Annual Accounts.</td>
<td></td>
</tr>
</tbody>
</table>

### THE GOVERNING BODY

#### Governance

1. Approve the CCG’s policies and procedures for the management of risk.
2. Approve the framework for procedural documents including relevant delegation to Committees of the Governing Body.
3. Approve and act in accordance with the Standards of Business Conduct and Conflicts of Interest Policy.
4. Subscribe to the Code of Conduct.
5. Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of Code of Conduct, and other ethical concerns.
6. Receipt of such reports as the Governing Body sees fit from the other committees in respect of its exercise of powers delegated.

### THE GOVERNING BODY

#### Audit

1. Approve the appointment (and where necessary dismissal) of External Auditors (and where necessary change/removal) of External Audit and to receive reports of the Audit Committee meetings and take appropriate action.
2. Receive the Annual Audit Letter received from the External Auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
3. Receive an Annual Report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
4. To receive reports from the Audit Committee and take appropriate action, including recommendations on the treatment of losses and special payments.

Not delegated
### RESERVATIONS TO THE GOVERNING BODY

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>5. To approve single items of loss or a special payment in excess of £10,000.</td>
<td></td>
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<tr>
<td></td>
<td>6. Approve the appointment (and where necessary change or removal) of internal audit service providers.</td>
<td></td>
</tr>
<tr>
<td>THE GOVERNING BODY</td>
<td><strong>Appointments / Dismissal</strong></td>
<td>Not delegated</td>
</tr>
<tr>
<td></td>
<td>1. Approve appointments and dismissals of members of the Governing Body in line with the Constitution.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Appoint and dismiss other committees (and individual members thereof) that are directly accountable to the Governing Body in line with the Constitution.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Confirm appointment of members of any committee of the CCG as representatives on outside bodies.</td>
<td></td>
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<tr>
<td></td>
<td>4. Approve proposals of the Remuneration Committee.</td>
<td></td>
</tr>
</tbody>
</table>
## Role of the Accountable Officer

This role of Accountable Officer is defined in the Constitution as:

a) Being responsible for ensuring that the Group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;

b) At all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems.

c) Working closely with the Chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the Members (through the Governing Body) of the organisation’s ongoing capability and capacity to meet its duties and responsibilities.

This will include arrangements for the ongoing developments of its Members and staff.

### Regulation and Control

1. Advise on risk, quality and governance, having regard to any guidance by the Secretary of State for Health, and including preparation of proposals to develop and monitor clinical standards in the CCG and its constituent member practices.

2. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Officer’s attention in accordance with SO 5.6. Such failures to be reported to the CCG in formal session.

3. If the Chief Officer considers the Governing Body is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Governing Body. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and ultimately the Department of Health.

### Strategy and Performance

1. Prepare the strategic plan for approval by the Governing Body.

2. Advise the Governing Body and Membership on the strategic aims and objectives of the CCG.

3. Ensure continuous appraisal of the affairs of the CCG by means of the provision of information to the Governing Body as the Governing Body may require from chiefs, committees, and officers of the CCG as set out in management policy statements.

4. The Chief Officer is accountable to the Chair, Non Officer Members and Locality Leads for ensuring that the Governing Body’s decisions are implemented, that the organisation works effectively and in accordance with government policy, for public service values and for the maintenance of proper stewardship. The Chief
### DELEGATIONS BY THE GOVERNING BODY TO THE CHIEF OFFICER

<table>
<thead>
<tr>
<th>BODY / INDIVIDUAL</th>
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<tbody>
<tr>
<td>Officer should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Governing Body.</td>
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</tr>
<tr>
<td>Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the National Audit Office (NAO) and other relevant bodies.</td>
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<tr>
<td>Prepare, consider and endorse the CCG's draft Annual Report for approval by the Governing Body.</td>
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</tr>
<tr>
<td>CHIEF OFFICER</td>
<td>Finance and Procurement</td>
<td>Not delegated</td>
</tr>
<tr>
<td>1. Sign a statement in the accounts outlining responsibilities as the Accountable Officer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.</td>
<td></td>
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</tr>
<tr>
<td>3. Approve decisions to procure for contracts up to or likely to reach a maximum of £9,999,999.99 over a period of 3 years (or the period of contract if longer).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Approve award of Capital or Revenue Healthcare or Non Healthcare contracts up to or likely to reach a maximum of £9,999,999.99 over a period of 3 years (or the period of contract if longer).</td>
<td></td>
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</tr>
<tr>
<td>5. Approve Outline and Final Business Cases for Capital Investment if the case is within the annual plan. If the case is outwith the plan, preparation of advice to the CCG.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Advise on acquisition, disposal or change of use of land and/or buildings.</td>
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<tr>
<td>7. Advise on approval of individual compensation payments.</td>
<td></td>
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</tr>
<tr>
<td>8. Advise on individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Officer and Chief Finance Officer (for losses and special payments) previously approved by the Governing Body.</td>
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</tr>
<tr>
<td>9. Achieve value for money from the resources available to the CCG and avoid waste and extravagance in the organisation's activities. Use to best effect the funds available for commissioning healthcare, developing services and promoting health to meet the needs of the local population. If the Clinical Commissioning Group is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Officer’s responsibility for value for money, the Chief Officer should draw the relevant factors to the attention of the Governing Body. If the outcome is an over-ruling it is normally sufficient to ensure that the advice and overruling of it are clearly apparent from the Minutes. Exceptionally, the Chief Officer should inform NHS England and ultimately the Department of Health. In such cases, and in those described in reference 24, the Chief Officer should as a member of the Governing Body vote against the course of action rather than merely abstain from voting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIEF OFFICER</td>
<td>Governance</td>
<td>Chief Finance Officer in respect of Financial Governance</td>
</tr>
<tr>
<td>1. Ensure effective management systems that safeguard public funds and assist CCG Chair to implement requirements of integrated governance including ensuring managers:</td>
<td></td>
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</tr>
<tr>
<td>• have a clear view of their objectives and the means to assess achievements in relation to those objectives;</td>
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</table>
### DELEGATIONS BY THE GOVERNING BODY TO THE CHIEF OFFICER

<table>
<thead>
<tr>
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<th>DELEGATION</th>
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</table>
|                   | • be assigned well defined responsibilities for making best use of resources;  
|                   | • have the information, training and access to the expert advice they need to exercise their responsibilities effectively. |
|                   | 2. Implement requirements of corporate governance. |
|                   |            | Chief of Corporate Services in respect of Corporate (non-finance) Governance |
### Role of the Chief Finance Officer

The role of the Chief Finance Officer is defined in the Constitution as:

a) Being the Governing Body’s professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
b) Making appropriate arrangements to support, monitor on the Group’s finances;
c) Overseeing robust audit and governance arrangements leading to propriety in the use of the Group’s resources;
d) Being able to advise the Governing Body on the effective, efficient and economic use of the Group’s allocation to remain within that allocation and deliver required financial targets and duties;
e) Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS Commissioning Board;
f) Being the Governing Body lead officer for Business Information Intelligence.

### Financial management

1. Prepare and review annually draft plans in respect of the application of available financial resources to support the agreed annual plans for approval by the Governing Body.
2. Operational responsibility for effective and sound financial management and information.
3. Ensure that expenditure by the CCG complies with Parliamentary requirements.
4. Ensure the accounts of the CCG are prepared under principles and in a format directed by the Secretary of State for Health. Accounts must disclose a true and fair view of the CCG’s income and expenditure and its state of affairs. Sign the accounts on behalf of the Governing Body.
DELEGATIONS BY THE GOVERNING BODY TO THE CHAIR

<table>
<thead>
<tr>
<th>BODY / INDIVIDUAL</th>
<th>DELEGATION</th>
<th>DELEGATED TO</th>
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</thead>
</table>
| CHAIR             | Role of the Chair  
The Chair of the Governing Body is responsible for:  
a) Leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this Constitution;  
b) Building and developing the Group’s Governing Body and its individual Members;  
c) Ensuring that the Group has proper constitutional and governance arrangements in place;  
d) Ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;  
e) Supporting the Accountable Officer in discharging the responsibilities of the organisation;  
f) Contributing to building a shared vision of the aims, values and culture of the organisation;  
g) Leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities;  
h) Overseeing governance and particularly ensuring that the Governing Body and the wider Group behaves with the utmost transparency and responsiveness at all times;  
i) Ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;  
j) Ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;  
k) Ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant Local Authority(ies)  
l) Ensuring that effective succession planning processes are in place.  
Where the Chair of the Governing Body is also the senior clinical voice of the Group they will take the lead in interactions with stakeholders, including NHS England. | Not delegated |
### Role of the Deputy Chair

The Deputy Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act. The Deputy Chair shall automatically become the Chair of the Governing Body for the interim period where a Chair has been removed from office or during an extended period of sickness absence, maternity leave or equivalent and another Chair is not immediately appointed.

### Role of Non Officer Members

Each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this Constitution. Each brings their unique perspective, informed by their expertise and experience.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>DEPUTY CHAIR</td>
<td>Role of the Deputy Chair</td>
<td>Not delegated</td>
</tr>
<tr>
<td></td>
<td>The Deputy Chair of the Governing Body deputises for the Chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act. The Deputy Chair shall automatically become the Chair of the Governing Body for the interim period where a Chair has been removed from office or during an extended period of sickness absence, maternity leave or equivalent and another Chair is not immediately appointed.</td>
<td></td>
</tr>
<tr>
<td>NON OFFICER MEMBERS</td>
<td>Role of Non Officer Members</td>
<td>Not delegated</td>
</tr>
<tr>
<td></td>
<td>Each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this Constitution. Each brings their unique perspective, informed by their expertise and experience</td>
<td></td>
</tr>
<tr>
<td>SFI REF</td>
<td>RESPONSIBILITY OF</td>
<td>DELEGATION</td>
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</tr>
<tr>
<td>10.1.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approval of all financial procedures.</td>
</tr>
<tr>
<td>10.1.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Advice on interpretation or application of SFIs.</td>
</tr>
<tr>
<td>10.1.6</td>
<td>ALL MEMBERS OF THE GOVERNING BODY AND EMPLOYEES</td>
<td>Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.</td>
</tr>
<tr>
<td>10.2.4</td>
<td>CHIEF OFFICER</td>
<td>Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the System of Internal Control.</td>
</tr>
<tr>
<td>10.2.4</td>
<td>CHIEF OFFICER &amp; CHIEF FINANCE OFFICER</td>
<td>Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.</td>
</tr>
<tr>
<td>10.2.5</td>
<td>CHIEF FINANCE OFFICER</td>
<td>To ensure all Governing Body members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.</td>
</tr>
</tbody>
</table>
| 10.2.6  | CHIEF FINANCE OFFICER | Responsible for:  
a) implementing the CCG’s financial policies and co-coordinating corrective action;  
b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented;  
c) ensuring that sufficient records are maintained to explain CCG’s transactions and financial position;  
d) providing financial advice to members of the Governing Body and staff.;  
e) maintaining such accounts, certificates etc as are required for the CCG to carry out its statutory duties;  
f) the design, implementation and supervision of systems of internal control. | Not delegated |
<p>| 10.2.7  | ALL MEMBERS OF THE GOVERNING BODY AND EMPLOYEES | Responsible for security of the CCG’s property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures. | All Members of the Governing Body and Employees |
| 10.2.8  | CHIEF OFFICER | Ensure that any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply. | Chief Finance Officer |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>RESPONSIBILITY OF</th>
<th>DELEGATION</th>
<th>DELEGATED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1.1</td>
<td>AUDIT COMMITTEE</td>
<td>Provide independent and objective view on internal control and probity.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.1.3</td>
<td>CHAIR</td>
<td>Raise the matter at the Governing Body meeting where Chair of Audit Committee considers there is evidence of ultra vires transactions or improper acts.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.2.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>a) Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)&lt;br&gt;b) Ensure the annual audit report is prepared for consideration by the Audit Committee.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.3</td>
<td>HEAD OF INTERNAL AUDIT</td>
<td>Review, appraise and report in accordance with NHS Internal Audit Standards and best practice.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.4</td>
<td>AUDIT COMMITTEE</td>
<td>Ensure cost-effective External Audit.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.5</td>
<td>CHIEF OFFICER &amp; CHIEF FINANCE OFFICER</td>
<td>Monitor and ensure compliance with Secretary of State for Health’s Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>11.6</td>
<td>CHIEF OFFICER</td>
<td>Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.</td>
<td>Nominated Officer</td>
</tr>
<tr>
<td>12.1.1</td>
<td>CHIEF OFFICER</td>
<td>Has overall responsibility for the CCG’s activities and ensuring the CCG stays within its Revenue Resource Allocation.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>12.1.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Will provide reports as required to the Secretary of State for Health, ensure draw down is for approved expenditure and timely and follows best practice in cash management.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.1.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Periodically review assumptions, submit a report to the CCG annually showing total allocations received and their proposed distribution.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.1.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Regularly update the CCG on significant changes to the initial allocation and the uses of such funds.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.2.1</td>
<td>CHIEF OFFICER</td>
<td>Compile and submit to the Governing Body a strategic plan which takes into account financial targets and forecast limits of available resources. The plan will contain:&lt;br&gt;• a statement of the significant assumptions on which the plan is based;&lt;br&gt;• details of major changes in workload, delivery of services or resources required to achieve the plan.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>13.2.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Submit budgets to the Governing Body for approval</td>
<td>Not delegated</td>
</tr>
<tr>
<td>SFI REF</td>
<td>RESPONSIBILITY OF</td>
<td>DELEGATION</td>
<td>DELEGATED TO</td>
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</tr>
<tr>
<td>13.2.3</td>
<td>OFFICER</td>
<td>Monitor performance against budget; submit to the Governing Body financial estimates and forecasts.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.2.5</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Ensure adequate training is delivered on an ongoing basis to budget holders.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.3.1</td>
<td>CHIEF OFFICER</td>
<td>Delegate budget to budget holders.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>13.3.2</td>
<td>CHIEF OFFICER &amp; BUDGET HOLDERS</td>
<td>Must not exceed the budgetary total or virement limits set by the Governing Body.</td>
<td>Budget Holders</td>
</tr>
<tr>
<td>13.4.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Devise and maintain systems of budgetary control.</td>
<td>Not delegated</td>
</tr>
</tbody>
</table>
| 13.4.2  | BUDGET HOLDERS   | Ensure that:  
  a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Governing Body;  
  b) Approved budget is not used for any other than specified purpose subject to rules of virement;  
  c) No permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment. | Not delegated |
| 13.4.3  | CHIEF OFFICER    | Identify and implement cost improvements and income generation activities in line with the plan. | Chief Finance Officer & Budget Holders |
| 13.6.1  | CHIEF OFFICER    | Submit monitoring returns. | Chief Finance Officer |
| 14.1    | CHIEF FINANCE OFFICER | Preparation of annual accounts and reports. | Not delegated |
| 15.1    | CHIEF FINANCE OFFICER | Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.  
  (Governing Body approves arrangements.) | Not delegated |
<p>| 15.4    | CHIEF FINANCE OFFICER | Review the banking arrangements of the CCG at regular intervals to ensure they reflect best practice and represent best value for money. | Not delegated |
| 16.     | CHIEF FINANCE OFFICER | Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash. | Not delegated |
| 16.2.3  | ALL EMPLOYEES    | Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with. | All employees |
| 17.     | CHIEF OFFICER    | Tendering and contracting procedure. | Chief Finance Officer |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>RESPONSIBILITY OF</th>
<th>DELEGATION</th>
<th>DELEGATED TO</th>
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<tbody>
<tr>
<td>17.5.3</td>
<td>CHIEF OFFICER</td>
<td>In-house services: Decision to tender for services.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.5.4</td>
<td>CHIEF OFFICER</td>
<td>Exceptions and instances where formal tendering procedures need not be applied or may be waived.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.5.5(b)</td>
<td>CHIEF OFFICER</td>
<td>Report waivers of tendering procedures to the Audit Committee.</td>
<td>Nominated Officer</td>
</tr>
<tr>
<td>17.5.6</td>
<td>CHIEF OFFICER</td>
<td>Exceptions and instances where formal tendering procedures need not be applied or may be waived.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.5.7(b)</td>
<td>CHIEF OFFICER</td>
<td>Report waivers of tendering procedures to the Audit Committee.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.5.8</td>
<td>CHIEF OFFICER</td>
<td>Responsible for the receipt, endorsement and safe custody of tenders received.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.7.6</td>
<td>CHIEF OFFICER</td>
<td>Responsible for the receipt, endorsement and safe custody of tenders received.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.7.7(a) &amp; (b)</td>
<td>CHIEF OFFICER</td>
<td>Designation of senior officers/managers authorised to open tenders.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.7(d)</td>
<td>ALL EXECUTIVE DIRECTORS &amp; MEMBERS</td>
<td>Opening tenders.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.7(e)</td>
<td>CHIEF OF CORPORATE SERVICES</td>
<td>Opening tenders.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.7(g)</td>
<td>CHIEF OFFICER</td>
<td>Shall maintain a register to show each set of competitive tender invitations dispatched.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.7.8(i)</td>
<td>CHIEF OFFICER</td>
<td>Admissibility of tenders.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.7.8(ii)</td>
<td>CHIEF OFFICER &amp; CHIEF FINANCE OFFICER</td>
<td>Where one tender is received will assess for value for money and fair price.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.9</td>
<td>CHIEF OFFICER</td>
<td>Responsible for treatment of ‘late tenders’.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>17.7.10</td>
<td>CHIEF OFFICER OR CHIEF FINANCE OFFICER</td>
<td>Electronic Auctions and Dynamic Purchasing Systems.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.11(a)</td>
<td>CHIEF OFFICER &amp; SPECIFICATION GROUP</td>
<td>Draft specification.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.7.11(a)</td>
<td>CHIEF OFFICER &amp; IN</td>
<td>Draft and submit in-house tender submission.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>SFI REF</td>
<td>RESPONSIBILITY OF</td>
<td>DELEGATION</td>
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<td>HOUSE TENDER GROUP</td>
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<tr>
<td>17.7.11(a)</td>
<td>CHIEF FINANCE OFFICER &amp; THE</td>
<td>Shortlist expressions of interest and evaluate tenders received.</td>
<td>Not delegated</td>
</tr>
<tr>
<td></td>
<td>EVALUATION GROUP</td>
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<tr>
<td>17.7.11(d)</td>
<td>CHIEF OFFICER</td>
<td>Nomination of officer to oversee and manage the contract awarded on behalf</td>
<td>Not delegated</td>
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<td>of the CCG.</td>
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<tr>
<td>17.8</td>
<td>CHIEF OFFICER</td>
<td>Quotations: Competitive and Non-Competitive (including 17.8.2 (ii) decision</td>
<td>Executive Director</td>
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<td>re requirement to obtain quotation in writing, 17.8.2 (iv) evaluation of</td>
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<td>quotations and 17.8.3 (b) source of goods from alternative sources).</td>
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<td>17.8.4</td>
<td>CHIEF OFFICER OR CHIEF FINANCE</td>
<td>No quotation shall be accepted which will commit expenditure in excess of</td>
<td>Not delegated</td>
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<td>OFFICER</td>
<td>that which has been allocated by the CCG and/or which is not in accordance</td>
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<td>with these Standing Financial Instructions except with the express</td>
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<td>authorisation of the Chief Officer.</td>
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<td>17.9.1</td>
<td>CHIEF OFFICER</td>
<td>Overriding duty to achieve best value for money.</td>
<td>Chief Finance</td>
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<td></td>
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<td>Officer</td>
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<tr>
<td>17.9.2</td>
<td>CHIEF OFFICER</td>
<td>Shall ensure that appropriate evaluation criteria are adopted to assess the</td>
<td>Chief Finance</td>
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<td>technical and financial capability of those firms that are invited to</td>
<td>Officer</td>
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<td>tender or quote.</td>
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<td>17.10.1(d)</td>
<td>CHIEF FINANCE OFFICER</td>
<td>No tender shall be accepted which will commit expenditure in excess of that</td>
<td>Not delegated</td>
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<td>which has been allocated by the CCG and/or which is not in accordance with</td>
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<td>these Instructions except with the express authorisation of the Chief Officer</td>
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<tr>
<td>17.10.1(e)</td>
<td>CHIEF OFFICER OR CHIEF FINANCE</td>
<td>Acceptability of tenders.</td>
<td>Not delegated</td>
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<td></td>
<td>OFFICER</td>
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<tr>
<td>17.10.2</td>
<td>DESIGNATED BUDGET HOLDER</td>
<td>Award of contracts up to the amount specified in the budgetary scheme of</td>
<td>Not delegated</td>
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<td>delegation.</td>
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<tr>
<td>17.10.2</td>
<td>CHIEF OFFICE &amp; CHIEFS</td>
<td>Award of contracts up to the amount specified in the budgetary scheme of</td>
<td>Not delegated</td>
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<td>delegation.</td>
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<tr>
<td>17.10.2</td>
<td>CCG GOVERNING BODY</td>
<td>Award of contracts over the amount specified in the budgetary scheme of</td>
<td>Not delegated</td>
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<td>delegation.</td>
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<tr>
<td>17.11</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Use of correct form of contract as required by Instruction 17.11.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>17.11.5</td>
<td>CHIEF OFFICER</td>
<td>The Chief Officer shall nominate officers with delegated authority to enter</td>
<td>Not delegated</td>
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<td>into contracts of</td>
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<td>17.11.6(f)</td>
<td>CHIEF OFFICER</td>
<td>The Chief Officer shall nominate an officer who shall oversee and manage each contract on behalf of the CCG.</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>17.12.1(a)</td>
<td>CHIEF OFFICER</td>
<td>Use of competitive tendering or quotation procedures.</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>18.1.1</td>
<td>CHIEF OFFICER</td>
<td>Must ensure the CCG enters into suitable contracts with service providers for the provision of NHS services and consider the extent to which any NHS standard contract conditions are mandatory.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>18.2</td>
<td>CHIEF OFFICER</td>
<td>Ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure against the contract.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>19.2.1</td>
<td>CHIEF OFFICER</td>
<td>As the Accountable Officer, ensure services are commissioned in line with the Plan and reach the required standards.</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>19.2.2</td>
<td>CHIEF OFFICER</td>
<td>Ensure regular reports are provided to the Governing Body detailing actual and forecast expenditure for each contract.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>19.2.3</td>
<td>CHIEF OFFICER</td>
<td>Ensure that all agreements for provision of services with non-NHS providers achieve quality and are cost effective</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>19.3.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Will maintain a system of control to ensure effective accounting of expenditure against each contract.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>19.3.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Must account for Out of Area Treatments/Non Contract Activity in accordance with national guidelines.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>20.1.1</td>
<td>GOVERNING BODY</td>
<td>Establish a Remuneration, Appointments &amp; Terms of Reference Committee.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>20.1.2</td>
<td>REMUNERATION COMMITTEE</td>
<td>Advise the Governing Body on and make recommendations on the remuneration and terms of service of the Chief Officer, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the CCG’s circumstances and any national agreements. Monitor and evaluate the performance of individual senior employees. Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>20.1.3</td>
<td>REMUNERATION COMMITTEE</td>
<td>Report in writing to the Governing Body its advice and its bases about remuneration and terms of service of directors and senior employees.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>20.1.4</td>
<td>GOVERNING BODY</td>
<td>Approve proposals presented by the Chief Officer for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>20.2.2</td>
<td>CHIEF OFFICER</td>
<td>Approval of variation to funded establishment of any department.</td>
<td>Chief Officer or Nominated Officer</td>
</tr>
<tr>
<td>20.3</td>
<td>CHIEF OFFICER</td>
<td>Approval of appointment of staff, including agency staff, appointments and re-grading within</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>SFI REF</td>
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| 20.4.1 and 20.4.2 | CHIEF FINANCE OFFICER | Payroll: The Chief Finance Officer is responsible for:  
  a) Specifying timetables for submission of properly authorised time records and other notifications;  
  b) Final determination of pay and allowances;  
  c) Making payments on agreed dates;  
  d) Agreeing method of payment;  
  e) Issuing instructions (as listed in SFI 20.4.2). | Not delegated |
| 20.4.3 | CHIEF OFFICER | Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time. | Chief Officer |
| 20.4.4 | CHIEF FINANCE OFFICER | Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies. | Not delegated |
| 20.5 | CHIEF OFFICER | Ensure that all employees are issued with a Contract of Employment in a form approved by the Governing Body and which complies with employment legislation; Deal with variations to, or termination of, contracts of employment. | Not delegated |
| 21.1.1 | GOVERNING BODY | The Governing Body will approve the level of non-pay expenditure on an annual basis. | Not delegated |
| 21.1.2 | CHIEF OFFICER | Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. | Budgetary Scheme of Delegation |
| 21.1.3 | CHIEF OFFICER | Set out procedures on the seeking of professional advice regarding the supply of goods and services. | Chief Finance Officer |
| 21.2.1 | REQUISITIONER | In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the CCG. In so doing, the advice of the CCG’s adviser on supply shall be sought. | Not delegated |
| 21.2.2 | CHIEF FINANCE OFFICER | Shall be responsible for the prompt payment of accounts and claims. | Not delegated |
| 21.2.3 | CHIEF FINANCE OFFICER | a) Advise the Governing Body regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;  
  b) Prepare procedural instructions on the obtaining of goods, works and services incorporating | Not delegated |
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<tbody>
<tr>
<td>21.2.4</td>
<td>APPROPRIATE EXECUTIVE DIRECTOR</td>
<td>Make a written case to support the need for a pre-payment.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>21.2.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approve proposed pre-payment arrangements.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>21.2.4</td>
<td>BUDGET HOLDER</td>
<td>Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered).</td>
<td>Not delegated</td>
</tr>
<tr>
<td>21.2.5</td>
<td>CHIEF OFFICER</td>
<td>Authorise who may use and be issued with official orders.</td>
<td>Delegation via the budgetary scheme of delegation</td>
</tr>
<tr>
<td>21.2.6</td>
<td>MANAGERS AND OFFICERS</td>
<td>Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer</td>
<td>Managers and officers via the budgetary scheme of delegation</td>
</tr>
<tr>
<td>21.2.7</td>
<td>CHIEF OFFICER &amp; CHIEF FINANCE OFFICER</td>
<td>Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the relevant guidance.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>21.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>22</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Ensure that Governing Body members are aware of the Financial Framework and ensure compliance</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.1.1 &amp; 2</td>
<td>CHIEF OFFICER</td>
<td>Capital investment programme: a) Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; b) Responsible for the management of capital schemes and for ensuring that they are delivered</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
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<tr>
<td>23.1.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Certify professionally the costs and revenue consequences detailed in the business case for capital investment.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.1.3</td>
<td>CHIEF OFFICER</td>
<td>Issue procedures for management of contracts involving stage payments.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.1.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.1.4</td>
<td>CHIEF OFFICER</td>
<td>Shall issue to the manager responsible for any scheme specific authority to commit expenditure, proceed to tender and accept a successful tender.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.1.4</td>
<td>CHIEF OFFICER</td>
<td>Issue a scheme of delegation for capital investment management in accordance with Estate code and Standing Orders.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.1.5</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.3.1</td>
<td>CHIEF OFFICER</td>
<td>Maintenance of asset registers (on advice from Chief Finance Officer).</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.3.5</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.3.8</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Calculate and pay capital charges in accordance with Department of Health requirements.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>23.4.1</td>
<td>CHIEF OFFICER</td>
<td>Overall responsibility for fixed assets.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.4.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approval of fixed asset control procedures.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>23.4.5</td>
<td>GOVERNING BODY, EXECUTIVE MEMBERS AND ALL SENIOR STAFF</td>
<td>Responsibility for security of CCG assets including notifying discrepancies to Chief Finance Officer, and reporting losses in accordance with CCG procedure.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>24.2</td>
<td>CHIEF OFFICER</td>
<td>Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>24.2</td>
<td>CHIEF FINANCE</td>
<td>Responsible for systems of control over stores and receipt of goods.</td>
<td>Not delegated</td>
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<td>24.2.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Security arrangements and custody of keys.</td>
<td>Local Security manager</td>
</tr>
<tr>
<td>24.2.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Set out procedures and systems to regulate the stores.</td>
<td>Not delegated</td>
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<tr>
<td>24.2.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Agree stocktaking arrangements.</td>
<td>Not delegated</td>
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<tr>
<td>24.2.5</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approve alternative arrangements where a complete system of stores control is not justified.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>24.2.6</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>24.2.6</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Operate system for slow moving and obsolete stock, and report evidence of significant overstocking.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>24.3.1</td>
<td>CHIEF OFFICER</td>
<td>Identify persons authorised to requisition and accept goods from NHS Supplies stores.</td>
<td>Budgetary Scheme of Delegation</td>
</tr>
<tr>
<td>25.1.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Prepare procedures for recording and accounting for losses, special payments.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.2</td>
<td>ALL STAFF</td>
<td>Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Officer and/ or Chief Finance Officer.</td>
<td>All staff</td>
</tr>
<tr>
<td>25.2.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Where a criminal offence is suspected the police must be informed if theft or arson is involved. In cases of fraud and corruption the relevant Local Counter Fraud Specialist (LCFS) and NHS Protect Operational Fraud Team must be informed in line with Secretary of State for Health Directions.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Notify NHS Protect, Local Counter Fraud Specialist and External Audit of all frauds.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Notify Governing Body and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.5</td>
<td>GOVERNING BODY</td>
<td>Approve write off of losses in excess of £10,000.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.10</td>
<td>AUDIT COMMITTEE</td>
<td>Approve write off of losses up to £10,000.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>25.2.7</td>
<td>CHIEF FINANCE</td>
<td>Consider whether any insurance claim can be made.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>SFI REF</td>
<td>RESPONSIBILITY OF</td>
<td>DELEGATION</td>
<td>DELEGATED TO</td>
</tr>
<tr>
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</tr>
<tr>
<td>25.2.8</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Maintain losses and special payments register.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>26.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Responsible for accuracy and security of computerised financial data.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>26.1.2</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Satisfy him/her self that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>26.1.3</td>
<td>CHIEF OFFICER</td>
<td>Shall publish and maintain a Freedom of Information Scheme.</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>26.2.1</td>
<td>RELEVANT OFFICERS</td>
<td>Send proposals for general computer systems to Chief Finance Officer</td>
<td>Not delegated</td>
</tr>
<tr>
<td>26.3</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>28</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Ensure all staff are made aware of the CCG policy on the acceptance of gifts and other benefits in kind by staff.</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>29.1</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Ensure only contractors included on the CCG lists receive payments; maintain a system of control to ensure prompt and accurate payments and validation of same.</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>30</td>
<td>CHIEF OFFICER</td>
<td>Retention of document procedures in accordance with Department of Health guidance.</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>31.1</td>
<td>CHIEF OFFICER</td>
<td>Establishment of a risk management programme.</td>
<td>Chief of Corporate Services</td>
</tr>
<tr>
<td>31.1</td>
<td>GOVERNING BODY</td>
<td>Approve and monitor risk management programme.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>31.2</td>
<td>GOVERNING BODY</td>
<td>Decide whether the CCG will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.</td>
<td>Not delegated</td>
</tr>
<tr>
<td>31.4</td>
<td>CHIEF FINANCE OFFICER</td>
<td>Where the Governing Body decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are</td>
<td>Not delegated</td>
</tr>
<tr>
<td>SFI REF</td>
<td>RESPONSIBILITY OF</td>
<td>DELEGATION</td>
<td>DELEGATED TO</td>
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<tr>
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<td>appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Governing Body decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the &amp; Chief Finance Officer shall ensure that the Governing Body is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.</td>
<td></td>
</tr>
</tbody>
</table>
SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued for the Regulation of the conduct of the Clinical Commissioning Group's members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the CCG. They are designed to ensure that the CCG's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Governing Body and the Scheme of Delegation adopted by the CCG.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the CCG and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the CCG's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Governing Body and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

10.2 Responsibilities and delegation

10.2.1 The Clinical Commissioning Group

The Governing Body exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
(d) Defining specific responsibilities placed on members of the Clinical Commissioning Group and employees as indicated in the Scheme of Delegation document.

10.2.2 The Governing Body has resolved that certain powers and decisions may only be exercised by the Governing Body in formal session. These are set out in the ‘Schedule of Matters Reserved to the Governing Body’ document. All other powers have been delegated to such other committees as the CCG has established or to individual roles.

10.2.3 The Clinical Commissioning Group will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the CCG.

10.2.4 The Chief Officer and Chief Finance Officer

The Chief Officer and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Officer is ultimately accountable to the Governing Body, and as Accountable Officer, to the Secretary of State, for ensuring that the Governing Body meets its obligation to perform its functions within the available financial resources. The Chief Officer has overall executive responsibility for the CCG’s activities; is responsible to the Chair and the Governing Body for ensuring that its financial obligations and targets are met and has overall responsibility for the CCG’s system of internal control.

10.2.5 It is a duty of the Chief Officer to ensure that Members of the Governing Body employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.6 The Chief Finance Officer

The Chief Finance Officer is responsible for:

(a) implementing the CCG’s financial policies and for co-coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the CCG’s transactions, in order to disclose, with reasonable accuracy, the financial position of the CCG at any time;

and, without prejudice to any other functions of the CCG, and employees of the CCG, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to other members of the Governing Body and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the CCG may require for the purpose of carrying out its statutory duties.
10.2.7 Governing Body Members and Employees

All members of the Governing Body and employees, severally and collectively, are responsible for:

(a) The security of the property of the CCG;
(b) Avoiding loss;
(c) Exercising economy and efficiency in the use of resources; and
(d) Conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.8 Contractors and their employees

Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Officer to ensure that such persons are made aware of this.

10.2.9 For all members of the Governing Body and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Governing Body and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

11. AUDIT

11.1 Audit Committee

11.1.1 An independent Audit Committee is a central means by which a Governing Body ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Governing Body. In accordance with Standing Orders the Governing Body shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2005) to perform the following tasks:

(a) Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Officer and Governing Body;
(b) Reviewing the work and findings of the external auditor appointed by the Audit Commission CCG and considering the implications of and management's responses to their work;
(c) Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;
(d) Ensuring that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body;
(e) Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;
Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives;

Monitoring compliance with Standing Orders and Standing Financial Instructions;

Reviewing schedules of losses and compensations and making recommendations to the Governing Body;

Reviewing schedules of debtors/creditors balances £5,000 and over six months old and explanations/action plans;

Review the annual report and financial statements prior to submission to the Governing Body focusing particularly on:

- the wording in the Statement of Internal Control and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas;
- significant adjustments resulting from audit.

Reviewing the annual financial statements and recommend their approval to the Governing Body;

Reviewing the external auditors report on the financial statements and the annual management letter;

Conducting a review of the CCG’s major accounting policies;

Reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the CCG’s published financial accounts or reputation;

Reviewing any objectives and effectiveness of the internal audit services including its working relationship with external auditors;

Reviewing major findings from internal and external audit reports and ensure appropriate action is taken;

Reviewing ‘value for money’ audits reporting on the effectiveness and efficiency of the selected departments or activities;

Reviewing the mechanisms and levels of authority (e.g. Standing Orders, Standing Financial Instructions, Delegated limits) and make recommendations to the CCG;

Reviewing the scope of both internal and external audit including the agreement on the number of audits per year for approval by the CCG Governing Body;

Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

Reviewing waivers to Standing Orders;

Reviewing hospitality and sponsorship registers;
Reviewing the information prepared to support the controls assurance statements prepared on behalf of the Governing Body and advising the Governing Body accordingly.

11.1.2 The minutes of the Audit Committee meetings shall be formally recorded and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action. The Committee will report to the Governing Body annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements.

11.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Governing Body. Exceptionally, the matter may need to be referred to the Department of Health.

11.2 Chief Finance Officer

11.2.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit function meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of Internal Audit recommendations;

(iv) progress against plan over the previous year;

(v) a strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

11.2.2 The Chief Finance Officer or designated internal or external auditor is entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
11.3 Role of Internal Audit

11.3.1 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(1) an independent and objective opinion to the Accountable Officer, the Governing Body, and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives;

(2) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

11.3.2 Internal Audit will review, appraise and report upon policies, procedures and operations in place to:

(a) establish and monitor the achievement of the organisation's objectives;

(b) identify, assess and manage the risks to achieving the organisation’s objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioral and ethical expectations), procedures, laws and Regulations;

(e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

11.3.3 The Head of Internal Audit will provide to the Audit Committee;

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit Committee, based upon the management's Assurance Framework that will enable the auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation;

(b) Regular updates on the progress against plan;

(c) Reports of management's progress on the implementation of action agreed as a result of Internal audit findings;

(d) An annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This opinion is used by the Governing Body to inform the SIC and by NHS England as part of its performance management role;
11.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

11.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Officer of the CCG.

11.3.6 The Head of Internal Audit reports to the Audit Committee and is managed by the Chief Finance Officer. The reporting system for Internal Audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.7 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit Committee.

11.4 External Audit

11.4.1 The External Auditor is both appointed by the Audit Commission and paid for by the CCG. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the recognised supervisory body Audit Commission if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Chief Officer and Chief Finance Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

11.5.2 The CCG shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, and guidance.

11.5.3 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Protect and the Regional NHS Protect team in accordance with the NHS Counter Fraud and Corruption Manual, or with any successor body with which the LCFS or equivalent is required to report to pursuant to any subsequent guidance in future.

11.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the CCG.

11.6 Security Management

11.6.1 In line with their responsibilities, the Chief Officer will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The CCG shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) or equivalent as specified by the Secretary of State for Health guidance on NHS Protect.

11.6.3 The CCG shall nominate an Officer to be responsible to the Governing Body for NHS security management.
11.6.4 The Chief Officer has overall responsibility for controlling and coordinating security. However, key tasks are delegated to a named Officer (and the appointed LSMS).

12. **REVENUE RESOURCE ALLOCATION CONTROL**

12.1.1 The CCG is required by statutory provisions not to exceed its Revenue Resource Allocation. The Chief Officer has overall executive responsibility for the CCG’s activities and is responsible to the CCG for ensuring that it stays within its Revenue Resource Allocation.

12.1.2 The definition of use of resources is set out in RAB Directions on use of resources (available on the Departmental Finance Manual web-site).

12.1.3 Any sums received on behalf of the Secretary of State excluding charges arising under Parts 4, 5, 6 and 7 of the NHS Act 2006 is treated as sums received by the CCG.

12.1.4 The Chief Finance Officer will:

(a) provide reports as required in the form required by the Secretary of State;

(b) ensure money drawn from the Department of Health against the financing requirement arising from the Revenue Resource Allocation is required for approved expenditure only, and is drawn down only at the time of need, follows best practice as set out in ‘Cash Management in the NHS’;

(c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the CCG to fulfill its statutory responsibility not to exceed its Annual Revenue Resource and Capital Resource Allocations.

13. **ALLOCATIONS, ANNUAL PLAN, BUDGETS, BUDGETARY CONTROL AND MONITORING**

13.1 **Allocations**

13.1.1 The Chief Finance Officer of the CCG will:

(a) periodically review the basis and assumptions used by the Area Team for distributing allocations and ensure that these are reasonable and realistic and secure the CCG’s entitlement to funds;

(b) prior to the start of each financial year submit to the CCG for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

(c) regularly update the CCG Governing Body on significant changes to the initial allocation and the uses of such funds.

13.2 **Preparation and Approval of Annual Plan and Budgets**

13.2.1 The Chief Officer will compile and submit to the Governing Body an Annual Plan which takes into account financial targets and forecast limits of available resources. The plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.
13.2.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Officer, prepare and submit budgets for approval by the Governing Body. Such budgets will:

(a) be in accordance with the aims and objectives set out in the plan;
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

13.2.3 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body.

13.2.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

13.2.5 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.3 Budgetary Delegation

13.3.1 The Chief Officer may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

13.3.2 The Chief Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the Governing Body.

13.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Officer, subject to any authorised use of virement.

13.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Officer, as advised by the Chief Finance Officer.

13.4 Budgetary Control and Reporting

13.4.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Governing Body in a form approved by the Governing Body containing:
(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Officer’s and/or Chief Finance Officer’s view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers.

13.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Governing Body;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorized, subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Officer other than those provided for within the available resources and manpower establishment as approved by the Governing Body.

13.4.3 The Chief Officer is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

13.5 Capital Expenditure

13.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 23).

13.6 Monitoring Returns

13.6.1 The Chief Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in accordance with the published timetable.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, on behalf of the CCG, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the CCG’s accounting policies, and generally accepted accounting practice;
(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

14.2 The CCG's annual accounts must be audited by an auditor appointed by the Audit Commission CCG. The CCG's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The CCG will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK ACCOUNTS

15.1 General

15.1.1 The Chief Finance Officer is responsible for managing the CCG’s banking arrangements and for advising the CCG Governing Body on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Department of Health. In line with ‘Cash Management in the NHS’ the CCG should minimise the use of commercial bank accounts and use Government Banking Service (GBS) accounts for all banking services.

15.1.2 The Governing Body shall approve the banking arrangements.

15.2 Bank and GBS Accounts

15.2.1 The Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the CCG's non-exchequer funds (if any);

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Governing Body all arrangements made with the CCG’s bankers for accounts to be overdrawn;

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the CCG’s accounts.

15.3.2 The Chief Finance Officer must advise the CCG's bankers in writing of the conditions under which each account will be operated.
15.4 Tendering and Review

15.4.1 The Chief Finance Officer will review the banking arrangements of the CCG at regular intervals to ensure they reflect best practice.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

16.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

16.2 Fees and Charges

16.2.1 The CCG shall follow the Department of Health's guidance in setting prices for NHS service agreements.

16.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

16.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.3 Debt Recovery

16.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

16.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Finance Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

- ordering and securely controlling any such stationery;

- the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

- prescribing systems and procedures for handling cash and negotiable securities on behalf of the CCG.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.
16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the CCG is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the CCG from responsibility for any loss.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedures to be followed by the CCG in relation to all contract opportunities with the CCG and for awarding all contracts with the CCG shall comply with the Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

This section of SFIs is structured in the following sections:

- This section: Legislation and Policy Framework, referring to the main requirements of law and policy. This section is not definitive and other guidance may also be applicable to any decision or procurement (SFIs 17.1 to 17.4 inclusive).
- The decision to tender and exceptions to the requirements to tender (SFI 17.5 to 17.6).
- Tendering Procedure, where a decision is made to tender pursuant to SFI 17.5 and SFI 17.6 (SFI 17.7).
- Quotations where no tender process (SFI 17.8).
- Evaluation of tenders and quotations (SFI 17.9).
- Award of contracts (SFI 17.10).
- Form of Contract (SFI 17.11).
- Specific Requirements (SFI 17.12)

17.2 Legislation Governing Public Procurement

(a) The CCG shall comply with the Public Contracts Regulations 2006 2015 (the “Regulations”) and any EU Directives relating to EU procurement law having direct effect in England (the “Directives”) and any other duties derived from the EU Treaty (“Treaty Obligations”) and any duties derived from the UK common law (“Common Law Duties”) (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in these SFIs as “Procurement Legislation”). The Procurement Legislation as from time to time amended shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

(b) The CCG should consider obtaining support from any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures.

(c) The CCG shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity.

17.3 Guidance on Public Procurement and Commissioning
The CCG should have regard to all relevant guidance and legislation issued by the Department of Health in relation to the conduct of procurement practice and the commissioning of health care services, including but not limited to:

(a) The CCG Procurement Guide for Health Services (Department of Health May 2008) or any successor guide issued by the Department of Health.

(b) The Principles and Rules for Cooperation and Competition

(c) the Department of Health’s “Capital Investment Manual” and “Estate code” in respect of capital investment and estate and property transactions, save where either has been superseded by later published guidance.

(d) Strengthening Financial Performance and Accountability in 2016/17

(e) in the case of management consultancy contracts the Department of Health guidance “The Procurement and Management of Consultants within the NHS”; and

(f) the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013;

or any successor to such guidance issued from time to time.

17.4 Principles of Gateway Reviews and Best Practice Guidance

(a) The CCG should consider applying the principles of the Gateway Review Process (see: www.dh.gov.uk/gatewayreviews) to each procurement process undertaken.

(b) The CCG should assess each procurement against the Risk Potential Assessment.

(c) The CCG will utilize the Gateway review process for all procurements assessed as high risk under the Risk Potential Assessment.

17.5 Decision to Seek Tenders, and Exceptions

17.5.1 Presumption to Tender

Where:

(a) a contract opportunity that is required to be advertised under the Regulations (i.e. the contract opportunity is governed by the Regulations and the value of the contract opportunity as calculated pursuant to the Regulations exceeds the relevant financial threshold for the requirement to run a formal tender process); or

(b) the contract opportunity would pass the Cross Border Test. The Cross Border Test is passed (subject to any subsequent judicial precedent in the UK Courts or the European Court of Justice) if the contract opportunity under consideration would be (whatever the value of the contract and whether or not the contract opportunity is a Part B service under the Regulations, or falls outside the requirement to tender under the Regulations) of certain interest to any body located in a member state of a European Union other than the United Kingdom;

then subject to SFI 17.5.5 the CCG shall ensure that contract opportunities with the CCG are advertised in accordance with SFI 17.7.3 and where more than one
response is received that competitive tenders are invited in accordance with SFI 17.7.4 for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services;
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- subject to SFI 17.12.1 for disposals.

The CCG must adhere to the current Procurement Strategy and ensure that all contract opportunities follow the provisions contained therein. In authorising contracts, the thresholds contained in the current budgetary Scheme of Delegation must be applied.

17.5.2 Commissioning Health Care Services: Decision to Advertise

Health care services are classed as Part B Services ‘Light Touch’ under the Public Contracts Regulations 2015. As such, no requirement to advertise arises by virtue of SFI 17.5.1(a) above but may do under SFI 17.5.1(b) and each contract opportunity should be assessed against the Cross Border Test.

17.5.3 In-House Services: Decision to Procure Services

The Chief Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The CCG may also determine from time to time that in-house services should be market tested by competitive tendering.

17.5.4 Exceptions and instances where formal tendering procedures need not be applied

Where a contract opportunity is required to be tendered under SFI 17.5.1, such contract opportunities need not be advertised and formal tendering procedures need not be applied where:

(a) the estimated expenditure or income:
   (i) for a contract opportunity (for goods and non healthcare services) does not, or is not reasonably expected to, exceed £50,000; or
   (ii) for any contract opportunity (for healthcare services) does not, or is not reasonably expected to, OJEU limits.

(b) any disposal falls within SFI 17.12.1 and/or within SFI 25.1.3;

(c) the requirement can be met under an existing contract without infringing Procurement Legislation;

(d) the CCG is entitled to call off from a Framework Agreement and the requirements of SFI 17.6 (Use of Framework Agreements) have been followed;

(e) a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the CCG; or

(f) an exception permitting the use of the negotiated procedure without notice validly applies under Regulation 14 Article 32 of the Regulations.

Formal tendering procedures may be waived in the following circumstances:
in very exceptional circumstances where the Chief Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate CCG record;

where the timescale genuinely precludes competitive tendering for reasons of extreme urgency brought about by events unforeseeable by the CCG and not attributable to the CCG. Failure to plan work properly is not a justification for waiving the requirement to tender;

where the works, services or supply required are available from only one source for technical or artistic reasons or for reasons connected with the protection of exclusive rights;

when the goods required by the CCG are a partial replacement for, or in addition to, existing goods and to obtain the goods from a supplier other than the supplier who supplied the existing goods would oblige the CCG to acquire goods with different technical characteristics and this would result in:

- incompatibility with the existing goods; or
- disproportionate technical difficulty in the operation and maintenance of the existing goods;

but no such contract may be entered in for a duration of more than three years;

when works or services required by the CCG are additional to works or services already contracted for but for unforeseen circumstances such additional works or services have become necessary and that such additional works or services:

- cannot for technical or economic reasons be carried out separately from the works or services under the original contract without major inconvenience to the CCG; or
- can be carried out or provided separately from the works or services under the original contract but are strictly necessary to the latest stages of performance of the original contract; provided that the value of such additional works or services does not exceed 50% of the value of the original contract.

for the provision of legal advice and/or services provided that any provider of legal advice and/or services commissioned by the CCG is regulated by the Solicitors Regulation Authority for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel’s opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

17.5.5 Monitoring and Audit of Decision not to seek Tenders

The waiving of competitive tendering procedures should not be used with the object of avoiding competition or solely for administrative convenience or subject to SFIs 17.5.4 (j) to (k) to award further work to a provider originally appointed through a competitive procedure.
(b) Where it is decided that competitive tendering need not be applied or should be waived, the fact of the non application or waiver and the reasons for it should be documented and recorded in an appropriate CCG record and reported to the Audit Committee at each meeting.

(c) Where the CCG proposes not to conduct a tender process in relation to a contract opportunity for a new health care service or a significantly changed health care service then the CCG shall consider such proposals at a meeting of the Governing Body as recommended by the CCG Procurement Guide, in line with the Procurement Regulations, the Scheme of Delegation and Procurement Strategy.

17.5.6 Contracts which subsequently breach thresholds after original approval not to seek tenders

Contract opportunities estimated to be below the financial limits set in this SFI 17 or below the threshold for the application of the requirement to tender under the Regulations, for which formal tendering procedures are not used, but which subsequently prove to have a value above such limits, shall be reported to the Chief Officer, and be recorded in an appropriate CCG record.

17.5.7 Building and Engineering Construction Works

Not Applicable.

17.6 Use of Framework Agreements

The CCG may utilise any available framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

(a) the framework agreement was procured on its behalf. The CCG should satisfy itself that the original procurement process included the CCG within its scope;

(b) the framework agreement includes the CCG’s requirement within its scope. The CCG should satisfy itself that this is the case;

(c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and

(d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

17.7 Tendering Procedure

17.7.1 Equality of Treatment

The CCG shall ensure that no sector of any market (public, private, third sector/social enterprise) is given an unfair advantage in the design or conduct of any tender process.

17.7.2 Non-Discrimination

(a) The subject matter and the scope of the contract opportunity should be described in a non-discriminatory manner. The CCG should utilise generic
and/or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or their suppliers.

(b) All participants in a tender process should be treated equally and all rules governing a tender process must apply equally to all participants.

17.7.3 Advertisement of Contract Opportunities

Where a formal tender process is required under SFI 17.5.1 then:

(a) where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required, an OJEU Notice should be utilised; or

(b) without prejudice to SFI 17.7.3(c) below where a contract opportunity does not fall within the Regulations the CCG shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers (including providers in member states of the EU other than the UK) to access appropriate information about the contract opportunity so as to be in a position to express an interest; and

(c) in relation to any contract opportunity for health care services that falls below the threshold for light touch but is above the tender threshold of the CCG shall as a minimum advertise on www.supply2health the procurement portal operated by the Department of Health www.gov.uk/contracts-finder.

17.7.4 Choice of Procedure

(a) Where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required then the CCG shall utilise an available tender procedure under the Regulations.

(b) In all other cases the CCG shall utilise a tender procedure proportionate to the value, complexity and risk of the contract opportunity and shall ensure that invitations to tender are sent to a sufficient number of providers to provide fair and adequate competition (in any event no less than two).

17.7.5 Invitation to tender

(a) All invitations to tender shall state the date and time that is the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

- submitted electronically through the appropriate process using the Bravosolution etendering service, as instructed within the tender documentation;
- or where requested submitted in a plain sealed package or envelope bearing a preprinted label supplied by the CCG (Or the word "tender" followed by the subject to which it related and the latest date and time for the receipt of tender) addressed to the Chief Officer or notified nominated manager;
- Tender envelopes/packages bear no names or marks indicating the sender. Where courier or postal services are used to deliver tender documents such services must not identify the sender on the envelope or on any receipt required by such services

(c) Every invitation to tender must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the CCG, its employees or officers concerning the contract opportunity tendered.
17.7.6 Receipt and safe custody of tenders

(a) The Chief Officer or his/her nominated representative (who may not be from the department that sponsored or commissioned the relevant invitation to tender, referred to as the Originating Department for the remainder of this SFI 17.7) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

(b) The date and time of receipt of each tender shall be endorsed on the tender envelope/package by the Chief Officer or his/her nominated representative.

(c) In the case of Electronic tenders will provide an auditable date/time stamp of all actions is automatically created through the Bravolution etendering service. This audit trail is available for review in real time by all officers with appropriate access rights and cannot be edited.

17.7.7 Opening tenders and Register of tenders

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Officer (who may not be from the Originating Department). Where electronic, the nominated registered electronic tendering user will be able to access the electronic tenders and release them once the time and date for opening has passed.

(b) A member of the CCG Governing Body will be required to be one of the two approved persons present for the opening of paper based tenders estimated to be of a value of above £50,000. The rules relating to the opening of paper based tenders will need to be read in conjunction with any delegated authority set out in the CCG’s Scheme of Delegation.

(c) Subject to SFI 17.7.11 the involvement of Finance Directorate staff in the Originating Department’s preparation of an invitation to tender will not preclude the Chief Finance Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(d) All Executive Directors/members will be authorised to open paper based tenders regardless of whether they are from the Originating Department provided that the other authorised person opening the tenders with them is not from the Originating Department.

(e) The CCG’s Chief of Corporate Services will count as a Director for the purposes of opening paper based tenders.

(f) An auditable electronic log of actions, which may not be edited, is created including procurement and supplier time/date stamped actions. Every paper based tender received shall be marked with the date of opening and initialled by those present at the opening.

(g) A register shall be maintained by the Chief Officer, or a person authorised by him/her, to show for each competitive paper based invitation to tender despatched:

- the names of all organisations/individuals invited to tender;
- the names of all organisations/individuals from which tenders have been received;
- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender; and
- a note where price alterations have been made on the tender and suitably
Each entry to this register shall be signed by those present at the opening of the relevant tenders.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(a) The nominated registered electronic tendering user will be able to access the electronic tenders and release them once the time and date for opening has passed.

(b) An electronic register is maintained within Bravo

17.7.8 Admissibility of Tenders

(i) If for any reason the designated officers are of the opinion that the tenders received are not sufficient to demonstrate competition (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Officer.

(ii) Where only one tender is sought and/or received, the Chief Officer and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure best value for the CCG.

17.7.9 Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Officer or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Officer or his/her nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Officer or his/her nominated officer.

(iii) Accepted late tenders will be reported to the appropriate Governing Body in line with the Scheme of Delegation.

17.7.10 Electronic Auctions and Dynamic Purchasing Systems

(a) The CCG shall have policies and procedures in place for the control of all tendering activity carried out through dynamic purchasing systems and electronic auctions if such mechanisms are to be utilised by the CCG for tendering any contract opportunity. For further guidance on dynamic purchasing systems or electronic auctions refer to: https://www.gov.uk/government/organisations/cabinet-office

17.7.11 Accountability where in-house bid

(a) In all cases where the Governing Body or the Chief Officer determine that in-house services (should be subject to competitive tendering the following groups shall be set up:
• Specification group, comprising the Chief Officer or nominated officer/s and specialist officer whose function shall be to draw up the specification of the service to be tendered.
• In-house tender group, comprising a nominee of the Chief Officer and technical support to draw up and submit the in-house tender submission.
• Evaluation group, comprising normally a specialist officer, a supplies or commissioning officer and a Chief Finance Officer representative whose function is to shortlist expressions of interest received and evaluate tenders received. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.

(b) No officer or employee of the CCG directly engaged or responsible for the provision of the in-house service subject to competitive tendering may be a member of any of the specification or evaluation group established under SFI 17.7.11(a) but the specification group may consult with and take into account information received from such officers or employees in drawing up the CCG’s specification subject at all times to observing the duty of non-discrimination at SFI 17.7.2. No member of the in-house tender group may participate in the evaluation of tenders.

(c) The evaluation group shall make recommendations to the Governing appropriate body in line with the Scheme of Delegation and the Procurement Strategy.

(d) The Chief Officer shall nominate an officer to oversee and manage the contract awarded on behalf of the CCG.

17.8 Quotations: Competitive and Non-Competitive

17.8.1 Requirement to obtain competitive quotations

(a) Subject to 17.8.1(b) and 17.8.1(c) competitive quotations are required for all contract opportunities where formal tendering procedures are not adopted and where the intended expenditure of income exceeds, or is reasonably expected to exceed £10,000.

(b) Competitive quotations are not required where a contract opportunity need not be advertised and tendered under SFI 17.5.4 (b) to (f) inclusive.

(c) Competitive quotations are not required where the requirement to advertise and tender a contract opportunity has been waived under SFI 17.5.4 (g) to (l) inclusive.

17.8.2 Competitive Quotations

Where competitive quotations are required under SFI 17.8.1:

(i) quotations should be obtained from at least 3 organisations/individuals based on specifications or terms of reference prepared by, or on behalf of, the CCG.
(ii) quotations should be obtained in writing unless the Chief Officer or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in an appropriate CCG record.

(iii) all quotations should subject to compliance with the provisions of the Freedom of Information Act 2000 be kept as confidential and should be retained for six months from the date of receipt for inspection.

(iv) the Chief Officer or his/her nominated officer should evaluate each quotation received applying evaluation criteria in accordance with SFI 17.9 and select the quote which gives the best value.

17.8.3 Non-Competitive Quotations

(a) Subject to SFI 17.8.3(b) below non-competitive quotations in writing must be obtained for any contract opportunity where formal tendering procedures are not adopted and where competitive quotations are not required under SFI 17.8.1.

(b) Where competitive tendering or a competitive quotation is not required, the CCG shall use NHS Logistics Authority NHS Supply Chain for procurement of all goods unless the Chief Officer or nominated officers deem it inappropriate. The decision to use alternative sources must be documented in an appropriate CCG record.

17.8.4 Quotations to be within Financial Limits

No quotation shall be accepted by the CCG which will commit expenditure in excess of that which has been allocated by the CCG except with the express authorisation of either the Chief Officer or Chief Finance Officer.

17.9 Evaluation of Tenders and Quotations

17.9.1 Overriding duty to achieve best value

The CCG shall ensure that it seeks to obtain best value for each contract opportunity.

17.9.2 Choice of Evaluation Methodology

The CCG must for each contract opportunity which is subject to a tender or a competitive quotation choose to adopt evaluation criteria based on either:

(a) the lowest price; or

(b) the most economically advantageous tender, based on criteria linked to the subject matter of the contract opportunity including but not limited to some or all of:

- quality;
- price;
- technical merit;
- aesthetic and functional characteristics;
- environmental characteristics;
- running costs;
- cost effectiveness;
- after sales service;
• technical assistance;
• delivery date;
• delivery period; and/or
• period of completion.

17.9.3 Each invitation to tender or invitation to supply a competitive quotation must state the evaluation criteria to be used to evaluate the tender or quotation and the relative weightings of each such criterion.

17.10 Award of Contracts and Formal Authorisation

17.10.1 Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender.

(b) Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders (see SFI 17.7.9 above).

(c) Where examination of tenders reveals errors which would affect the tender figure, the tenderer may be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

(d) No tender shall be accepted by the CCG which will commit expenditure in excess of that which has been allocated by the CCG except with the express authorisation of the Chief Officer.

(e) No tender shall be accepted by the CCG which is obtained contrary to these SFIs except with the express authorisation of the Chief Officer or Chief Finance Officer.

(f) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be kept confidential and should be retained for 12 months from the date set for the receipt of tenders for inspection.

17.10.2 Authorisation of Tenders and Competitive Quotations

(a) Providing all the requirements set out in these Standing Financial Instructions and the Procurement Strategy have been fully complied with, formal authorisation and awarding of a contract may be decided by appropriate staff in line with the thresholds contained in the current budgetary Scheme of Delegation.

(b) These levels of authorisation may be varied or changed by the CCG and need to be read in conjunction with the CCG’s Scheme of Delegation.

(c) Formal authorisation must be put in writing. In the case of authorisation by the CCG Governing Body this shall be recorded in their minutes.

17.10.3 Tender reports to the CCG Governing Body

Reports to the CCG Governing Body will be made on an exceptional basis only and will relate to high risk/high value contracts in line with the Scheme of Delegation and the Procurement Strategy.
17.11 Form of Contract

17.11.1 Form of contract: General

Subject to the remainder of SFI 17.11 below the CCG shall consider the most applicable form of contract for each contract opportunity (including to the extent appropriate any NHS Standard Contract Conditions available) and should consider obtaining support from a suitably qualified professional advisor (including where appropriate legal advisors).

17.11.2 Statutory Requirements

The CCG must ensure that all contracts that are governed by mandatory statutory requirements (whether contained in Statute, Regulations or directions) comply with such requirements.

17.11.3 Contracts for Health Care Services

Where a mandatory requirement of the Department of Health, the CCG shall utilise the most relevant NHS commissioning contract for the commissioning of health care services, or where a mandatory requirement of the Department of Health include standard provisions.

17.11.4 Contracts for Building or Engineering Works

Not Applicable.

17.11.5 Employment, Agency and Consultants Contracts

The Chief Officer shall nominate officers with delegated authority to enter into permanent and temporary contracts of employment and other contracts for agency staff or persons engaged on a consultancy basis.

17.11.6 Compliance Requirements for all Contracts

The CCG may only enter into contracts within the statutory powers delegated to it by the Secretary of State or otherwise derived from Statute and each such contract shall:

(a) comply with the CCG’s Standing Orders and Standing Financial Instructions;

(b) comply with the requirements of all EU Directives directly enforceable in the UK and all other statutory provisions;

(c) require (where applicable) the standards set out in the Standards for Better Health (as issued by the Department of Health from time to time) to be followed;

(d) embody substantially the same terms and conditions of contract as were the basis on which tenders or quotations were invited;

(e) be entered into and managed to obtain best value;

(f) have an officer nominated by the Chief Officer to oversee and manage each contract on behalf of the CCG.

17.12 Specific Requirements

17.12.1 Disposals (See overlap with SFI No.25)
Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Officer or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the CCG;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and/or

(d) land or buildings concerning, subject to compliance with all applicable Department of Health guidance.

17.12.2 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 27.3).

Not Applicable.

18. CONTRACTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17)

18.1 Contracts

18.1.1 The Chief Officer, as the Accountable Officer, is responsible for ensuring the CCG enters into suitable contracts and for considering the extent to which any NHS Standard Contract Conditions are mandatory for contracts for the commissioning of NHS services.

All contracts will be entered into pursuant to the guidance, templates and tools contained in the Commissioning Packs issued by NHS England and the Department of Health Strategic Commissioning Development Unit.

All contracts should aim to implement the agreed priorities contained within the Commissioning Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Officer should take into account:

• the standards of service quality expected;
• the relevant national service framework (if any);
• the provision of reliable information on cost and volume of services;
• the NHS National Performance Assessment Framework;
• that contracts build where appropriate on existing Joint Investment Plans;
• that contracts are based on integrated care pathways.

18.2 Reports to Governing Body on contracts

The Chief Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure against the contract.

19. COMMISSIONING

19.1 Role of the CCG in Commissioning Services
19.1. The CCG has responsibilities for commissioning services on behalf of the resident population. This will require the CCG to work in partnership with NHS England Commissioning Board Area Team, local NHS Trusts, CCGs, and FTs, local authority, users, carers, the voluntary sector and social enterprise to develop an Annual Plan.

19.2 Role of the Chief Officer

19.2.1 The Chief Officer as the Accountable Officer has responsibility for ensuring services are commissioned in accordance with the priorities agreed in the Annual Plan. This will involve ensuring contracts are put in place with the relevant providers, based upon integrated care pathways.

19.2.2 The Chief Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

19.2.3 Where the CCG makes arrangements for the provision of services by non-NHS providers it is the Chief Officer, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided.

19.3 Role of Chief Finance Officer

19.3.1 A system of financial monitoring must be maintained by the Chief Finance Officer to ensure the effective accounting of expenditure under the contract. This should provide a suitable audit trail for all payments made under the agreements, but maintains patient confidentiality.

19.3.2 The Chief Finance Officer must account for Out of Area Treatments/Non Contract Activity financial adjustments in accordance with national guidelines.

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE CCG GOVERNING BODY AND CLINICAL COMMISSIONING GROUP(S) AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Governing Body shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report).

20.1.2 The Committee will:

(a) advise the Governing Body about appropriate remuneration and terms of service for officer members employed by the CCG and other senior employees, covering:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Governing Body on the remuneration and terms of service of officer members of the Governing Body and Clinical Commissioning Group members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the CCG - having proper
regard to the CCG's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members of the Clinical Commissioning Group (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

20.1.3 The Committee shall report in writing to the Governing Body the basis for its recommendations. The Governing Body shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Clinical Commissioning Group members. Minutes of the Governing Body's meetings should record such decisions.

20.1.4 The Governing Body will consider and need to approve proposals presented by the Chief Officer for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The CCG will pay allowances to the Chair and non-officer members of the Governing Body in accordance with instructions issued by the Secretary of State for Health.

20.2 Funded Establishment

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department may not be varied without the approval of the Chief Officer or the nominated officer in charge of the department.

20.3 Staff Appointments

20.3.1 No officer or Member of the Clinical Commissioning Group or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Officer; and

(b) within the limit of their approved budget and funded establishment.

20.3.2 The Governing Body will approve procedures presented by the Chief Officer for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Chief Finance Officer will issue instructions regarding:
(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act;
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit, or cash to employees and officers;
(i) procedures for the recall of cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash;
(m) a system to ensure the recovery from those leaving the employment of the CCG of sums of money and property due by them to the CCG.

20.4.3 Appropriately nominated managers and Clinical Commissioning Group members have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil Clinical Commissioning Group obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Governing Body shall delegate responsibility to an officer for:
ensuring that all employees are issued with a Contract of Employment in a form approved by the Governing Body and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Governing Body will approve the level of non-pay expenditure on an annual basis and the Chief Officer will determine the level of delegation to budget managers.

21.1.2 The Chief Officer will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

21.1.3 The Chief Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the CCG. In so doing, the advice of the CCG’s adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Officer) shall be consulted.

21.2.2 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 The Chief Finance Officer will:

(a) advise the Governing Body regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
(i) A list of Governing Body and Clinical Commissioning Group members/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with Regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer member of the Clinical Commissioning Group must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the CCG if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Officer if problems are encountered.

21.2.5 Official orders

Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Finance Officer;
(c) state the CCG’s terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Officer.

21.2.6 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
(b) contracts are advertised where required by these SFIs;
(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
   (i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
   (ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”; the Code of Conduct for NHS Managers (2004); and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry).

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Officer;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;
(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the CCG to a future uncompetitive purchase;

(j) changes to the list of members/employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

21.2.7 The Chief Officer and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Concode and Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

21.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with that Act. (See overlap with Standing Order No. 9.1)

22. FINANCIAL FRAMEWORK

22.3.1 The Chief Finance Officer should ensure that members of the Governing Body are aware of the Financial Framework. This document contains directions which the CCG must follow. It also contains directions to the Area Team regarding revenue and capital resource allocation and funding to the CCG. The Chief Finance Officer should also ensure that the direction and guidance in the framework is followed by the CCG.

23. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

23.1 Capital Investment

23.1.1 The Chief Officer:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

23.1.2 For every capital expenditure proposal the Chief Officer shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual is produced setting out:
(i) an option appraisal of potential benefits compared with known costs to
determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(b) that the Chief Finance Officer has certified professionally to the costs and
revenue consequences detailed in the business case and involved
appropriate CCG personnel and external agencies in the process.

23.1.3 The Chief Finance Officer shall issue procedures for the regular reporting of
expenditure and commitment against authorised expenditure.

23.1.4 The approval of a capital programme shall not constitute approval for expenditure
on any scheme.

The Chief Officer shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.5);

(c) approval to accept a successful tender (see overlap with SFI No. 17.5).

The Chief Officer will issue a scheme of delegation for capital investment management
in accordance with Estatecode guidance and the CCG's Standing Orders.

23.1.5 The Chief Finance Officer shall issue procedures governing the financial
management, including variations to contract, of capital investment projects and
valuation for accounting purposes. These procedures shall fully take into account
the delegated limits for capital schemes as most recently issued by DoH.

23.2 Private Finance (see overlap with SFI No. 17.10)

23.2.1 Not Applicable

23.2.2 LIFT Exclusivity (see Appendix 3)

Not Applicable

23.3 Asset Registers

23.3.1 The Chief Officer is responsible for the maintenance of registers of assets, taking
account of the advice of the Chief Finance Officer concerning the form of any
register and the method of updating, and arranging for a physical check of assets
against the asset register to be conducted once a year.

23.3.2 Each CCG shall maintain an asset register recording fixed assets. The minimum
data set to be held within these registers shall be as specified in the Manual for
Accounts as issued by the Department of Health.

23.3.3 Additions to the fixed asset register must be clearly identified to an appropriate
budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates,
supplier's invoices and other documentary evidence in respect of purchases
from third parties;

(b) stores, requisitions and wages records for own materials and labour including
appropriate overheads;
lease agreements in respect of assets held under a finance lease and capitalised.

23.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

23.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

23.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Manual for Accounts issued by the Department of Health.

23.3.7 The value of each asset shall be depreciated using methods as specified in the Manual for Accounts issued by the Department of Health.

23.3.8 The Chief Finance Officer shall calculate and pay capital charges as specified in the Manual for Accounts issued by the Department of Health.

23.4 Security of Assets

23.4.1 The overall control of fixed assets is the responsibility of the Chief Officer.

23.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

23.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

23.4.4 Whilst each employee and officer has a responsibility for the security of property of the CCG, it is the responsibility of Governing Body members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Governing Body. Any breach of agreed security practices must be reported in accordance with agreed procedures.

23.4.5 Any damage to the CCG’s premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Governing Body members and employees in accordance with the procedure for reporting losses.

23.4.6 Where practical, assets should be marked as CCG property.
23.5 NHS LIFT

Not Applicable.

24. STORES AND RECEIPT OF GOODS

24.1 General position

24.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

24.2 Control of Stores, Stocktaking, condemnations and disposal

24.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Officer. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer.

24.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as health service property.

24.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

24.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

24.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

24.2.6 The designated Manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

24.3 Goods supplied by NHS Logistics

24.3.1 For goods supplied via the NHS Logistics central warehouses, the Chief Officer shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

25. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

25.1 Disposals and Condemnations
25.1.1 **Procedures**

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

25.1.2 When it is decided to dispose of a CCG asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

25.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

25.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

25.2 **Losses and Special Payments**

25.2.1 **Procedures**

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

25.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Officer and/or Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Officer. Where a criminal offence is suspected, the Chief Officer and/or Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS and Operational Fraud Team (OFT) in accordance with Secretary of State for Health’s Directions.

25.2.3 **Suspected fraud**

The Chief Finance Officer must notify NHS Protect and the External Auditor of all frauds.

25.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Governing Body, and

(b) the External Auditor.

25.2.5 Within limits delegated to it by the Department of Health, the Governing Body shall approve the writing-off of losses.
25.2.6 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the CCG’s interests in bankruptcies and company liquidations.

25.2.7 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

25.2.8 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

25.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

25.2.10 All losses and special payments must be reported to the Audit Committee at every meeting. The Audit Committee may approve single items of expenditure up to £10,000. For items in excess of £10,000, the Audit Committee may make a recommendation to the Governing Body. For urgent payments, the Chief Officer must obtain the approval of the Governing Body Chair or the Audit Committee Chair and the payment must be approved at the next Governing Body meeting.

26. INFORMATION TECHNOLOGY

26.1 Responsibilities and duties of the Director of Finance

26.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the CCG, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG’s data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

26.1.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

26.1.3 A named Director shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the CCG that is made publicly available.

26.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application
26.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of CCGs in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:
(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

26.3 Contracts for computer services with other health bodies or outside agencies

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

26.3 Requirements for computer systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:
(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Finance Officer staff have access to such data;
(d) such computer audit reviews as are considered necessary are being carried out.

27. FUNDS HELD ON TRUST

Not Applicable

28. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer shall ensure that all staff are made aware of the CCG policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff'; the Code of Conduct for NHS Managers 2004; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

29. PAYMENTS TO INDEPENDENT CONTRACTORS
29.1 Duties of the Chief Finance Officer

The Chief Finance Officer shall:

(a) maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;

(b) ensure that regular independent verification of claims is undertaken, to confirm that:

(i) rules have been correctly and consistently applied;

(ii) overpayments are detected (or preferably prevented) and recovery initiated;

(iii) suspicions of possible fraud are identified and subsequently dealt with in line with the Secretary of State for Health’s Directions on the management of fraud and corruption.

(d) ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

(e) ensure that a prompt response is made to any query raised by the Prescription Pricing Division of the NHS Business Services Authority, regarding claims from contractors submitted directly to them.

30. RETENTION OF RECORDS

30.1 The Chief Officer shall be responsible for maintaining archives for all records required to be retained in accordance with NHS Code of Practice - Records Management Part 2 (2nd Edition) 2009.

30.2 The records held in archives shall be capable of retrieval by authorised persons.

30.3 Records held in accordance with NHS Code of Practice - Records Management 2006, shall only be destroyed at the express instigation of the Chief Officer. Detail shall be maintained of records so destroyed.

31. RISK MANAGEMENT AND INSURANCE

31.1 Programme of Risk Management

The Chief Officer shall ensure that the CCG has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Governing Body.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; internal audit, clinical audit, health and safety review;
f) a clear indication of which risks shall be insured;
g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health guidance.

31.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Governing Body shall decide if the CCG will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Governing Body decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

31.3 Insurance arrangements with commercial insurers

31.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, four exceptions when CCGs may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) for insuring motor vehicles owned by the CCG including insuring third party liability arising from their use;

(2) where the CCG is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

(3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the CCG for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a CCG’s powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health.

4) where a premises landlord requires the organisation to take out insurance as condition of occupancy

31.4 Arrangements to be followed by the Governing Body in agreeing Insurance cover

(1) Where the Governing Body decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Governing Body decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Governing Body is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up
formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Chief Finance Officer should ensure documented procedures also cover the management of claims.
Appendix 1

Address of NHS Doncaster Clinical Commissioning Group

The principal place of business of the CCG is given below:

NHS Doncaster Clinical Commissioning Group
Sovereign House
Heavens Walk
Doncaster
South Yorkshire
DN4 5HZ
Telephone: 01302 566300
Email: enquiries@doncasterccg.nhs.uk
Item 15

Receipt of Minutes from Committees
Minutes of the Audit Committee
Held on Thursday 12 January 2017 at 9:00-11:30am
Meeting Room 3, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ

Committee Members Present
Miss Anthea Morris (Chair) Lay Member
Dr Andrew Oakford Locality Lead
Dr Karen Wagstaff Locality Lead
Mrs Sarah Whittle Lay Member
Dr Emyr Wyn Jones Secondary Care Doctor Lead

Formal Committee Members Present:
Mrs Sarah Atkins Whatley Chief of Corporate Services
Mrs Hayley Tingle Chief Finance Officer
Mrs Julia Holmes Assistant Head of Finance
Mrs Annette Tudor Internal Audit – 360 Assurance
Mr Kevin Watkins Internal Audit – 360 Assurance
Mrs Claire Partridge External Auditor - KPMG
Mrs Tracy Wyatt Deputy Chief Finance Officer
Mr James Boyle External Auditor, KPMG

In attendance:
Miss Lindsay Moore Senior Corporate Services
Mrs Elaine Dower Support Officer (taking Notes)
Mr Andrew Russell Chief Nurse (for item 6.2)

Action

1. Apologies for Absence

There were no apologies received for this meeting

2. Declarations of Interest

The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group (CCG).

Declarations declared by members of the committee are listed in the CCG’s Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link: www.doncasterccg.nhs.uk

The meeting was noted as quorate.

Declarations of interest from sub committees / working groups:
None declared.

*Declarations of interest from today’s meeting:*

Dr Wagstaff informed the Committee of her interest in one of the practices mentioned in the minutes of another meeting in relation to contracting arrangements. The Committee noted that no decisions were being made, and therefore Dr Wagstaff could remain in the room for any discussions.

### 3. Minutes of the meeting held on 10 November 2016

The minutes of the meeting held on 10 November 2016 were agreed as an accurate record.

### 4. Matters Arising via Action Tracker

The actions within the tracker were noted as complete with the exception of the meeting with Internal Audit to discuss the Internal Audit Workplan for 2017/18. The Committee noted that a meeting is needed with Internal Audit, at least two Audit Committee members and the CCG executive team. It was agreed that the 26th January or 2nd February would be most convenient. Miss Moore to check the availability of the Executive Committee and arrange the meeting on the most convenient date.

The Draft Audit Plan will be added to the agenda for the Audit Committee in March 2017.

### 5. External Audit

#### 5.1 External Audit Technical Update and Review of the External Audit Plan

Mrs Partridge and Mr Boyle presented the External Audit Technical Update to the Committee, and advised that the Audit Deliverables are outlined on page 5.

The Technical Update highlights the main technical issues which are currently having an impact on the health sector. There are 2 updates for which action was suggested and one for which action is required which are:

- **Single Oversight Framework (SOF) Shadow Segmentation:**
  The CCG are requested to understand their position and ensure internal performance management frameworks align to the SOF and action plans are developed and put in place to address under performance.

  Miss Moore

  Miss Moore

  Mrs Atkins Whatley / Mrs Tingle
• Proposed Changes to NHS Pension Scheme Regulations: Comments on the draft legislation can be submitted via email or post; this consultation closes on 26 January 2017.

• NHS Injury Cost Recovery Scheme: Guidance for 2016/17. Trusts should familiarise themselves with this guidance, including how related transactions are recorded in the annual accounts.

The Committee were also informed that the mechanisms are in place for the Estates and Technology Fund to ensure that plans are followed through. It was agreed that an update to Governing Body would be useful in respect of the Doncaster Area. Mrs Tingle agreed to take this action forward.

Dr Oakford informed the Committee that IT equipment had been purchased for practices however there appears to be a backlog in the installation process. Mrs Holmes agreed to speak to Mrs Lawrence in relation to this.

Miss Morris asked if the Technical Update is able to be circulated to Governing Body. Mrs Partridge and Mr Boyle confirmed that this would be possible. Mrs Tingle and Mrs Atkins Whatley agreed to speak to Dr Crichton around this and look at which elements could be included in the Chair and Chief Officer report.

External Audit Plan

Mr Boyle advised the Committee that there has been more focus on sustainability which has been picked up on in the plan and as much work as possible will be brought forward to take into account and deal with the rise in adverse opinions. There have been two significant risks identified;
• Fraudulent recognition of income
• Management override of controls

KPMG have also identified one further significant risk:
• Accounting for co-commissioning. In order to address this risk a more in depth understanding of the processes in place is required.

Mrs Partridge and Mr Boyle also highlighted that there is further work planned on the CCG’s medium term plan with regard to Value for Money. Work around this is on-going and plans are being developed to look at how savings are managed in order to meet the targets being set. If any issues or risks are identified an update will be provided to Audit Committee.

Mrs Tingle advised that Committee that she is presenting an update on the financial plan to the Governing Body on 19th January and will also discuss the efficiency savings. Mrs Tingle also
informed the Committee that contracts with RDaSH and DBH have been agreed with very challenging efficiency savings of £4.5million included in the DBH contract and £500k included in the RDASH contract, leaving up to £5m of savings unidentified. Mrs Tingle advised the Audit Committee that this represents a significant financial risk for the CCG and we need to challenge ourselves, as Governing Body members, on whether we are being sufficiently ambitious, especially around prescribing savings. Mrs Atkins Whatley also placed this in the wider context of the Place Plan which requires a shift in culture towards more self-care and prevention. Audit Committee members noted these points and recommended that an Audit Committee recommendation be escalated to the Governing Body as part of Mrs Tingle’s presentation for greater ambition and holding to account. Audit committee will provide a slide for the presentation.

6. Internal Audit

6.1 Internal Audit Progress Report and Technical Update

Mrs Tudor and Mr Watkins informed the Committee that the delivery of work from the 2016/17 Internal Audit Plan is progressing and is detailed in the report. One audit report has been issued since the last Audit Committee meeting which is around the Section 117 (Mental Health Act Aftercare) Review.

Stage 3 of the assessment of the CCG’s 2016/17 Assurance Framework and associated processes has also been completed and has not identified any concerns that would have an adverse impact on the Head of Internal Audit Opinion.

Work in progress includes the Budgetary Control & Financial Systems audit, and the Conflicts of Interest Audit.

A Governance Assurance Workshop is planned.

The Audit Committee noted the report and the assurances contained within it.

6.2 Section 117 (Mental Health Act Aftercare) Report

This review was requested by NHS Doncaster CCG and examined the effectiveness of controls in place. A meeting with the Chief Nurse and the Named Nurse for Safeguarding Adults was held and it was agreed that time in the Internal Audit Plan for 16/17 allocated to ‘Section 117’ would be used to independently evaluate the progress made. Originally it was intended that the opinion be on the direction of travel, but this evolved into a formal comment piece.
Mrs Dower noted the significant amount of work which had been completed since the CCG took over responsibility for Section 117s from Doncaster PCT, but noted that the work was not formally captured and therefore a limited opinion was issued in respect of governance arrangements and the quality review of Section 117 care.

It was noted that actions had already been identified by the CCG in many of the identified areas, and the Internal Audit recommendations served to formalise these. The recommendations will be presented to the Section 117 meeting later this month, which will accept them, and the recommendations will then form the basis of the action plan moving forwards.

Mr Russell confirmed that the Limited Assurance report will be notified verbally to the confidential Governing Body in January 2017. The gaps identified in the work plan will be populated with actions and will be discussed at the Governing Body meeting in February 2017 and then taken forward via the Section 117 meeting and the Individual Placements Steering Group. Regular updates will also be provided to Audit Committee via the monitoring of Audit Recommendations.

Dr Jones welcomed the report and action plan, noting that this was a complex area requiring a partnership approach, representing a high risk to the organisation. Dr Jones confirmed that the quality aspects would be overseen by the Quality & Patient Safety Committee.

The Committee discussed the financial risk and impact, and it was noted that a higher-level conversation is planned around this element.

It was agreed to consider the appropriate placing of a follow-up report or re-audit in the 2017/18 Internal Audit Workplan.

7. **Financial Reporting**

7.1 **Finance Exception Reports**

Mrs Holmes presented the financial report to the Committee and advised that this report identifies any losses and special payments, waiving of Standing Orders or Standing Financial Instructions and debtors or creditor balances over six months old and over £5,000.

There are no losses or special payments to report since the last meeting of the Audit Committee.

No new applications to waive the tenders and quotes procedures have been processed since the last meeting.
There are three outstanding Debtors over six months old and over £5,000.

- A DMBC invoice for £16,606.91 is under query and the SBS Debt Management Team is actively pursuing this directly with DMBC.
- An invoice for £5,901.54 raised to a PHB client is being considered for payment by instalment. The CCG is liaising with the debtor to reach an acceptable agreement.
- A DMBC invoice for £7,011.05 has now been agreed in principle and had been passed to a DMBC approver for imminent payment.

There are no outstanding Creditors over six months old and over £5,000.

Mrs Holmes informed the Committee that there has recently been a break in at a GP practice resulting in two new computers being stolen. An Information Governance review has been completed and it was confirmed that there was no patient identifiable information on the Laptops.

The Committee noted the report.

8. Integrated Governance, Risk Management and Internal Control.

8.1 Assurance Framework Quarter 3 Report

Mrs Atkins Whatley informed the Committee that discussions have been held at Governing Body and Strategy and Organisational Development Forum around what is required from the Assurance Framework moving forward. In light of these discussions the existing format of the Assurance Framework has been refreshed at a relatively high level during the last Quarter and the position is presented for Governing Body approval as at quarter-end. The format will change for the next report at the end of Quarter 4.

The risks being treated as at the end of the Quarter are;

**Risk 1.3 relating to health inequalities** - This risk remains at a score of 8 (below the risk toleration threshold) but is being treated to strengthen controls and assurances. The Health & Wellbeing Board workshop on health inequalities took place during October 2016 and a partnership action plan is being developed from this workshop.

**Risk 1.4 relating to the challenging financial position for 2016/17.**
This risk remains at a score of 12 (above the risk toleration threshold) and is being treated with an action plan 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”. Progress on the RightCare Workstreams (respiratory, endocrine, neurology, musculoskeletal and prescribing) continues. The monthly Finance Report received by the Governing Body continues to identify potential overspends in other areas such as the acute contract, prescribing, funded nursing care and individual placements. We are still forecasting to achieve the CCG’s year-end control total in 2016/17, however the financial position remains challenging.

Risk 2.4 relating to provider performance
This is an on-going risk which the Governing Body keeps sight of on the Assurance Framework. 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 continues to receive monthly Quality & Performance reports which identify performance areas which are off trajectory and debates recovery plans.

Risk 4.4 relating to different commissioning
This risk continues to be treated as there are many different commissioning footprints and collaborations emerging at a rapid pace to address the challenges in the 5 Year Forward View. NHS Doncaster CCG is strongly engaged in the development of the Doncaster Place Plan, the South Yorkshire & Bassetlaw Sustainability & Transformation Plan, the Working Together Joint Committee (8 local CCGs), the Transforming Care Partnership, and joint commissioning for Ambulance and urgent transport. During the last Quarter we have seen significant progress in this area. Governing Body supported the Doncaster Place Plan in October 2016, and supported the South Yorkshire & Bassetlaw Sustainability & Transformation Plan in November 2016.

Mrs Whittle requested clarity on the Risk relating to Organisational Development and whether the Committee felt that this has been closed too soon as the plans are not yet in place. Mrs Atkins Whatley confirmed that the risk has been closed as the controls have been tightened up but further actions can be added if and when required.

The Committee acknowledged that a risk to the CCG at present is the A&E department not meeting their targets but noted that this is on the CCG risk register and weekly meetings are in place to raise, monitor and discuss issues. Mrs Whittle asked if A&E needed a risk rating in its own right as it currently sits under ‘Urgent Care’.
Mrs Atkins Whatley agreed to amend the Assurance Framework cover sheet for Governing Body to reflect the discussions held at last week’s Strategy & Organisational Development Forum.

The Committee agreed that it would be useful to highlight each of the proposed 4 new strategic objectives and focus on the risks associated with each in turn at each Audit Committee meeting throughout the year.

8.2 Review of implementations of Audit Committee Recommendations

The Committee noted the report and agreed that 19 actions are to remain open and 4 of the recommended 5 are to be closed. Risks to be closed: 33/01, 37/03, 37/06, 38/03. The Committee requested that risk 37/05 remain open until all register of interest forms are confirmed as received.

8.3 Integrated risks arising from other Committees

Remuneration Committee: There has been no meeting held since the April 2016 meeting.

Engagement & Experience Committee: No risks to report.

Executive Committee: No risks to report.

Quality & Patient Safety Committee: Good progress across a number of work areas. No further risks to report.

Primary Care Commissioning Committee: Vulnerable practices were discussed alongside the financial viability and direction of travel for Federations.

Clinical Reference Group: There are no risks arising from this Group. The last meeting was very well represented by CCG staff and partners and useful discussions were held.

9. Administration Arrangements

9.1 Review of Audit Committee Forward Planner

The Committee reviewed and noted the Audit Committee forward planner and agreed it would be useful if it could be adapted moving forwards to reflect the new approach to the assurance framework risks. Mrs Atkins Whatley agreed to look at this.
9.2 Minutes of the Corporate Governance Management Group Meeting held on 14 December 2016.

The Committee noted the minutes and acknowledged that Ms Hague has now left the CCG and Gareth Jones has been recruited into her post and commences employment on 8th February 2017.

9.3 Review of Policies

The Committee noted and approved the changes made to the following policies:

- Fraud, Corruption & Bribery Policy
- Whistleblowing Policy
- Freedom of Information Policy
- Information Governance Policy

Mrs Atkins Whatley advised the committee that once policies have been updated they are uploaded onto the website and staff are made aware in the monthly staff briefing as well as having input into relevant polices via the Colleague Engagement Group. The Corporate Governance Management group will be looking at the implementation and impact of the EU Data Protection Regulations.

10. Any Other Business

Mr Watkins informed the Committee that he has been invited to join the South Yorkshire & Bassetlaw Patient Transport Services Procurement Board to carry out a Project Assurance Role.

11. Date and Time of Next Meeting

Thursday 9th March 2017 at 9:00am – 12noon in Meeting Room 3, Sovereign House, Heavens Walk, Doncaster, DN4 5HZ
Minutes of the Quality & Patient Safety Committee
Held on Thursday 1st September 2016 at 9.00am
Boardroom, Sovereign House

Formal Committee Members Present:
Dr Emyr Jones (Chair) Secondary Care Doctor Member
Mr Ian Boldy Designated Nurse Safeguarding Adults and Head of Individual Placements
Dr Jeremy Bradley GP Representative
Mrs Suzannah Cookson Head of Quality, Designated Nurse for Safeguarding & LAC
Ms Elaine Dower 360 Assurance
Mrs Wendy Feirn Senior Nurse, Quality & Patient Safety
Mrs Zara Head Primary Care Quality Nurse
Mrs Andrea Ibbeson Named Nurse for Children's Safeguarding
Mrs Chris Quinn Patient Experience Manager
Mr Mark Randerson Head of Medicines Management
Mrs Jenny Rayner Senior Officer for Quality
Mr Andrew Russell Chief Nurse
Mrs Andrea Stothard Quality & Patient Safety Manager

Formal Committee Members in Attendance:
None

In attendance:
Lesley Twigg

Action

1. Welcome and Apologies

Dr Jones welcomed everyone to the meeting.

Apologies for absence were received from:
- Mr Booth, Specialist Placements Manager
- Mrs Bradley, Deputy Head Medicines Management Team
- Dr Britten, GP Lead for Quality
- Dr Victor Joseph, Consultant in Public Health, Doncaster Council
- Mrs Tyler, CHC Operational Lead

2. Declarations of Interest

No declarations were made.
3. Minutes and Actions of the Previous Meeting – Enclosure A & B

The minutes of the meeting held on Thursday 7th July 2016 were approved as a true record with the following amendments:

- Remove Mr Russell from the attendance section of the minutes.
- Item 6.5; Paragraph 2, replace Mrs Cookson with Mrs Shepherd.
- Item 6.7; Q4 Case Conferencing, paragraph 1, line 3; delete ‘doctor’ and replace with GP for Safeguarding.
- Agenda items 7.2 and 7.5 reworded, minutes from 7th July will be circulated with the minutes of this meeting.

Please refer to the action log for updates on all outstanding actions.

4. Matters Arising not on the Agenda

The Committee went through the action log for the meeting. All updates are recorded on the action log.

360 Assurance Feedback

Mrs Dower from 360 Assurance attended the meeting to provide feedback on the two recent audits that had been undertaken. Dr Jones apologised on behalf of the committee that this had not been included on the agenda.

Mrs Dower said that this had been a follow up audit following the Brown Jacobson report and said that the actions on that report had not been SMART which had made it hard for the CCG to monitor the action plan.

CHC Feedback

Mrs Dower said that more work was required to address weaknesses with patient consent, forms, paper and electronic files and that there is an action plan within the report that the CCG can use to action these issues. Mrs Dower added that this review was a non-opinion piece of work and that the report will go to the Audit Committee next week.

Mr Russell said that the work plan had views based on the Brown Jacobson report but acknowledged that it was not as robust as it could be. Dr Jones asked if this would also go to the Individual Placements Steering Group (IPSG), Mrs Dower confirmed that it would once the CCG had reviewed the report. Dr Jones asked that the recommendations from this review were included in a revised action plan and that Mr Russell and Mr Boldy lead on taking this work forwards. Mr Russell agreed and said that the action plan would go to IPSG where the actions would be monitored and that any exceptions would come to this committee. Dr Jones and the committee agreed this approach with Dr Jones adding that quality needs to be at the forefront of this work, Mr Russell agreed.

Mrs Dower added that all risks identified in the review were medium but that
two are high risk; this was not their rating but the CCGs as the CCG risk matrix is different to that of 360 Assurance. Mr Russell added that no significant risks to patients were identified; Dr Jones said that SMT had commissioned Brown Jacobson to do the external review and that SMT they may wish to consider reviewing the value of doing this but would leave that with Mr Russell to consider and then take forward if appropriate.

**Care Home Feedback**

Mrs Dower said that this review had been a non-opinion review and that they had been asked to look at how far the CCG had progressed and to determine the current position. Mrs Dower said that the report will go to the Audit Committee next week.

Mrs Dower fed back that Doncaster CCG and the Local Authority had made significant progress with the joint strategy, improved governance and a good relationship between the two organisations. There are however still some weaknesses that need to be addressed, for example, Delivery Plan for the Health Element; Governance Controls; Key Quality Outcomes; a formal process for how concerns regarding care homes are raised. Mr Boldy said that the report provides a good stocktake of where we are, Mr Russell added that the Care Home Strategy Group has now moved to implementation and is now called the Care Home Implementation Board, there are 5 workstreams within this:

- Health
- Workforce and Education (CPA)
- Commissioning & Contracting
- Engagement & Communication
- Fees & Quality

Mr Russell said that each work stream has been asked to develop an action plan and that the Board are sighted on this work and that a wealth of information is provided to Governing Body regarding Care Homes quality. Dr Jones said that there should be two distinct reporting mechanism’s for Governing Body; Mr Russell responded that we do this for RDaSH and DBHIT and asked if the committee supported this approach, the committee and Dr Jones agreed this would be useful. Mr Russell said that he will pick this up with Mr Boldy when they meet on the 6th September 16 to discuss the IP report for this meeting.

**Action 01 / 01.09.16:** Mr Russell and Mr Boldy to discuss the Care Home reporting mechanism at the planned meeting on 6th September 16.

Dr Jones asked if anyone had anything further to ask about the Care Home or CHC report, no one had. Dr Jones thanked Mrs Dower for attending and providing feedback and asked if she could email both of the reports to Mrs Twigg who will circulate with the minutes of this meeting.

**Action 02 / 01.09.16:** Mrs Dower to email both reports to Mrs Twigg who will...
circulate them to committee members with the minutes of the meeting

5. QUALITY

5.1 Medicines Management Report – Enclosure C

Mr Randerson highlighted the following to the committee from his report:

Antibiotic Audit

Discussed and agreed at CQRG.

T2 & T3 Breaches

Mr Randerson has discussed the breaches with Mr Davies in RDaSH and this seems to be a trend with patients who are sectioned, there have been 6 technical breaches and 6 where medication has been given to a patient without a treatment plan. Dr Jones asked if consent was required when a patient was sectioned; Mr Randerson said that when a patient is sectioned consent is not needed but it is required when the section ends. Mr Russell said that even if a patient is sectioned that the trust need to consider capacity in line with the Mental Health Act and the Mental Capacity Act. Mr Randerson said that he had discussed the breaches with Mrs Stothard regarding whether this needs to be a watching brief or should be raised with the Trust at CQRG, following discussion the committee agreed that Mr Davies should be invited to the RDaSH CQRG on 7th September 16 to provide an update and assurance on this issue.

Action 03 / 01.09.16: Mr Davies to be invited to the RDaSH CQRG on 7th September 16 to provide an update and assurance on T2 / 3 breaches. SD

Item 7a

Mr Randerson updated that 360 Assurance audit on PbR drugs in rheumatology and ophthalmology has been received, there is a high degree of non-compliance in both departments with ophthalmology 46% non-compliant and 33% for rheumatology. Mr Singh DBH Medical Director is aware and this has been put onto the DBHfT ACQRG agenda for discussion on 13th September.

Item 7b

Mr Randerson said that a Health & Safety issue had been identified by DBHfT regarding ‘biologicals’, this is to be discussed at FPIG with an update being provided at the next Q & PSC meeting on 3rd November 16.

Dr Jones asked if anyone had any further questions for Mr Randerson; no further questions asked.

5.2 DBHfT Quality Report – Enclosure D
Mrs Cookson updated that there are no issues and that mortality rates for the Trust are improving. Numbers of SI’s are a decreasing trend but numbers reported on Datix are increasing.

Mrs Cookson said that Q1 CQUINs have been attained apart from sepsis.

Work on Maternity Services is on-going and this will be an evolving story, there has been negative feedback from junior doctor’s regarding rota’s. Dr Jones asked about the impact of the closures at Bassetlaw and Mrs Cookson responded that Mr Singh is doing a lot of work with the Royal College on a review of the service. Dr Jones asked if the review would be Bassetlaw or the whole service; Mrs Cookson said it would be the whole service with Mr Russell adding that this would also include pediatrics’. Mrs Cookson went on to say that the Trust are working up an action plan and developing quality indicators, the CCG is invited to the Trust’s Quality meetings which are open and honest.

Mrs Cookson informed the committee that the ACQRG meetings for the Trust have now moved to monthly from bi-monthly meetings.

Mr Russell asked the committee if they were happy to approve the DBHfT ACQRG Terms of Reference (ToR) with the amendments suggested by Richard Parker. Mr Russell said that if additional approval was needed he would speak to Mrs Atkins-Whatley. NOTE: The committee approved the ToR.

Post Meeting Note: DBHfT Terms of Reference to be agreed at the next Strategic Contracting meeting. Mrs Twigg to ask Mrs Hudson to add to the agenda.

Dr Jones asked if anyone had any further questions for Mrs Cookson; no further questions asked.

5.3 FCMS Quality Update – Verbal

Mr Russell updated the committee that quarterly Quality meetings had been organised with FCMS. Mrs Cookson added that there had been a meeting last week and that the minutes of the meeting would be circulated to committee members with the minutes of today’s meeting.

Mrs Cookson said that FCMS provide a robust quality performance report and that there is healthy debate at the meetings. Mr Russell said that there had been a local press article about GPs not being available on the OoH Service and that we are urgently working with FCMS to address this and also understand their contingency plans and the impact to patients when a GP is not available within the service. Mr Russell added that this is less than 2% of the time with Mrs Stothard adding that Mrs Leighton is doing a contract query and there are discussions on whether this should be logged as a Serious Incident (SI). Mr Russell said that this would be logged on the risk register and the CCG would respond appropriately. Dr Jones asked if the CCG were responsible if FCMS were not providing the service we had commissioned; Mrs Cookson asked if the committee would like to see the quality report, the
committee said this would be helpful.

Dr Jones asked if anyone had any further questions for Mrs Cookson; no further questions asked.

**Action 04 / 01.09.16:** Mrs Twigg to circulate the minutes of the FCMS Quality meeting with the minutes and actions of this meeting and the latest FCMS Quality report.

**5.4 RDaSH Quality Report – Enclosure E**

Mrs Cookson said the patient in the Bungalow 2 / Sapphire Lodge incident had now moved to a new provider and that the internal investigation was on-going. The planned LADO meeting to discuss this had been cancelled and has now been re-arranged; Dr Jones asked if this needed to be removed as a standing agenda item, both Mrs Cookson and Mr Russell said that it can.

**Action 05 / 01.09.16:** Mrs Twigg to remove Bungalow 2 / Sapphire Lodge as a standing agenda item for this meeting.

Dr Jones asked the committee if they had any further questions for Mrs Cookson, nothing further asked.

**5.5 Care Home Report – Enclosure F**

**Care Home Strategy Update**

Mr Boldy updated that the Care Home Strategy Group has now moved to the Care Home Implementation Board (CHIB) and this will be jointly chaired by the CCG and DMBC. There will be 5 work streams reporting into CHIB, the work streams are:

- Workforce and Education (CPA)
- Commissioning & Contracting
- Engagement & Communication
- Fees & Quality
- Health

Mr Boldy informed the committee that the DMBC have developed a Quality Monitoring Tool which is being reviewed at the moment and will go live on 1st January 2017.

Mr Boldy updated that there are still concerns regarding fees and that the market is also concerned regarding financial viability with vacancies currently at 20%.

**Care Homes Update**

The Royal: Mr Boldy said that this care home has now received a good rating from CQC.
Runwood House: Mr Boldy said that this had previously been a DMBC care home and that gaps in quality had been identified and that we are keeping an eye on this home.

Mr Boldy said that overall CQC reports for care homes are improving in quality and generally feel more positive than negative.

Dr Jones said that there had been good collaborative work between the CCG and DMBC.

Dr Jones asked the committee if they had any further questions for Mr Boldy, nothing further asked.

5.6 Individual Placements, Including CHC, S117, Children’s IP & Quality Assessments’ – Verbal

Mr Russell said that he was meeting with Mr Boldy and Mr Booth on the 6th September to develop a report which will come to this meeting.

**PUPOC**

Mr Russell updated that an options paper had been taken to Governing Body and that the decision has been made that we will continue to host this for 9 CCGs rather than 12. The 2nd tranche have been outsourced to CHS Healthcare. We will miss then end of September 16 deadline but have been able to demonstrate that we have taken all reasonable and practicable steps to finish the project as soon as possible. Significant time and resource continues to be spent on this work.

**CHC / Section 117**

Mr Russell said that this work was on-going and that there is a challenge regarding the Local Authority contribution regarding eligibility, at present there are 100 cases where we are unable to come to a decision regarding eligibility.

Dr Jones asked if these individuals were already receiving care; Mr Russell said that they were and that the impact is more regarding social care contributions. Dr Jones asked if there was anything this committee needed to be concerned about; Mr Russell said that any concerns would be brought to this meeting. Mr Boldy updated that there were no complaints coming through regarding this issue. Dr Jones said that it would be good to have a formal report on this; Mr Russell said that he would pick this up at the planned meeting with Mr Boldy and Mr Booth on the 6th September 16.

**Action 06 / 01.09.16:** Mr Russell to include the 100 CHC eligibility cases in the meeting planned for 6th September 16.

**CASA Update**

Mr Russell update the committee that all adult and children’s care packages
are moving to CASA from 1st October 16. It will be more straight forward to have one provider and so far there have been very few issues with moving adults to CASA but there have been some challenges regarding moving children as parents are rightly concerned and need assurance.

CASA are hoping that 60% of staff will TUPE over from current providers and they will recruit the other 40%. Dr Jones asked if this had gone to SMT; Mr Russell confirmed that it had and that this had gone through the formal procurement process before CASA were awarded the contract. Mr Boldy said that we had received an MP letter about a child moving to CASA and that this was down to miscommunication. Dr Jones asked that this committee is provided with regular updates on this at future meetings.

**Action 07 / 01.09.16:** Mr Russell to add to the IP report that is being developed for future meetings.

**Section 117**

Mr Russell updated that this is much improved from 2 years ago and that the S117 Group report to the Individual Placements Steering Group.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

5.7 **Primary Care Quality Report – Enclosure G**

Mrs Cookson introduced Mrs Head, who has taken up post on 16th August 16 as the Primary Care Quality Nurse.

**Primary Care Quality Update**

Mrs Cookson updated that the specification for the proactive coordinated care element of the primary care model is now in final draft and due in place by September 2016, this will go to the Primary Care Delivery Group for ratification; other areas of the specification are being developed. Practices were invited to return submissions for work against this specification to commence in October 16, to date 5 practices have responded. Mrs Cookson said that new documents are coming out all the time and there are strict guidelines regarding the Forward View. Dr Bradley asked if GPs have been involved in this work; Mrs Cookson confirmed that they have been. Dr Jones asked if the GPs who work with the CCG have been involved and also the locality leads; Dr Bradley said that they had. Mrs Cookson said that they are having conversations now to talk through and invite practices to do an action plan.

**Primary Care Case Conferencing**

Mrs Cookson said that case conferencing for July 16 has been disappointing and that the Children’s Trust is doing some work to unpick this to identify issues or themes. Mrs Cookson added that not all of the issues were GP related and that social workers are not being given enough time to complete this. Mrs Ibbeson fed back that she is meeting with Dr Kelly and Mrs Turner on
the 8th September 16 and this is a planned discussion at this meeting.

Mrs Cookson said that we are in a healthy position and that CQC monitoring shows practices are doing well with 2 areas rated as outstanding.

Dr Jones welcomed Mrs Head and asked if she would be a standing member of the committee; Mrs Cookson confirmed that she would be and that Mrs Denman will also join the team 6th September 16 would also be a member. Dr Jones asked that the Terms of Reference were amended to include both Mrs Head and Mrs Denman.

Dr Jones asked the committee if they had any further questions for Mrs Cookson, nothing further asked.

**Action 08 / 01.09.16:** Mrs Twigg to amend the committee ToR and Mr Russell to discuss with Mrs Atkins-Whatley regarding whether any further action need be taken with the ToR.  

**Primary Care Practice Discussion & Dashboard (Both papers tabled)**

Mrs Cookson said that the reports were two tiered and that quality in primary care is more about the learning and to understand what is behind the data. Dr Jones asked if this was national; Mrs Cookson confirmed that it was and added that it is not RAG rated and is available to anyone trying to improve quality. Mrs Cookson said that this is not a punitive piece of work and goes hand in hand with the Quality Strategy.

Mr Russell said that this is never just about how a decision is made regarding a practice and that there is a triangulation of information and also a clear process of escalation and surveillance; Dr Jones said that this is work in progress and that consultation has been excellent but asked where this went next; Mrs Cookson said that this would go to Primary Care Committee once the work was done. Dr Jones asked when GPs would input to this, Mrs Cookson replied that once GPs had had input this would go to the Clinical Reference Group (CRG), Mr Russell said that at the moment this was still data and this needs to be analysed. Dr Jones asked for Dr Bradley’s view on this and Dr Bradley said that the GPs and CRG need to understand where the data has come from with Mr Russell adding that this is described in the Quality Strategy but that we need to look at this in more detail to allow us to make informed decisions. Dr Jones said that he would speak to Dr Crichton before this goes to the CRG.

**Action 09 / 01.09.16:** Dr Jones to discuss the Primary Care data with Dr Crichton once the work has been completed.

Dr Jones asked the committee if they had any further questions for Mrs Cookson on this agenda item, nothing further asked.

**Northfield Update**

The committee noted that the dashboard would start to identify practices that may be outliers in relation to quality. The committee discussed that any quality
issues would need to be discussed in line with the Quality Assurance Strategy.

5.8 Transforming Care Update – Verbal
Mr Russell updated that this was moving at pace and that the steering Group is chaired by Mrs Pederson. A local based meeting has been established and this is chaired by the Local Authority. There are work streams to look at closure of beds and moving patients from long term hospital into the community. There is pressure nationally to move at pace and the TCP footprint has been awarded funding to support the work. The TCP Board is mindful that there will be no discharge unless it is safe and appropriate. Dr Jones asked which patients this impacted; Mr Russell said that this was patients with Learning Difficulties or a diagnosis of Asperger’s and asked if the committee would like a formal update for future meetings. The committee and Dr Jones agreed this.

Action 10 / 01.09.16: Mr Russell to provide a written update on Transforming Care for future meetings, Mrs Twigg to amend agenda’s to reflect this.

5.9 Q1 Serious Incident Report – Enclosure H
Dr Jones said that the position looks stable; Mrs Cookson responded that there have been delays in reporting by RDaSH.

Dr Jones asked the committee if they had any further questions for Mrs Cookson on this agenda item, nothing further asked.

5.10 Complaints Report – Enclosure I
Mrs Quinn updated the committee that the report was as expected with most complaints regarding PUPOC but that Q2 is looking quieter for that area.

Mr Russell added that there had been a few cases of legal representatives acting on behalf of the estate of deceased patients and we are robustly challenging these and assured the committee that if we got it wrong this is accepted.

Dr Jones asked the committee if they had any further questions for Mrs Quinn or Mr Russell, nothing further asked.

6. PATIENT SAFETY

6.1 IPC Update – Enclosure J
Mrs Feirn highlighted the following from her report:

0 cases of MRSA but two cases have been attributed to DBHfT. DBHfT screening surveillance has identified a 45% reduction in the number of MRSA colonised patients.
CDI is currently rated green and the first faecal transplant has been undertaken at DBHT.

The District Infection Prevention & Control Committee (DIPCC) has now moved to Public Health and will be part of the Health Protection Assurance Group (HPAG).

React to Red implementation in care homes starts in September 2016.

Issues have been identified with children’s booster vaccinations and remedial action is being taken to address the issues.

Dr Jones asked the committee if they had any further questions for Mrs Feirn, nothing further asked.

6.2 Q1 Safeguarding Adults & Children – Enclosure K

Mrs Ibbeson updated the committee that the report is still in draft format and that it will grow and develop with time, she wanted the report to evidence the increased resource and capacity in this area and now contains both local and national safeguarding context for children. Mrs Ibbeson added that the position of Mrs Cookson as Vice Chair of DSCB has enabled Mrs Ibbeson to strengthen the health influence historically driven by social care and the police. Mrs Ibbeson continues to work closely with the Head of Strategy to inform Service Development. Dr Jones said that the report is comprehensive and that he liked the executive narrative in the report and that it is clear that excellent working relationships have been formed; Mrs Feirn added that she also likes the format of the report.

Mrs Ibbeson informed the committee that the CCG are leading into a safeguarding review for an adult who died in a fire.

Dr Jones asked the committee if they had any further questions for Mrs Ibbeson, nothing further asked.

6.3 Caldicott Log – Verbal Update

Mr Russell said that there was nothing to update on the Caldicott Log. Mr Russell asked that the Caldicott Workplan and Caldicott Management Statement be removed from future agenda’s.

Action 11 / 01.09.16: Mrs Twigg to remove the Caldicott Workplan and Caldicott Management Statement from future agenda’s.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

6.4 CQC Update – Verbal Update

Mr Russell said that this agenda item had been covered under other agenda items today.
6.5 Quality & Safety Risk Register – Verbal Update

Mr Russell said that this agenda item had been covered under other agenda items today.

6.6 Quality & Safety Work Plan 2016/17 – Verbal Update

Mrs Rayner tabled the work plan, Mr Russell said that Mrs Rayner had looked at the strategic direction and across all of the CCG directorates when developing the plan and concentrating on what is new. Dr Jones asked committee members if the plan reflects the work of this committee adding that the plan will be a living document and our framework for the next 12 months, the committee agreed that it did. Dr Jones asked committee members to review the plan and provide comments directly to Mrs Rayner.

Mr Russell said that the plan would be brought to this meeting on a quarterly basis.

**Action 12 / 01.09.16:** Mrs Twigg to send the Work Plan out with the minutes of this meeting for committee members to review and provide comments back to Mrs Rayner by close on Friday 23rd September 16.

Dr Jones asked the committee if they had any further questions for Mrs Rayner or Mr Russell, nothing further asked.

7. Any Other Business

Mr Russell asked if the planned meeting on 5th January should be changed as this would mean committee members providing updates over Christmas, Mrs Twigg to consider availability and provide alternative dates in January to move this meeting.

**Action 13 / 01.09.16:** Mrs Twigg to check availability to re-arrange the January 17 meeting.

8. Date and Time of Next Meeting

Thursday 3rd November 2016 at 09.30 - 11.30 in the Boardroom, Sovereign House.
### FUTURE MEETING DATES

<table>
<thead>
<tr>
<th>DATE</th>
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<tr>
<td>Thursday 5&lt;sup&gt;th&lt;/sup&gt; January 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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<tr>
<td>Thursday 2&lt;sup&gt;nd&lt;/sup&gt; March 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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<tr>
<td>Thursday 4&lt;sup&gt;th&lt;/sup&gt; May 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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<tr>
<td>Thursday 6&lt;sup&gt;th&lt;/sup&gt; July 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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<tr>
<td>Thursday 7&lt;sup&gt;th&lt;/sup&gt; September 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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<tr>
<td>Thursday 2&lt;sup&gt;nd&lt;/sup&gt; November 2017</td>
<td>0930 - 1130</td>
<td>Boardroom, Sovereign House</td>
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Minutes of the Quality & Patient Safety Committee
Held on Thursday 3rd November 2016 at 9.30am
Boardroom, Sovereign House

Formal Committee Members Present

<table>
<thead>
<tr>
<th>Committee Members Present</th>
<th>Role</th>
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<tbody>
<tr>
<td>Dr Emyr Jones (Chair)</td>
<td>Secondary Care Doctor Member</td>
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<tr>
<td>Mr Andrew Russell</td>
<td>Chief Nurse</td>
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<tr>
<td>Mr Ian Boldy</td>
<td>Named Nurse, Safeguarding Adults</td>
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<tr>
<td>Dr Jeremy Bradley</td>
<td>GP Representative, DCCG</td>
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<tr>
<td>Mrs Andrea Ibbeson</td>
<td>Named Nurse for Children's Safeguarding</td>
</tr>
<tr>
<td>Mrs Wendy Feirn</td>
<td>Senior Nurse, Quality &amp; Patient Safety</td>
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<tr>
<td>Mrs Chris Quinn</td>
<td>Patient Experience Manager</td>
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<tr>
<td>Mr Mark Randerson</td>
<td>Head of Medicines Management</td>
</tr>
<tr>
<td>Mrs Jenny Rayner</td>
<td>Senior Officer for Quality</td>
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<tr>
<td>Mrs Zara Head</td>
<td>Primary Care Quality Nurse</td>
</tr>
<tr>
<td>Mrs Andrea Stothard</td>
<td>Quality &amp; Patient Safety Manager</td>
</tr>
<tr>
<td>Mrs Leah Denman</td>
<td>Named Nurse for Safeguarding Adults</td>
</tr>
</tbody>
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Formal Committee Members in Attendance: None

In attendance: Ms Rhona McCleery, Minutes
Dr Nabeel Alsindi, Clinical Lead for Primary Care and CTC
Mrs Gemma Sessions, Senior Support Officer (Item 5.7 only)

Action

1. Welcome and Apologies

Dr Jones welcomed everyone to the meeting.

Apologies for absence were received from:
- Mrs Suzannah Cookson, Deputy Chief Nurse
- Dr Victor Joseph, Consultant in Public Health, DMBC
- Mr Rupert Suckling, Assistant Director Public Health, DMBC

2. Declarations of Interest

The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group (CCG).

Declarations declared by members of the committee are listed in the CCG’s
Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link:
www.doncasterccg.nhs.uk

The meeting was noted as quorate.

Declarations of interest from today’s meeting: No Declarations were received.

3. Minutes and Actions of the Previous Meeting – Enclosure A & B

The minutes of the meeting held on Thursday 1st September 2016 were approved as a true record with the following amendments:

- Page 2, Item 4 – Mr Russell commented on 360 Assurance Feedback. He attended the Audit Committee on the 8th September and the Committee accepted the recommendations in both the 360 reports. Action plans have been drawn up and the Audit Committee will continue to monitor the actions and delivery. It will be reported through here on progress reports for info and oversight.
- Page 8, Item 5.7 – Primary Care Update – Dr Bradley wished to note that it was Mrs Cookson who gave the assurance and not him.

Please refer to the action log for updates on all outstanding actions.

**Action 001/03.11.16** – Mrs Twigg to add Individual Placements Quality Report to January 2017 Agenda. Confirm with Mr Russell.

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 Medicines Management Report – Enclosure C

Mr Randerson highlighted the following to the committee from his report:

**Antimicrobial Stewardship**

Public Health Antimicrobial stewardship Indicators released as part of the ‘Fingertips’ dataset – overall use, high risk antibiotics and trimethoprim-to-nitrofurantoin ratio. There is a new indicator included and therefore flexibility will be needed in the Primary Care Dashboard.

**Right Care**

At the previous meeting Mr Randerson commented that there was a session to take place at the Strategy and Organisational Development meeting around
high risk options in prescribing. Two things came out of this; The first was Optimise Rx, which is now coming to the end of a 3 week trial, and a Primary Care Rebates Group has been established.

There is a national consultation around Gluten free products and access to Paracetamol on the NHS. All areas are concerned whether the amount spent on these is appropriate. This is due for release October/November 2016.

Digital Roadmap

There are 7 practices going live on Electronic Repeat Dispensing. This is improving at pace.

Contracting

Now entering a 2 year contracting round with providers. There are a set of commissioning intentions around Medicines Management that will come up at strategy and organisational development.

Secondary/Primary care interface

There is a good news story in the area of prescribing anti-epileptic drugs. A model was looked at for supporting GPs and RDaSH have agreed that they will undertake prescribing titration and ensure patients are on stable dosing before returning their care to the GPs.

There is progress with Diabetes Network regarding formulary choices and switching policy for strips and needles. Mr Randerson and Mr Russell will meet to further discuss choice and engagement with patients. Dr Jones commented that there are 2 issues; one is the direct marketing to patients and the second is that there are often commercial elements for the promotion of specific treatments. Both are outside our control but we should remain wary. Mr Randerson confirmed that there is a national tool with all factors to consider and it is just a question of working through it.

**Action 002/03.11.16** – Mr Randerson and Mr Russell will arrange to meet to discuss driving the processes through.

RDaSH

There is a good rolling audit process in place. Concerns have been raised regarding incidents of DVT post-orthopaedic surgery. There is a meeting arranged for January 2017 between RDaSH and DBH to discuss where they are in terms of the policy, how does this vary from National and what are the reasons for variants. Mr Randerson queried whether this should be raised at the CQRG meeting. It was agreed that he should. Dr Jones commented that if there is National Guidance then we as a Commissioning organisation can request the information. The committee supports and endorses this work and would like to hear more about it.

**Prescribing for Protected Groups – Transgender**

There is an ongoing piece of work by South Yorkshire and Bassetlaw around the draft Shared Care Framework. There are 7 gender identity clinics in
England that have been served notice by NHS England. The SYB work is developing in terms of the guidance & support and models of care.

Dr Jones asked the committee if they had any further questions for Mr Randerson, nothing further asked.

Mr Randerson left the meeting.

5.2 DBHfT Quality Report – Enclosure D

Mr Russell agreed to take any questions in the absence of Mrs Cookson.

Mr Russell highlighted that the CQUIN evidence was received on time and this was an improvement from last year. A lot of hard work was done to get the appropriate evidence through in a timely fashion.

Maternity – it is worth noting that the visit by the Royal Colleges has been arranged. The CCG have had sight of the Terms of Reference, which are very broad and is confident that the Royal Colleges will pick up on any issues that have emerged, and that the CCG (including Bassetlaw) have had the ability to feed into that process.

Mrs Ibbeson confirmed that she and Mrs Cookson are working with Mr Golze to review service specifications. Any recommendations that come from the Royal Colleges visit will be built into the specifications.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

5.3 FCMS Quality Update – Verbal

Mr Russell confirmed that the FCMS quality elements are included within the provider report that goes to the Governing Body and we will continue to share outputs from the quarterly quality meetings through to here for more in depth discussion. Items can then be escalated to the Governing Body when felt necessary, or through to the contractual process with FCMS.

Surge and Escalation group and the A&E delivery group will manage the Winter Planning and check what is in place.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

5.4 RDaSH Quality Report – Enclosure E

Mr Russell gave a brief update.

There have been interesting conversations building on the work around the transformational plans and how we understand the quality impact of these.

As part of the contracting, RDaSH have to submit their cost improvement and quality impacts on an annual basis. There are some gaps due to the transformational programme and the Transforming Care work, these are
interlinked. The outcome in terms of cost savings and the quality impact aren’t that clear. There will be a conversation at CQRG around how strengthen the quality assurance around the transformational programme and monitor the impact.

Strategic contracting – there is a view from RDaSH that the transformational programme will improve quality as they move towards a place based approach. They are moving forward to a new Dashboard approach to quality assurance internally. They will move away from quarterly reports towards the monthly dashboards. This information will be shared with this committee.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

5.5 Care Home Report – Enclosure F

Mr Boldy gave a brief update on the Care Home Report.

No significant change from the previous few meetings. There is now a Care home Implementation Board with 5 sub groups who have their own action plans and workstreams.

Quality Monitoring

The Local Authority is still working through their pilot sites and there will be a full roll out in January 2017.

Quality Monitoring of Out of Area Placements

This continues to be developed. Areas of concern are staring to be unpicked. This is being done with the support of the Local Authority and their monitoring team.

Current Areas of Concern – Mr Boldy talked through 3 homes.

    The first home has seen a significant deterioration over the past few weeks. Action Planning is now taking place and the concerns are low staffing and poor management. They will be given a further week from today to assess the response.

    Eastfield Hall – the owners informed the CCG 2 weeks ago that the home was being closed and giving 28 days notice. Significant building work was required and it was felt that this was too costly. Placements are being sought for the residents.

    Victoria Lodge – This home is now down to 10 residents and CQC enforcement action continues.

Business as usual in terms of other updates. The only other significant update is the release of the National Guidance that has come from the Care home Vanguards. Good links have been made with the Deputy National Lead and the Vanguard in Wakefield. Mr Russell commented that the Guidance has
given us a clear idea of timescales.

Dr Jones noted the CQC reports listed. Mr Russell confirmed that the risks are being mitigated by regular support and visits from the Local Authority, the CCG and CHC teams.

Dr Jones asked the committee if they had any further questions for Mr Boldy, nothing further asked.

5.6 Individual Placements, Including CHC, S117, Children’s IP & Quality Assessments’ – Verbal

This item has been covered already within the discussion around the Action Log.

5.7 Primary Care Quality Report – Enclosure G

Mrs Head talked through the update.

The performance intelligence team are still working on the dashboard matrix.

Primary Care Transformation

Most practices are involved and some have a little more support in place. 1 practice has declined involvement.

Arising issues and activity

There is ongoing quality and assurance dialogue with 4 practices, including visits and support. Mrs Head has so far visited 14 practices with appointments to visit a further 8. The overall response has been positive. There are good teams in place and strong work being carried out. Dr Jones commented that it does sound positive and that practices are more likely to welcome the help via the CCG rather than via NHS England.

Case Conference Reporting

There is a definite increase between August and September and we are hoping that September will also be improved. The plan was that during October, each practice needing to submit a report would be telephoned, check that they had the correct details and then a prompt given to produce the report.

Mrs Ibbeson commented that the reason there was no upsurge in the number of review conferences was because the date of the review conference and they are in the middle of changing their processes to what is used for the Initial conferences. There will be an evaluation of the pilot currently taking place in December. Mrs Ibbeson issued an invitation to Mrs Head who agreed to attend. A formal invitation will be sent.

Action 003/03.11.16 – Mrs Ibbeson to issue a formal invitation to Mrs Head, to attend the evaluation of the safeguarding standards pilot being carried out in December.

It is hoped that having all reporting sent to one central point will make it easier
for all. Social workers have been asked not to contact practices in respect of conference invitations so that requests only come from one source, ensuring that reports are only sent to one source.

**CQC reports**

There have been 6 CQC reports received. 5 overall, were Good and 1 was Inadequate. Princess Street ‘requires improvement’ in the Well-Led area and they have implemented an action plan with support in place. West End Clinic received an overall Inadequate rating. An action plan has been drawn up and they are being visited regularly. CQC will revisit within 6 months. Mexborough Health Centre also have an action plan in place to work on the ‘requires improvement’ rating for Well-Led.

Dr Alsindi queried whether the overall picture was similar to that Nationally. Mrs Head said that if there are issues, these do tend to be in the Well-Led domain. There are more areas that link into the Well-Led domain than any of the other domains. 9 times out of 10 if any area requires improvement, it tends to be in the Well-Led domain.

Dr Jones asked the committee if they had any further questions for Mrs Head, nothing further asked.

**Primary Care Dashboard – Verbal**

Mrs Sessions attended to present an overview of the dashboard. This matrix is currently only in Draft format.

Mrs Sessions talked through the contents and sources. The report should not be used as a performance management tool; it should be used to start conversations within practices. It could help implement shared learning. Dr Alsindi confirmed that the feedback from engagement sessions was taken on board. Questions were answered and further feedback was given. Dr Alsindi confirmed that this information is in the public domain already. Dr Bradley queried whether it was a case of reinventing the wheel. The aim of this Dashboard is to give practices a Quarterly update rather than them receiving the CQC information only 2 weeks prior to inspection, thus allowing more time for improvement in the run up to inspections.

Practices will be able to log onto the PBCI portal to retrieve their own, specific data. Dr Jones feels that this would be a useful tool for practices and is a positive inducement for them to make improvements. It also allows the CCG to look at the comparisons and identify practices that may need extra support.

Initially this information will be sent to practices on a quarterly basis but will remain accessible via the portal. Mr Empson is preparing a specification for each measure so that practices can see where the data has been sourced from.

Dr Jones commented that this was an excellent piece of work. Further work may be needed with practices to gain feedback on how the report is presented to them. It was suggested that an indicator, as per the CQC reports, is added allowing Practices to quickly identify their information. This committee would
like to see the report only if there are any major discrepancies or improvements needing discussion. Mrs Sessions confirmed that the CQC ratings would also be added to the dashboard at some stage.

The Committee is very pleased to see that objective measurements are being gathered, displayed and shared with practices and that the work is ongoing.

Dr Jones asked the committee if they had any further questions for Mrs Sessions or Dr Alsindi, nothing further asked.

Mrs Sessions and Dr Alsindi left the meeting.

5.8 Transforming Care Update – Verbal

Mr Russell confirmed that a report would be brought to this meeting after the next scheduled checkpoint. Much of the challenge will be around the pace of discharge from Hospital Care and the Bed Closures behind this. The measurement is across the patch and we have the locally known challenges such as Hesley to contend with.

At the moment we are on track with our progress but will report back to this committee after the NHS England feedback. Dr Jones commented that it is important for this committee to see the Quality and Safety elements and as a CCG there will inevitably be Contracting and Commissioning elements also. Mr Russell commented that there are patients with long term forensic needs and it is important that discharges are safe for both the patient and the communities.

**Action 004/03.11.16** – Mr Russell to prepare a report on Transforming Care to present at the next meeting.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

**Mrs Denman joined the meeting at this point.** Dr Jones asked if she could give a brief update on the Care Home discussed by Mr Boldy as per item 5.5.

The levels of concern were raised yesterday (02.11.16), and legal advice has been given. The legal advice from Mr Jenkins (DMBC) is that people need to be assessed. If they do not have Capacity in relation to staying in the home or moving, the Mental Capacity Act should be used and best interest decisions made. Those with capacity should be supported to make their own decisions. A meeting is to be arranged with the Receivers themselves – not the company acting on their behalf – to let them know the high levels of concern. Relatives and Carers have been involved in the discussions. There is capacity in Doncaster Care Homes for people to move to. However, this may not be in the immediate locality.

5.9 Q2 SI Report

Mrs Stothard gave an overview of the report.

Quarter on quarter is showing an increase in reporting for RDaSH. There is a decrease in the reporting from DBH but no issues have been identified as a result and we are keeping a close eye on this. There has been a flurry of IG
incidents from RDaSH which tend to be in relation to information that has been left within evacuated buildings. Assurances are now in place that action will be taken to mitigate this in future with a Senior Manager in charge.

Dr Jones asked about the Death linked to Maternity Services at DBHfT. The patient was known to mental health services within the Nottingham Healthcare Trust and this is being investigated. It has come through as an SI due to the nature of it being an unexpected death. The patient was known as a suicide risk during pregnancy.

Dr Jones queried the drop in Bassetlaw reports Qtr 1 to Qtr 2. Mrs Stothard will check this figure outside the meeting.

Post meeting note 03.11.16 – Mrs Stothard checked, and there was only 1 SI reported for Bassetlaw so the report is correct.

Dr Jones asked the committee if they had any further questions for Mrs Stothard, nothing further asked.

5.10 Q2 Complaints Report – Enclosure I

Mrs Quinn asked that the committee noted this report.

There was an increase in the number of complaints from 15 to 21 (16 of which were CHC). MP enquiries have remained fairly static.

For PUPoC, a number of little concerns have been dealt with and PUPoC is no longer the main theme of the complaints. An action plan is in place to monitor outcomes and lessons learned from the CHC complaints. Mrs Quinn is meeting with the CHC leaders on a weekly basis.

Two MP letters were received about the Autism Pathway for adults. Both letters concerned the same patient. 1 was related to the strategy (which is Local Authority led) and 1 was related to access to formal diagnosis and the exercise of choice.

Dr Jones asked the committee if they had any further questions for Mrs Quinn, nothing further asked.

5.11 Q1 Attainment for RDaSH and DBHfT for noting – Enc J&K

Mrs Stothard was present to answer any queries arising from the report.

There is only 1 Amber rating under Sepsis. All data was received pretty much on time and it was comprehensive. The evidence for Qtr 2 was due 1st November, but this has not been received from either organisation at the time of this meeting. Mrs Stothard will chase this up. A lot of coordination is needed to pull this together.

Dr Jones asked the committee if they had any further questions for Mrs Stothard, nothing further asked.

6. PATIENT SAFETY
6.1 IPC Update – Enc L

Mrs Feirn provided a brief update.

There have been no further cases of MRSA across Doncaster. CCG remain on zero and DBHFt remain on 2.

In terms of CDI we are under trajectory but there has been a spike in cases in the community. That is reflected across the whole of Yorkshire and Humber. The data is skewed because it is not the number of cases but the number of positive isolates. 2 patients have had faecal transplantation that has worked, and they accounted for several of the cases.

Julie Finch, on behalf of NHS England is leading a piece of work around collecting data for Yorkshire and Humber. Mrs Feirn is to feed back the number of lapses of care to Mrs Finch, attributed to each organisation and that work is ongoing.

Outbreak numbers remain low. There are also low levels of Flu circulating in the community.

DBHFt have done point of care testing for a couple of years on Acute Medical units and the EDs and this year have extended this to the Frailty Unit and the Emergency Unit ATC at Bassetlaw.

In terms of the Pressure Ulcer programme, RDaSH are now working on the React to Red within the Care Home Forum. It is being delivered using the 5 locality method.

Mrs Feirn has been working with Dr Joseph to update the Doncaster TB Strategy and this is now complete.

Dr Jones asked the committee if they had any further questions for Mrs Feirn, nothing further asked.

6.3 Safeguarding Adults and Children’s Update - Verbal

Safeguarding Children

Mrs Ibbeson gave an update.

When the case is closed relating Child A, the Child Death in September 2014, the DSCB will be publishing their Serious Case Review. All organisations are aware and the statements and responses have been prepared. The CCG is working closely with DSCB to see if there is anything they need us to do. The action plan is very much worked and we have been supporting DSCB with this. There is nothing contentious to note.

Another point to touch on is Unaccompanied Children. There are 2 agreements being worked on, the Dublin and the Dubs agreements. The Local Authority and the Children’s Trust are meeting on a weekly basis to get updates on the local situation. We continue to work closely with them. It was felt that there was some naiveté around the health needs of these children. Concerns have been expressed to the Local Authority. These children will have a large ‘wrap around’ service but there is a risk that Children who are Accompanied may have less focus placed on them and this just needs considering. A regional event was held alerting all relevant staff of the potential
upcoming need to be available.

Mrs Ibbeson recalled a previous issue of a gap within Child Sexual Abuse. She and Mrs Rayner have worked with a multiagency group to bring about an Action Plan. This has now been completed and the Children’s Board have endorsed it. They would now like it to be monitored and thanked the CCG for being proactive.

**Action 005/03.11.16** – Mrs Ibbeson to send plan to Ms McCleery for distribution with the minutes from this meeting.

Dr Jones asked the committee if they had any further questions for Mrs Ibbeson, nothing further asked.

**Safeguarding Adults**

Mr Boldy provided the update.

We are leading a Safeguarding Adults review of a Gentleman who passed away in a house fire. The key piece of concern in this situation is that the individual concerned was on a pressure relieving mattress. This exacerbated the fire. RDaSH and DBH are working with us to complete this piece of work. The Fire Service has implemented the investigation. Dr Jones has asked if this incident should be reported to HRMA. It is felt that it should as it involves a piece of Medical Equipment. Mrs Feirn confirmed that it had gone to the Community Equipment meeting and it was about prompting patients who smoke and have, particularly the Air Mattresses, to look at fire resistant clothing and bedding.

There is also a domestic homicide review being discussed at present. This is as a result of quite a high profile stabbing in Doncaster. A meeting on the 22nd November will look whether it meets the criteria and decide if it is to be confirmed to the Home Office that a review will be undertaken, this can take up to 6 months to complete.

The final item is some discussion around a further Safeguarding Adults review on another high profile media case. This was a homeless gentleman who was seriously assaulted. There are questions as to whether this should go under the review process.

Dr Jones asked the committee if they had any further questions for Mr Boldy, nothing further asked.

**6.6 Caldicott Update**

Mr Russell confirmed that there was nothing to report on this occasion.

**Action 006/03.11.16** – Mrs Twigg to remove the Caldicott workplan from future Agendas.

**6.7 CQC Update – Verbal**

Mr Russell confirmed that there was no update on this occasion, only that
RDaSH have had their CQC re-inspection and we are awaiting the results from this.

6.8 Quality & Safety Risk Register – Verbal

We are tasked with continuing the Risk Register at each meeting and considering whether we have identified any concerns. Nothing has been heard today that warrants being added as an individual risk. The risk around the Inadequate Practice in item 5.7 would be monitored via the Primary Care Committee.

6.9 Quality & Safety Work Plan 2015-16 – Verbal

Dr Jones confirmed that this item can now be removed from future Agendas.

**Action 007/03.11.16** – Mrs Twigg to remove this item from future Agendas.

6.10 Mental Capacity and Deprivation of Liberty Policy (not listed on the Agenda)

Dr Bradley queried whether there is the intention to share this with General Practice as it would be very useful. Mr Russell confirmed that there are a number of resources out there, this is our policy, and is a useful summary so do take it into practices and amend and use it as necessary. Some feedback has been given on the policy and these minor amendments will be made. Subject to these small amendments being made approval has been given.

**Action 008/03.11.16** – A copy of the policy, once amendments have been made, is to be sent to each practice with a covering note. It will also be added to the portal.

**Care and Treatment Review Policy (CTR) for approval – Enc N**

**CTR Memorandum of Understanding (MOU) for approval – Enc O**

This has been done on behalf of both Adults and Children. The CTR guidelines are the same for both. A copy of these has been sent to DMBC, The Children’s Trust and RDaSH asking them to sign up to this. It will give a clear understanding of sharing and engagement.

The committee is happy to approve the policy and MOU.

7. Any Other Business

None was raised.

8. Minutes and Information

- Medicines Management Group Aug and Sept – Enc P & Q
- Incident Management Group – Enc R
- Area Prescribing Committee August 16 – Enc S
9. Date and Time of Next Meeting


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Minutes of the Quality & Patient Safety Committee
Held on Thursday 19th January 2017 at 9.30am
Boardroom, White Rose House

Formal Committee Members Present:
- Dr Emyr Jones (Chair) Secondary Care Doctor Member
- Mr Andrew Russell Chief Nurse
- Mrs Suzannah Cookson Deputy Chief Nurse, Designated Nurse Safeguarding Children & LAC
- Mr Ian Boldy Designated Nurse Safeguarding Adults, DCCG
- Dr Jeremy Bradley GP Representative, DCCG
- Mrs Wendy Feirn Senior Nurse, Quality & Patient Safety
- Mrs Chris Quinn Patient Experience Manager
- Mr Mark Randerson Head of Medicines Management
- Mrs Jenny Rayner Senior Officer for Quality
- Mrs Zara Head Primary Care Quality Nurse
- Mrs Andrea Stothard Quality & Patient Safety Manager
- Mrs Leah Denman Named Nurse for Safeguarding Adults.
- Dr Lindsay Britten DP Representative, DCCG
- Mr Victor Joseph Consultant in Public Health, DMBC

Formal Committee Members in Attendance: None

In attendance: Mrs Lesley Twigg Minutes

Action

1. Welcome and Apologies

Dr Jones welcomed everyone to the meeting.

Apologies for absence were received from:
- Mrs Andrea Ibbeson, Named Nurse for Children's Safeguarding

2. Declarations of Interest

The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group (CCG).

Declarations declared by members of the committee are listed in the CCG’s
Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link: www.doncasterccg.nhs.uk

The meeting was noted as quorate.

Declarations of interest from today’s meeting: No Declarations were received.

3. Minutes and Actions of the Previous Meeting – Enclosure A & B

The minutes of the meeting held on Thursday 3rd November 2016 were approved as a true 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 DBHfT Quality Report – Enclosure D

Mrs Cookson updated that Mrs Moira Hardy is covering at ACQRG for Mr Richard Parker whilst he is covering the Trust Chief Executive role. Dr Jones asked if there were any concerns regarding the Trust Business Intelligence Report; Mrs Cookson said that the Maternity / Paediatric review is now completed and that the Trust are awaiting the report, once received this will come to ACQRG. It was noted that at the current time, there was no inpatient paediatric service at Bassetlaw hospital. A number of initiatives were in place to provide a paediatric assessment service and should an inpatient stay be necessary, children would be transferred to DRI and care provided there. Dr Jones asked if paediatrics’ in Bassetlaw were impacting on Doncaster; Mrs Cookson responded that she had arranged a Paediatric presentation at the February 2017 ACQRG.

Mrs Cookson highlighted the waiting times in ED and added that this has been an issue nationally for all acute Trusts. Mr Russell informed the meeting that NHS England had issued a letter regarding bed pressures over winter and issues are being picked up across the CCG. Quality issues are being identified and challenged and there is a clear structure in place to address. Mr Joseph asked if mortality rates had increased over the winter period; Mr Russell replied that this is not known as the latest BIR is for November 2016 and that we would expect to see an increase in SI’s and complaints reported by the Trust.
and this hasn’t happened but that the CCG would continue to monitor this alongside all other quality intelligence.

Mrs Cookson reported that there is work underway to analyse patients from out of area (OoA) who are in beds in DRI so that as commissioners we can influence this. Mrs Cookson asked the committee to note that there has been a Never Event in ED, the patient is okay but a Root Cause Analysis (RCA) is being undertaken.

The Trust are expecting CQC to visit again in the near future, Q & PSC will be updated once dates etc are known.

Mrs Cookson updated that members of the CCG are being invited to various quality meetings in the Trust. Dr Jones said that the update was very encouraging as the Trust is going through a huge transition.

Dr Britten asked about the Park Hill Quality Summit; Mr Russell updated that the summit had been held the day before on 18th January 2017 and that it had been very positive and that Park Hill have 28 days to respond on receipt of the CQC report. One of the key areas that Park Hill are working on is to separate operational and clinical leadership, a lot of actions identified by CQC are easily resolved and asked that the minutes note that Park Hill had received a rating of Excellent for care and that CQC despite requiring some immediate actions to be undertaken, are not overtly concerned around the immediate safety of patients accessing care. Park Hill has developed an action plan to address CQC findings. On-going assurance was discussed and Mr Russell reported that Contractual meetings with Park Hill would include a quality element and the Quality Summit had agreed that where possible the CQC plan would align with improvement plans required by the CCG.

Dr Britten asked if the CCG commission services from Park Hill; Mr Russell said that we commissioned directly and also via DBHfT. Dr Jones added that it would be good if Park Hill and DRI had attendance at cross Clinical Governance Groups; Mr Russell said that this had been suggested and had already been agreed. Mrs Stothard updated that DBHfT have also offered to support Park Hill with reporting Serious Incidents. Dr Britten asked if we have sight of any Doncaster patients in other private hospitals; Mr Russell said that Mr Emmerson is aware and makes those links. Dr Jones said it was reassuring that Park Hill are taking up the offer of support from the CCG and DBHfT.

Dr Jones asked the committee if they had any further questions for Mrs Cookson or Mr Russell, nothing further asked.

5.2 FCMS Quality Update – Verbal

Mr Russell updated that FCMS provide a raft of data and this is analysed from
a quality aspect. The CCG have a quality meeting with FCMS on a bi-monthly basis. Dr Jones asked if a paper on quality measures could come to the next committee meeting in March 2017; Mr Russell said that this should be added to the matrix as a quarterly written update with verbal updates in-between.

Mr Russell added that this is a very open and enjoyable meeting; Mrs Cookson agreed and said that they have done a lot of work on staffing, skills mix and competencies. Dr Jones asked if GP cover has been sorted; Mrs Cookson confirmed that it had and also the Nurse Practitioner role. Dr Britten said she would be interested in attending the FCMS Quality meeting; Mrs Twigg to send her the meeting dates.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

**Action 01/2017:** Mrs Twigg to send Dr Britten future dates of the FCMS Quality meeting. Mrs Twigg to add that the FCMS update will be a quarterly report on the matrix with a verbal update provided between reports.

### 5.3 RDaSH Quality Report – Enclosure D

Mrs Cookson provided a brief update.

Mrs Cookson updated that Transformation is on-going and that Mrs Wendy Joseph, Deputy Director of Nursing now attends CQRG.

The Trust have developed a new dashboard, the copy seen at the January 2017 meeting was Trust wide but they will bring a Doncaster specific version of the dashboard to the next meeting in February 2017. Mrs Cookson said that there is a meeting week commencing 23.01.17 to constructively challenge Intermediate Care adding that the relationship with the Trust is very open and transparent. Dr Jones asked if this was new metrics; Mr Russell replied that the Trust are developing reports covering key areas and by locality; Dr Britten said that Mrs Jo McDonough had undertaken a presentation last week on the transformation in Primary Care looking at patients and pathways. Mr Russell added that this goes both ways with the place pattern based on RDaSH’s footprint and that this is joined up and linked at every level. Dr Jones said this sounds very positive given the complexity of different services in different locations; Mrs Cookson said that she is confident that the Doncaster dashboard will have this level of data.

Dr Jones asked the committee if they had any further questions for Mrs Cookson, nothing further asked.

### 5.4 Care Home Report – Enclosure E
Mr Boldy gave a brief update on the Care Home Report.

There are no significant changes and the strategy is moving forwards with 5 sub-groups as follows:

- Workforce and Education
- Commissioning & Contracting
- Engagement & Communication
- Fees & Quality
- Health

Mr Boldy said that the market is unsettled, for example, Four Seasons Healthcare is selling the homes they have in Doncaster, and other providers are picking these up. Bed availability is at 20% and the CCG and LA processes are very robust but the discussions regarding fees have been very challenging. Dr Jones asked if this reflected the national picture; Mr Boldy responded that market movement is not affecting quality and there are no significant concerns being raised by residents or their families. Dr Jones said that it was very positive how well the relationship between the LA and CCG has been during this work.

Dr Britten asked about a Quality Premium payment, Mr Boldy said that this is part of the fees conversation with Mr Russell adding that the LA are having conversations regarding linking fees to quality and that the quality should be in the contract rather than paid as a premium and that ultimately the complexity of care required should define the cost.

Dr Britten said that the End of Life group (EoL) has identified some money for training; Mr Russell asked if the workforce sub group were involved with this and Dr Jones adding that the CCG and LA need to define what their responsibility for training staff is. Mr Russell agreed and said that the care home sub group looking at Workforce & Education would welcome the input from the EoL group and said that he and Dr Britten should discuss outside of this meeting.

Dr Jones said that the positive impact on use of healthcare resources was reassuring and asked the committee if they had any further questions for Mr Boldy, nothing further asked.

**Action 002/17**: Mr Russell and Dr Britten to discuss involvement of the EoL group with the Workforce & Education sub group of the Care Home Implementation Board.

### 5.5 Individual Placements Report - Verbal

The committee agreed to cover agenda item 5.11 during the discussion for this agenda item as they are the same thing.
Mrs Quinn updated that she is involved in service user and family’s feedback and that she will bring a report on this to future meetings.

Dr Jones said that the CCG focus should be on quality and safety and the wider concerns of the CCG delivering the service that is commissioned. Mr Boldy said that the systems and processes that have been put in place are working well. Dr Jones asked if we were actively getting assurance and Mr Russell responded that Learning Difficulties, Care Homes and Out of Area placements quality is covered.

Dr Britten asked about quality of care packages and CHC processes; Mr Russell replied that decision includes finance and quality impact and that there is a national drive for this to be done in time and not undertaken in hospital and that we commission high quality care.

Dr Jones asked if the report coming to this committee in March 2017 could be formal and with an emphasis on quality; Mr Russell confirmed that it would with Mr Boldy adding that CHC will be audited in May 2017 with the re-audit being based on the original Browne Jacobson audit.

Dr Jones asked the committee if they had any further questions for Mr Boldy, nothing further asked.

5.6 Medicines Management Update – Verbal

Mr Randerson updated that primary care implementation of Optimise Rx system is on track to go live on 1st April 2017 and that the profile is being written at the moment.

Medicines Management is working with Mrs Head to look at why some GP practices are prescribing out of kilter with the Doncaster. Dr Jones asked if this was possibly a subject that could be covered at the TARGET sessions; Mr Randerson indicated that this is in the plan.

Mrs Cookson updated that Mrs Head was picking up wound management with practice nurses.

Mr Randerson informed the committee that internal audit have undertaken an internal audit at DBHfT regarding storage of medicines in ED and Diagnostic Day Unit. Some issues have been identified; particularly the safe storage of IV fluids and an action plan is in place to address.

CCG Strategy Development Forum has endorsed the recommendation of the CCG Medicines Management Committee regarding E-Cigarettes i.e. not to be funded at NHS expense in Doncaster. DMBC indicating a similar direction of travel.

Mr Randerson update that guidance on Gluten Free is being tightened and that
we need to be sighted to make sure that the Quality Impact Assessment is watertight regarding decisions. Dr Jones said that he would be happy for the committee to review the quality aspects of this work; Mr Randerson agreed this approach. Mr Joseph asked if we knew the number of patients who require gluten free products, Mr Randerson said that he would establish an estimate of the numbers.

Dr Bradley updated that work is being done to develop a flowchart for the antipsychotic pathway and to work with the LMC. Dr Jones asked if this was by the CCG or Mental Health Trust; Dr Bradley responded that both are involved.

Dr Jones asked the committee if they had any further questions for Mr Randerson or Dr Bradley, nothing further asked.

### 5.7 Internal Audit / Assurance Plan - Verbal

Mr Russell updated that there are 3 internal audits managed via the Audit Committee, these are CHC, Section 117 and Care Homes. The recent Internal Audit in relation to Section 117 Aftercare responsibilities has delivered a ‘Limited Assurance’ opinion. A lot of work has been undertaken on the Section 117 workstream and we are further forward than a lot of other CCGs. That said, the Audit opinion is based upon the current absolute position. The Audit contains a suggested action plan. There are 16 actions on the action plan and none raised were new to us. The work plan is to be discussed at the Section 117 meeting and formally adopted and managed through the s117 meeting and Individual Placements Steering Group. Any concerns and exceptions will come to Q and PS Committee and then escalated to the Audit Committee if needed. Dr Jones asked Mrs Twigg to include Section 117 exception reporting to the reporting matrix for this meeting.

A further CHC audit is planned for later in the year and the report will come to Quality & Patient Safety committee once received.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

**Action 03/17:** Mrs Twigg to add Section 117 Exceptions to the reporting matrix.

### 5.8 Q3 Complaints Report – Enclosure H

Mrs Quinn highlighted to the group that for PUPOC appeals this is looked at in two stages, once the assessment is made and once the decision is made, Mr Russell added that they are expecting a lot of PUPOC challenges in the next few months and that there isn’t an increase in upheld challenges. Dr Britten asked how many challenges there have been; Mr Russell responded that the challenge is regarding the process and this is 20-25% with Dr Jones stating it is
a sensitive area and that as long as we are able to demonstrate that they are fair and objective that is all that we can do. Dr Jones asked if we are able to benchmark this; Mr Russell said that he would have a look at the national data to see if this is possible. Dr Jones said that this committee should keep an eye on this over the coming months.

Dr Jones asked the committee if they had any further questions for Mrs Quinn, nothing further asked.

**Action 04/17:** Mr Russell to look at benchmarking PUPOC challenges against the national data.

### 5.9 Primary Care Quality Report – Enclosure I

Mrs Head updated that she had attended a Dashboard presentation at the last Primary Care event and this had been very positive.

Mrs Head has visited 31 practices to date and is working with 5 on quality improvements and feedback has been very positive.

Mrs Head would like to set up Practice Nurse forum but is finding this very difficult and has highlighted that each practice has to pay for their practice nurse to attend TARGET, some practices are very good but others do not release or pay for their nurses to attend, the current process means that there is a two tier system with GPs and Practice Nurses and we are unable to assure quality with the Practice Nurses with the current system.

Dr Britten suggested that it would be useful to map this across all GP Practices with Dr Bradley suggesting that 1-2 GPs are involved in this work. Dr Jones agreed that GP involvement was important. Mr Joseph asked that Public Health nursing staff are also involved. Mrs Head agreed to take this forward.

Dr Jones asked the committee if they had any further questions for Mrs Head, nothing further asked.

**Action 05/17:** Mrs Head to set up a working group to look at Practice Nurse TARGET events and to include GPs on the group.

### 5.10 Q3 Serious Investigation (SI) Report – Enclosure J

Mrs Stothard asked that the report was taken as read but was happy to answer any questions.

Dr Jones said that the report was comprehensive and Mrs Stothard saying that we have a very good relationship with both Trusts for SI's.

Dr Jones asked the committee if they had any further questions for Mrs
Stothard, nothing further asked.

5.11 CHC Report – Enclosure Y
This agenda item has been covered in 5.5.

6. PATIENT SAFETY

6.1 IPC Update – Enclosure K
Mrs Feirn provided a brief update.

Mrs Feirn updated that the blood culture training provided to junior doctors has been changed from face to face to a DVD which lasts 8 minutes; this has been raised as a concern at DRI.

There has not been a Post Infection Review RCA meeting this month as there were no cases to be presented. Mr Russell queried the spike in CDI; Mrs Feirn responded that we have more robust processes in Doncaster and that there have now been a few patients who have recurring CDI infections who have had a faecal transplant and this has worked well.

Mrs Feirn updated the committee on how well the React to Red pilot is doing, Jo Calladine is in post in RDaSH and is working with 5 care homes, Mrs Feirn did express some concerns regarding what would happen at the end of the pilot.

Mrs Feirn asked the committee to note the Doncaster TB Service Specification paper that she and Mr Joseph have developed pointing out that there is still further work to be done. Mr Joseph updated that nationally TB numbers have increased and that Doncaster will be consistent with the national plan. Dr Jones asked who signed off the paper; Mrs Feirn said that this would be the Health Protection Assurance Group.

Mrs Feirn asked the committee to note the paper provided on Healthcare Associated Infections in Y & H.

Dr Jones asked the committee if they had any further questions for Mrs Feirn, nothing further asked.

6.2 Safeguarding Adults and Children’s Update – Enclosure N

Safeguarding Children

Mrs Cookson gave an update.

The Child Protection Information Sharing Project (CPIS) has now gone live at the Children’s Trust. DBHfT need a Symphony upgrade in ED for this and this
will be completed by the end of the financial year.

The DSC Board away day will be held next Thursday 26\textsuperscript{th} January 2017. There is a Suicide Workshop today and there is a policy in place for children who attempt suicide.

**Safeguarding Adults**

Mr Boldy gave an update.

Mr Boldy informed the committee that the Adult Safeguarding away day will be held in early February 2017.

There is a Lessons Learnt Review currently being undertaken and this was exploring the circumstances surround a person who died in a fire.

The CCG are having discussions with both RDaSH and DBHfT regarding ways to work together and whether there is scope to redesign the Safeguarding team offer across the Health economy. Mr Russell said that Mr Parker at DBH is keen to explore this as it may improve the quality of the service in the first instance and that there may be secondary benefits of possible efficiencies. Dr Jones said that this was good but that quality needed to be maintained.

Dr Jones asked the committee if they had any further questions for Mrs Cookson or Mr Boldy, nothing further asked.

### 6.3 LAC Mid-Year Report – Enclosure O

Mrs Cookson asked that the papers was as read and updated that the report had already been to SMT and it will go to the March 2017 Governing Body. The gap in initial health assessments is now completed and the new service is run by a team GP’s and a paediatrician from DRI.

Dr Jones asked the committee if they had any further questions for Mrs Cookson, nothing further asked.

### 6.4 Caldicott – Enclosures P, Q and R

**Caldicott Work Plan**

Mr Russell updated that the Caldicott Work Plan will come to this committee in May 2017 and then will be reported by exception for future meetings.

**Caldicott Log**

Mr Russell will bring any query / issues to this committee if any are received or report verbally if none received. One GP query has been received regarding a Looked After Child (LAC) regarding the legal gateway and sharing of
information. Dr Britten asked if this had been a breach; Mr Russell said that it hadn’t.

Dr Jones asked the committee if they had any further questions for Mr Russell, nothing further asked.

**Action 06/2017:** Mrs Twigg to update that the Caldicott Work Plan will come to the Q & PSC meeting in May 2017 and that future updates will be verbal by exception. Mrs Twigg to update the reporting matrix that the Caldicott Log will only come to Q & PSC by exception when a query / issue has been received.

6.5 CQC Update - Verbal

Mr Russell had nothing further to add under this agenda item as CQC has been discussed under other agenda items today. Dr Jones asked that CQC was a standing update for this meeting.

**Action 07/2017:** Mrs Twigg to add CQC update to the reporting matrix as a standing verbal update for future meetings.

6.6 Learning Candour & Accountability – Enclosure S & T

Mr Russell asked the committee to note the two papers issued and added that this report by CQC was a further response to the issues identified within Southern Healthcare and the way that unexpected deaths of service users were identified and appropriately investigated. Mr Russell said that the CCG and wider Health and Social Care system needed to consider the report. We need to work with Trusts on how to manage unexpected deaths, both RDaSH and DBHfT have done work in this area and it links into the recent publication and expectations in relation to the Learning Disabilities Review Programme (LeDeR) and how these are reported via the SI process. Dr Jones asked what the CCG responsibility is; Mr Russell responded that there are a number of recommendations’ and one in particular about reviewing local arrangements. There will be on-going work around the LeDeR and NHS England is looking to rationalise and fit into normal reporting processes and this will be led and coordinated by NHS England.

Dr Britten asked if there was any data; Mr Russell responded that RDaSH had checked back a couple of years on historical cases and that this will be built into IMG, CQRGs etc. Mr Joseph said that the LA had completed a paper on this a few years ago. Mr Russell said that Doncaster was not an outlier in this area and that the Learning Candour and Accountability Paper was not just about LD deaths but all deaths where we commission a service. Mrs Stothard added that this is part of the quality schedule for both Trusts.

Dr Jones asked the committee to accept and note the paper and asked if there
were further questions for Mr Russell, no further questions asked.

6.7 Quality & Safety Risk Register – Verbal

Mr Russell updated that there needs to be a conversation with Mrs Atkins-Whatley regarding the Section 117 audit and whether this sits on the Q & PSC risk register or the Corporate Risk Register.

Post Meeting Note: Following Discussion with Sarah Atkins Whatley, it was decided that the s117 internal Audit would be added to the Quality Risk Register as opposed to the corporate Risk Register.

6.8 Quality & Safety Work Plan

Mr Russell asked that the reporting matrix was updated to reflect that this will be the 2017/18 work plan and this will come to the May 2017 meeting.

Action 08/2017: Mrs Twigg to update the matrix to reflect that this will be the 2017/18 work plan and this will come to the May 2017 meeting.  

7. Any Other Business

Individual Funding Requests

Mr Joseph asked if there is an assurance report on Individual Funding Requests and are we assured that we know how this is going; Mr Russell said that he wasn’t sure if this came into another part of the CCG and that he would check and asked Mr Joseph if there was anything specific he wanted from the report. Mr Joseph said numbers received, approved, refused, complaints etc. Dr Jones agreed this would be good to see, Mr Russell said he will investigate if a quarterly report with this data can be produced.

Action 09/2017: Mr Russell to investigate whether IFR data can be pulled into a quarterly report and feedback at the next Q & PSC.  

Q2 CQUINS

Mrs Stothard informed the committee that Q2 CQUINs will be issued with the minutes and actions of this meeting.

Action 10/2017: Mrs Twigg to send Q2 CQUINs out with the minutes of the meeting.

8. Minutes and Information

- Medicines Management Group – Enc U
- Incident Management Group – Enc V
9. Date and Time of Next Meeting

Thursday 2\textsuperscript{nd} March 2017 at 09.30 - 11.30 in the Boardroom, Sovereign House

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Executive Committee
Held on Wednesday 4 January 2017 commencing at 9am
In Dr David Crichton’s Office, Sovereign House, Heavens Walk,
Doncaster, DN4 5HZ

Formal Members Present: Mrs Jackie Pederson – Chief Officer (Chair)
Dr David Crichton – Chairman
Mrs Sarah Atkins Whatley – Chief of Corporate Services
Mr Andrew Russell, Chief Nurse
Mr Anthony Fitzgerald – Chief of Strategy & Delivery
Mrs Hayley Tingle – Chief Finance Officer
Mrs Laura Sherburn – Chief of Partnerships
Commissioning

Formal Attendees Present: Mrs Lisa Devanney
Mr Ian Carpenter – Communications and Engagement Manager

In attendance: Mrs Jayne Satterthwaite – PA to Chair and Chief Officer (taking minutes)
Mrs Suzannah Cookson - Deputy Chief Nurse
Designated Nurse for Safeguarding & Looked After Children (Item 5)

ACTION

1. Apologies

There were no apologies received for this meeting.

2. Declarations of Interest

The Chair reminded committee members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group.

Declarations declared by members of the committee are listed in the CCG’s register of interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link www.doncasterccg.nhs.uk

The meeting was noted as quorate.

Declarations of interest from sub-committee/working groups:
None declared.

**Declarations of interest from today’s meeting:**

Dr Crichton declared a Financial interest in respect of Item 5, Looked after Children Report as he conducts Initial Health Assessments for those children aged between 5 and 18 years. It was considered appropriate that Dr Crichton remain in the room as the report was for comment and noting by the Executive Committee only.

3. **Minutes from the Meeting held on 7th December 2016**

The minutes from the Executive Committee meeting held on 7th December 2016 was agreed as a correct record subject to the following amendment:

Page 10, Bring Forward Agenda, Governing Body, January 2017 – Remove GP 5 Year forward View.

4. **Matters Arising**

**Fleet Solutions**

Mrs Devanney reported that formal feedback had now been received from Fleet Solutions Lease Cars and NHS Doncaster CCG may proceed to extend the offer of lease cars to all staff. Mrs Tingle highlighted that there is a possible risk in respect of staffing resources.

The Executive Committee agreed that a more detailed briefing paper should be presented at a future Informal Senior Management Team meeting for discussion.

**Checkpoint Assurance Briefing**

Mr Russell informed the Executive Committee that the number of instances of Chlostridium Difficile (C Diff) is below trajectory therefore no further action had been initiated. Root Cause Analysis continues and Mrs Wendy Feirn, Infection Control is involved in this.

**Market Place Session**

Mr Fitzgerald stated that he is holding a Strategy & Delivery Team Time Out session on 30th January and Quality, Innovation, Productivity and Prevention (QIPP) will be part of the discussions. He suggested that a suitable date for the Strategy & Organisational Development Forum to hold the follow up Market Place Session to discuss QIPP would be Thursday 30th March.
2017 from 12.30pm – 4pm in the Boardroom, Sovereign House.

**Post Meeting Note** - Mrs Satterthwaite is holding this date in the Senior Management Team diaries and the Boardroom, Sovereign House pending confirmation.

**National Diabetes Prevention Programme Wave 2**

Mr Fitzgerald reported that there is a lot of work ongoing in respect of potential services, Rightcare and bids for Sustainability & Transformation Plan (STP) funding. If any of the clinical pathways should change, they will be presented to the Clinical Reference Group for discussion.

**Future Leaders GP Fellow**

Mrs Sherburn stated that she had with Mr Patterson and confirmed our support. Dr Patterson confirmed that the start date would be 2018.

5. **Looked After Children Report**

Mrs Cookson attended the meeting to present the Looked After Children (LAC) report for comment and noting by the Executive Committee.

Mrs Cookson explained that she is the Designated Nurse for LAC and that the report, which will be presented to the Corporate Parenting Board in January 2016, provides the Board with current performance information, challenges across the system and the strategic planning in place to achieve a robust service for our children. The Governance arrangements will also require approval by the Board at the meeting. Mr Fitzgerald highlighted that there are a number of paediatric meetings which has resulted in some confusion regarding attendance, however he is meeting with colleagues form the Local Authority and will request clarification on the Governance.

It has been noted recently that there has been a decline in the number of Initial Health Assessments (IHAs) completed as a result of staffing issues. NHS Doncaster CCG has initiated a procurement process for a new service to provide IHAs for all Looked After Children. Dr Crichton commented that the procurement process has provided an opportunity to re-assess the service. Mrs Sherburn commented that the information regarding the holistic service provided by Rotherham Doncaster and South Humber NHS Foundation Trust (RDasH) may read more fluidly if it was included in the achievements section of the report.

The report will be presented to a future Governing Body meeting
and Mrs Cookson offered to facilitate the attendance of a Looked After Child at the meeting, during the patient story item, in order to hear their voice.

Mrs Pederson queried where the Quality Framework is reported. Mr Russell stated that it forms part of the quarterly Safeguarding report to the Quality & Safety Committee meeting and the minutes of this meeting are presented for noting to the Governing Body.

Mr Russell stated that a spotlight report will be presented as part of the Performance and Quality report to the Governing Body in March 2017.

The Executive Committee noted the Looked After Children report.

6. **RDaSH support to the Treatment LES**

Mrs Sherburn explained that the Treatment Room Local Enhanced Service (LES) is a contract held with all practices in Doncaster on a block basis. It covers a menu of options for practices to choose to deliver at their discretion. There are 5 practices in Doncaster which, in addition to receiving the block payment for the LES, also receive bespoke support from RDaSH which is commissioned via non-recurrent monies by NHS Doncaster CCG as follows:

- Removal of sutures and clips from uncomplicated wounds arising from secondary care procedures.
- Post-operative care of surgical wounds in patients who can attend surgery premises.
- Aural care and Ear Syringing.
- Dressing to uncomplicated gravitational leg ulcers.
- Wound care management and tissue viability - evidence-based, high quality assessment and treatment for patients presenting with acute and chronic wounds, with support from the specialist team.

Mrs Sherburn and Mrs Tingle met with the 5 practices on 14th December 2016 to discuss the proposal to end this contract from 1st April 2017. The practices raised concerns regarding their abilities to incorporate this activity within their current Treatment Room LES provision, predominantly due to a skill deficit within the practices. The issue of wound management was also raised and recognised as a gap across all of Doncaster. It was argued that ceasing this element of the service in particular should be rolled out for all practices. In recognition of the issues raised, the Executive Committee considered a number of options as follows:
Option 1
To discontinue the RDaSH service from 1st April, and for the 5 practices to deliver the activity within the Treatment Room LES block payment however they see fit, as currently the other Doncaster practices do. However risks with this option are:

- The complex wound care management service that RDaSH provide, which is anecdotally needed by several practices in the borough, is lost to the system.
- The 5 practices choose not to deliver the elements of the Treatment Room LES (which at the moment are not compulsory) that RDaSH currently provide, resulting in greater secondary care activity.

Option 2
To continue the RDaSH service and Treatment Room LES in their status quo for 2017-18, while further work is done. Risks with this option include:

- Perpetuating anomalies in the commissioning process.
- Further delay in resolving an issue that has been existing for 2 years already.
- Removal of momentum in reaching resolution.
- Affordability of the RDaSH service in the financial climate from 2017-18 onwards.

Option 3
The proposed option is a compromise of the above two. It is suggested that the Treatment Room LES is reviewed and the essential services are made mandatory rather than optional. Secondly, it is recognised that the wound care management element is a service that needs more work and a separate commissioning approach. Work is underway to define the gap around complex wound care, involving the Tissue Viability nurse from Doncaster Bassetlaw Hospitals NHS Foundation Trust (DBHFT), a practice nurse from Carcroft surgery, and the NHS Doncaster CCG Primary Care Quality nurse. This pathway should go to Clinical Reference Group for sign-off, and simultaneously, the appropriate activity and costing work done to understand how funding flows will be released. While this work is completed, it is proposed to extend the wound care element only of the RDaSH contract for the 5 practices, from 1st April 2017 for 3 months; with the aim that a bespoke wound care service across all of Doncaster would be commissioned thereafter.

Risks of this option include:

- Timescales of commissioning a new service slipping.
- RDaSH sign-up to delivery of the single element, and extension of contract.
- Practices declining the offer of the new revised Treatment Room LES.
It is felt that the above risks can be treated and adequately mitigated, and therefore this is the recommended option.

Mrs Sherburn requested that the Executive Committee give consideration and approve Option 3, the recommended option.

The Executive Committee considered and approved the recommended Option 3 with the proviso that the wound care element only of the RDaSH contract for the 5 practices, be extended for a period of 6 months from 1st April to 1st October 2017.

7. **Prior Approval Commissioning Threshold Approach**

Mr Fitzgerald presented the Prior Approval Commissioning Threshold Timeline to the Executive Committee for noting and discussion and explained that as part of the new Planned Care key area the threshold elements have been examined and debated in contract negotiations. Mr Fitzgerald and Mrs Pederson will meet with Mr Chris Edwards and Mr Ian Atkinson on Monday 9th January to discuss how it was approached at NHS Rotherham CCG. The timetable indicates the approach to Governance arrangements and where discussions and items may be presented.

A new Threshold Policy has been developed and it is important for engagement with Doncaster Bassetlaw Hospitals NHS Foundation Trust (DBHFT) on this and to obtain agreement of the policy by the Trust. It is therefore intended to invite consultants to TARGET sessions which are being held on the 8th and 15th February 2017 to present the policy for discussion. Dr Crichton advised that early notification of the sessions would be prudent.

Mrs Atkins Whatley stated that she would request the equality assessment from NHS Rotherham CCG for information.

The Executive Committee noted the Prior Approval Commissioning Threshold Approach and timetable.

8. **Financial Position versus QIPP**

Mrs Tingle reported that our Financial Plan was submitted to NHS England on 3rd January 2017. The financial position for 2017/2018 will be challenging. The introduction of HRG4+ will impact substantially and NHS England has specified that there will be no further allocation due to the increase in Quality, Innovation, Productivity and Prevention (QIPP).

The financial position for 2017/2018 was reported to the
Committee as £11.2m with challenging QIPP plans in place to deliver £6.2m.

Prescribing continues to be a financial risk to NHS Doncaster CCG. Mr Randerson, Head of Medicines Management is attending the Strategy & Organisational Development Forum on 5th January to talk through the progress made so far on the Higher Risk options which were agreed at a previous Strategy & Organisational Development Forum meeting.

Mr Fitzgerald informed the Committee that he was attending a South Yorkshire and Bassetlaw QIPP Programme session, facilitated by Mrs Alison Knowles, Locality Director, NHS England North (Yorkshire and the Humber), on Monday 9th January 2017 to look at what collective action may be taken and which areas were worth consideration.

The ‘Market Place’ session will also consider further opportunities and CCG level of QIPP ambition.

9. **End of Year Reporting**

Mrs Atkins Whatley informed the Executive Committee that the deadline for the Month 9 Governance Statement including significant control is 20th January 2017. The statement is about NHS Doncaster CCG as a statutory body and upon inspection of the documents, there are no issues which require reporting further to NHS England. The Governance Statement forms part of the Annual Report together with the Head of Internal Audit Opinion who provides assurance on the internal system of control. It is expected that Limited Assurance will be provided.

There has been a recent alteration in that we must engage with, and have sign off of, the Annual Report from the Health & Wellbeing Board. Councillor Pat Knight is Chair of the Board and Dr Rupert Suckling, Director of Public Health an attendee and sign off of the report will be sought when required.

The Executive Committee noted the verbal update.

10. **Bring Forward Agenda**

The Committee agreed the following:

**Strategy & Organisational Development Forum**

**January**
- E-cigarette position paper
- High Risk Options
- Preparation for Primary Care event on 12 January 2017
- Assurance Framework learning session
February
• Clinical Effective Commissioning
• Doncaster Place Plan – ambition for Joint Commissioning
• DBHFT Clinical Services Review
• Well Led Organisation.360°

March
• PUPoC update
• YAS Ambulance Requests (TBC)
• Local Authority Transformation Plans
• Patient Story discussion

**Governing Body**

January
• PCCC Quarterly Report
• Finance report including presentation, outcome of contracting and planning and Better Care Fund

February
• Clinical Effective Commissioning
• Well Led organisation.360°

11. **Items to Note/Receipt of Minutes**

The Executive Committee noted the receipt of the following minutes:

• DBHFT Strategic Contracting Group – Minutes from the meeting held on 11th October 2016.
• RDaS Strategic Contracting Group - Minutes from the meeting held on 17th October 2016.
• Joint Commissioning Co-ordination Committee – Draft minutes from the meeting held on 16th November 2016.

12. **Any Other Business**

**Escalation Meeting**

Mr Fitzgerald informed the Executive Committee that it was agreed at the System Resilience Group on 22nd December 2016 that an escalation meeting be scheduled to take place today to address pressures in the system. Community services are functioning but are also experiencing pressures and an update will be received in respect of the number of attendances at the Front Door Assessment Signposting Service (FDSASS), Emergency Department and Urgent Care Centre. Board on 6th January 2017.
Panorama Programme

Mr Carpenter informed the Executive Committee that the Panorama programme, scheduled to take place on 13th January 2017, will feature the success of the Children’s Sleep Charity in Doncaster which has been commissioned for a period of 3 years. The programme will be looking at the feedback from patients and obtaining a sense of value for money. A meeting has been arranged to discuss communications prior to the programme.

Locality Elections

Mrs Devanney reported that the Locality elections for the Central and North East Localities will run from 9th – 20th January 2107.

Meeting with MPs – 13th January 2017

Mrs Pederson reported that she and Dr Crichton are meeting with Caroline Flint MP and Dame Rosie Winterton MP on Friday 13th January 2017 where a number of items including Team Doncaster, the Doncaster Place Plan and Primary Care will be discussed.

13. Date and Time of Next Meeting

Wednesday 1st February 2017 at 9am, Dr Crichton’s Office, Sovereign House
Minutes of the Primary Care Commissioning Committee  
Held on Thursday 8 December 2016 commencing at 12.30pm  
In the Boardroom, Sovereign House

Present:  
Mrs Linda Tully – Lay Member (Chair)  
Mrs Sarah Whittle – Lay Member (Vice Chair)  
Mrs Jackie Pederson – Chief Officer  
Mrs Hayley Tingle – Chief Finance Officer  
Mrs Laura Sherburn – Chief of Partnerships Commissioning and Primary Care  
Dr Pat Barbour – Locality Lead, South East Locality  
Dr Niki Seddon – Locality Lead, North West Locality  
Mrs Suzannah Cookson – Head of Quality, Designated Nurse for Safeguarding and Looked after Children  
Mrs Carolyn Ogle – Senior Primary Care Manager, NHS England  
Dr Dean Eggitt – Medical Secretary, Doncaster Local Medical Committee

In attendance:  
Mrs Jayne Satterthwaite PA to Chair & Chief Officer - (Taking Minutes)  
Mr Ian Carpenter, Head of Communications & Engagement

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 2 member of the public in attendance and 1 member of NHS Doncaster CCG staff observing the meeting.

2. Apologies

Apologies were received from:

- Dr Nabeel Alsindi – Clinical Lead for Primary Care and Long Term Conditions  
- Dr Rupert Suckling – Director of Public Health  
- Mrs Debbie Hilditch, Health watch Doncaster Representative

3. Declarations of Interest

The Chair reminded committee members of their obligations to declare any interest they may have on any issues arising at
committee meetings which might conflict with the business of NHS Doncaster Clinical Commissioning Group.

Declarations declared by members of the committee are listed in the CCG’s register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link www.doncasterccg.nhs.uk

The meeting was noted as quorate.

**Declarations of interest from sub-committee/working groups:**

None declared.

**Declarations of interest from today’s meeting:**

Item 6 National Primary Care Transformation Fund (Capital Infrastructure & IT) Update

Dr Seddon declared a Financial interest in the National Primary Care Transformation Fund (Capital Infrastructure & IT) Update as a bid had been submitted from her practice. As this item provided an update only, Dr Seddon remained in the meeting.

4. **Minutes of the Previous Meeting held on 10 November 2016**

The minutes of the meeting held on 10 November 2016 were agreed as an accurate record.

5. **Matters Arising**

**Proactive Co-ordinated Primary Care Specification – Update on Practice Readiness - Recommendations**

Dr Alsindi has circulated the report to the Committee.

Following last month’s Committee, there were two practices remaining who required to draw up action plans to be fully ready to deliver this specification from January 2017. The Primary Care Team has now received updated proposals from the 2 practices, and the recommendation is put to the Primary Care Commissioning Committee that the practices are eligible to deliver the service and qualify for the full amount of payment from January 2017. The Committee approved this recommendation.

There remains 1 practice which is not taking up the offer to deliver the specification, and the CCG & LMC continue to investigate whether there are any tools/levers available to secure this service from another provider for that practice’s patient population.
Mrs Sherburn reported that she had written to both the Oakwood Surgery and The Mayflower Medical Practice, with the feedback from the last Committee meeting. A full update will be provided to February Committee meeting. In the meantime, Mrs Sherburn has received a request for the Oakflower practice to become an associate to the Mayflower contract prior to the full merger, so that back office functions can start to collaborate. Mrs Ogle is seeking clarification of the request, however this is not essentially a contract variation, it is at the practice’s own discretion.

Costs relating to IT migration are being finalised, and conversations are ongoing in the CCG regarding the funding stream for these.

It had been agreed to contact the practices to understand more about the patient consultation, and what kinds of questions were being asked. As Mr Carpenter and Mrs Hilditch were not in attendance at today’s meeting, it was agreed that the action should remain as outstanding and added to the Action Tracker.

Primary Care Quality Dashboard

The launch of the Primary Care Quality Dashboard (populated with practices’ own information) has been delayed, due to CCG staff capacity, however it is expected to ‘go live’ in January 2017. Mrs Head is visiting practices regarding what it will entail for them.

Draft Contingency Planning document for the event of contract termination in General Practice.

The final amendments have been made and Mrs Sherburn will circulate the plan.

6. National Primary Care Transformation Fund (Capital Infrastructure & IT) Update

Mrs Ogle informed the Primary Care Commissioning Committee that those practices in Cohort 1 (which was made up of practice bids that would be able to deploy the funds by March 2017) should have received an email confirming that they would receive their funding, subject to due diligence. The approval of the IT bids is taking longer to finalise however should be completed by the end of the week.

Cohort 2 practices (ie, bids that would spend the funds by March 2019) have received a communication explaining the way forward, asking for the practice to confirm whether they wish to proceed with their bid. Practices are in the process of responding to this.

Dr Seddon queried the number of practices in Cohorts 1 & 2 and raised concerns regarding the time invested in preparing the bids...
and many practices being unsuccessful. Mrs Ogle reported that there are 7 practices in Cohort 1 and 15 on Cohort 2. There will be another opportunity for Cohort 2 practices to work up and re-submit their bids. Dr Eggitt asked if non-recurrent GPFV funding could be accessed to help with the bid-revising process and associated costs. Whilst this is certainly a possibility, it will need to be planned for and considered in the context of other priorities for that funding.

The Primary Care Commissioning Committee noted the update.

7. **GP Forward View (GPFV) Implementation Plan**

Mrs Sherburn gave the following presentation regarding the GP Forward View Implementation Plan:

- The Primary Care Strategic Model is our plan.
- NHS Doncaster CCG is required to submit a GPFV implementation plan on 23 December 2016, covering:
  - How devolved funds for training of care navigators, and use of online consultations, will be deployed.
  - How funds for transformational support will be created and deployed.
  - How access to General Practice will be improved.
- In the outline plan submitted on 21 October 2016 we agreed that:
  - We should adopt the principle of embedding the GPFV approaches/funding routes within the Primary Care Strategic Model 4 pillars.
  - We should ramp up our support to GP collaboration/federation.
  - We would support workforce development alongside Health Education England (HEE) and South Yorkshire & Bassetlaw Primary Care Workforce group.

**GPFV Funds available to CCGs**

- Funds for care navigation training and up-skilling reception staff:
  - £54k 2017/2018 & £54k 2018/2019
- Transformational funds to: stimulate development of at scale providers for improved access; stimulate implementation of 10 high impact changes; secure sustainability of general practice:
  - £3 per head (£946K) non-recurrently 2017-2018.
- Releasing Time for Care programme, incorporating GP Improvement Leader Programme:
  - Not cash funds; development resources, training, consultancy, etc.
- Non-recurrent “slippage” from GP resilience programme:
  - NHS England now confirmed as £116K and must be spent by 31 March 2017.
- Extended access funding:
  - From 2018/2019, £3.34 per head (£1.06 million)
  - From 2019/2020, £6 per head (>£1.9 million);
Engagement October – November 2016

• LMC – Primary Care Team, 18 October 2016.
• Primary Care Provider Engagement Group 18 October 2016.
• Locality meetings October-November 2016.
• TARGET 9 and 23 November 2016.

Feedback from practices

• Positive and engaged re development of specifications.
• Frustration regarding the pace and impact of GPFV – general lack of resilience in primary care.
• Cautious support for the concept of care navigation training.
• Definite recognition needs to be done at scale.
• Engagement with development programmes will need backfill if they are to be effective.
• Challenge on using GPFV “transformational” money to fund specifications.
• More clarity needed on expectations re extended/integrated access from 2018-2019.

It was recommended by the Strategy & Organisational Development Forum on 1 December 2016 that the Doncaster GP Forward View Plan, taking into account the feedback from members, should focus on the following areas for each of the sections of the Plan:

How access to General Practice will be improved:
• Utilise the £116K “slippage” from the GP Resilience Fund, that gets allocated back to Doncaster, to fund additional placements for Health Care Assistants and Assistant Nurse Practitioner training.
• Use Practice Transformational Support funding to facilitate practices’ engagement with work that has the potential to free up capacity, e.g. the Releasing Time for Care Programme, GP Improvement Leader Programme.
• Use part of the Practice Transformational Support funding to run pilots around collaborating/working at scale to create additional access as per the Responsive Primary Care pillar in 2017-2018, ahead of the CCG receiving the funding to meet extended access requirements from 2018.

How funds for transformational support will be created and deployed:
• The majority will be to use this as per part 1, including the funding of backfill to allow practices to engage with these programmes and the CCG and system partners on the Doncaster Place Plan. This will be more defined and outcome based than the “headspace” investment between April and September 2016; essentially, it will form the Responsive Care pillar specification.
• The remainder will be allocated to the Keeping People Well pillar.
How devolved funds for training of care navigators, and use of online consultations, will be deployed

a) With the funding that has to be used by April 2017:
   • Buy care navigation training from established “suppliers” for all of Doncaster.
   • Focussed work, which may include commissioning a provider, on developing a Directory of Services which will be ready for a more structured care navigation training programme in 2017-2018.

b) With the funding available in 2017-2018 and 2018-2019
   • Continue to work with the other South Yorkshire & Bassetlaw CCGs through the Primary Care Workforce Group as they explore options for providing/arranging “at scale” training.

Mrs Sherburn requested that the Primary Care Committee:

- Agree the recommendations made.
- Agree for the transactional detail to be developed by the Primary Care team with oversight from the Senior Management Team, and submitted in the plan to NHS England on 23 December 2016.
- Receive the submission by email on 23 December 2016.
- Discuss progress on implementation at the February 2017 Primary Care Commissioning Committee meeting.

The Primary Care Commissioning Committee held a discussion and particularly debated the best use of the non-recurrent “slippage” of £116K. Dr Eggitt was concerned that deploying this money on training placements wouldn’t necessarily benefit Doncaster, as the workforce may well depart the borough once fully-fledged; and equally, the Committee recognised that the execution of this proposal would be quite complex and difficult to transact, as there were multiple factors to consider. Timing was a particular issue with this proposal.

An alternative suggestion was made in relation to the deployment of the slippage funds. Collaborating on back office functions like payroll, HR, and correspondence management would be a significant step towards creating more resilience in primary care, which is the intention for these funds. Secondly, it could catalyse the development of federation, and test the appetite of the emerging GP collaborations to work together to attract investment and improve services. It was agreed that the emerging federations in Doncaster would be invited to meet with the CCG to discuss how they could deploy this money to create a “hub” for back office functions, and that members of the PCCC would help the CCG develop a specification for this, based on other areas in the country.

Dr Eggitt also made the point that the transformational funds (ie, £3 per head in 2017-18) was not intended to pay for services from general practice, but should be invested in practices to allow them to transform their delivery of care to become sustainable and resilient. Mrs Sherburn stated that this would be achieved through designing
the Responsive Care Pillar to be primarily pump-priming and non-recurrent activity; ie engagement with development programmes, pilots of different ways of working, workforce development etc. Further work would be done to craft a set of requirements around this, and brought back to the Committee in February.

With the one amendment relating to the £116K, the Committee agreed the recommendations made and for the transactional detail to be developed by the Primary Care Team with oversight from the Senior Management Team. Mrs Whittle requested that the submission on 23rd December be shared with Committee members, and that progress on the implementation of the plan be discussed at the Primary Care Commissioning Committee on 9 February 2017. This was agreed.

8. Taking forward the Primary Care Strategic Model
   - Extended Primary Care
   - Keeping Well

**Extended Primary Care**

Mrs Sherburn explained that the Extended Primary Care is one of the 4 Pillars of the Primary Care Strategic Model for Doncaster and is concerned with supporting the delivery of services closer to the patient’s home. It is anticipated that the model will commence in April 2017 and will evolve over time as more services which could be moved from Secondary Care to Primary Care are identified.

Doncaster practices already provide a number of services. Some of these are commissioned nationally as Direct Enhanced Services (DES) or through existing Local Enhanced Services (LES). There are a number of reasons for changing the way NHS Doncaster CCG commissions LES through General Practice:

- For the benefit of the patient.
- For the benefit of the wider healthcare system.
- For the benefit of practices.

A new framework for LESs has been developed with input from the Local Medical Committee (LMC) and the Primary Care Provider Engagement Group and a system of LES Tiers 1-3 will be adopted. There are a number of points which require consideration some of which have been raised by the early engagement with the Primary Care Provider Engagement Group. There will continue to be regular engagement with this group in the run-up to April with input from the Clinical Reference Group, Strategy & Organisational Development Forum, Primary Care Commissioning Committee and to agree the approach to the following:

- What to do if practice(s) decline to sign up to the Tier 1 Enhanced Services.
• A final decision about the Glucose Tolerance and H.pylori Testing LES’s.
• Understanding how patients will feel about going to another practice for services that they have either previously received in hospital or in their own practice.
• The standards required for approval to deliver each Tier 2 Enhanced Service and how the CCG will be assured that patients are receiving a high quality service.
• Whether a practice approved for a Tier 2 Enhanced Service is required to accept inter-practice referrals if they get sufficient activity from their own patients.
• How best to make inter-practice referrals as straightforward for the referring practice as Secondary Care referrals currently are.
• Any unforeseen consequences of increased inter-practice referrals.
• The process by which potential new LES’s are identified and worked up for subsequent inclusion in this framework.
• A detailed review of the existing Treatment Room LES, which is a basket of services not paid on individual activity, and whether the services delivered by practices with this funding can be split up and transferred into this framework, potentially for 2018/19.

Dr Barbour queried why minor surgery is commissioned by NHS England. Mrs Ogle replied that it was included in the DES therefore remained with NHS England however it can be influenced by CCGs and that transferring the management to the CCG could be an option.

Keeping Well
Keeping Well is one of the 4 Pillars of the Primary Care Strategic Model for Doncaster concerned with proactive disease prevention and it is anticipated will be implemented from April 2017.

The Doncaster Place Plan and the South Yorkshire Sustainability & Transformation Plan (STP) both cite prevention as a key factor for success. GP and practice teams have a crucial role in promoting health and preventing disease and there is potential for general practice to take a more central role in ill health prevention and public health.

A model for prevention has been developed for Doncaster with the endorsement of the Health & Wellbeing Board to communicate prevention at different levels such as addressing causes of ill health, reducing disease risk factors and detecting disease early and the management of Long Term Conditions. It helps to communicate how disease prevention can take place within general practice.

A Clustered Risk Factor approach identified individuals who have multiple risk factors that are known to cause ill health. These risk
factors include cancer, circulatory and respiratory disease and are
known to be the leading cause of death for the population of
Doncaster. Smoking, high body mass index, alcohol intake and
physical inactivity are known to cause these diseases. The clustered
risk factor approach would involve the practice identifying patients
with multiple risk factors and offering support to reduce them.

It is proposed to target those patients aged 18-40 years as these are
not covered by the NHS Health Check programme. Practices would
deliver wellbeing interventions including a Healthy Behaviour Self-
management action plan which may include referral to wider
community services.

Mrs Whittle queried Public Health involvement in the development of
the model. Mrs Sherburn stated that Public Health drafted the
majority of the documentation relating to the Keeping Well model as
it currently stands.

Mrs Cookson highlighted that those individuals with unhealthy
lifestyles may have extenuating factors to consider such as Domestic
Violence which may contribute. Mrs Sherburn stated that this would
be picked up in the list of potential interventions that a practice could
make.

Mrs Sherburn stated that the next steps are to finalise the draft
documents, ascertain funding routes for the Pillars and create a
mobilization plan for delivery which will be presented to this
Committee in February 2017 for final approval. It will also be
presented to the Membership for discussion at the Doncaster Wide
Primary Care event on 12 January 2017.

9. Primary Care Co-Commissioning Internal Audit Report

Mrs Tully presented the Audit Report to the Primary Care
Commissioning Committee for noting. The report covers the
Governance Structure, operational arrangements and the
management of Conflicts of Interest. Any recommendations made by
Internal Audit have been addressed and as a result the Committee is
now fully compliant.

The Amended Primary Care Co-Commissioning Internal Audit Report
will be presented at a future Audit Committee meeting.

10. Primary Care Commissioning Committee Summary Report to
Governing Body

Mrs Tully presented the Primary Care Commissioning Committee
Summary Report which covers the period from April 2016 to October
2016. The report details the progress for the six meetings over the
first two quarters – Quarter 1 April – June 2016 and Quarter 2 July to
October 2016.

The Primary Care Commissioning Committee takes a robust but proportionate approach to the management of potential or real Conflicts of Interest to ensure full compliance with statutory guidance whilst avoiding restricting local innovation. During the six meetings referred to in the report, there has been no exclusions affecting the quorum of the meetings. The report will be presented to the Governing Body in January 2017.

Mrs Ogle stated that NHS England will also require sight of the report and will liaise with Mrs Satterthwaite on how this may be done.

11. **Primary Care Commissioning Committee Forward Programme**

Mrs Sherburn presented the Forward Planner to the Committee and the following points were made:

- 5 year GP Forward View to be added to the programme for February 2017.
- Oakwood-Mayflower merger also to be added to Feb 2017 agenda
- Dr Seddon highlighted that Colposcopy should be part of the Extended Primary Care Pillar specification developments.
- Dr Barbour queried of the Pharmacy LES should also be added. Mrs Tingle stated that she would investigate. There are issues with the collation of data from the Business Services Authority.

The Primary Care Commissioning Committee noted the Forward Programme.

12. **Quality Update**

Mrs Cookson gave the following verbal update to the Committee:

- A decision is awaited regarding the Oakwood merger.
- Mrs Zara Head is working to support those practices within the resilience programme. She is also in the process of visiting all practices in Doncaster.
- There has been increased effort to complete the Initial Health Assessments in respect of Looked after Children.
- 3 practices recently inspected by the Care Quality Commission (CQC) have received a rating of ‘Good’.

The Primary Care Commissioning Committee noted the update.
13. Receipt of Minutes

The following minutes were received and noted by the Primary Care Commissioning Committee:

- Provider Care Delivery Group – Minutes of the meeting held on 4 November 2016.

14. Any Other Business

Dr Barbour commented that it would be beneficial to have information on the national position when discussing various agenda items.

Dr Seddon informed the Committee that, when referring patients for Bone Density scans, the reports are taking 6 months to be returned to the GP and some patients require further treatment thereby resulting in a delay. Mrs Cookson stated that she would investigate and address contractually where necessary and requested that Dr Seddon report the incident through the Issues Log.

15. Date and Time of Next Meeting

Thursday 9 February 2017, Boardroom, Sovereign House at 12.30pm
Minutes of the Primary Care Commissioning Committee
Held on Thursday 9 February 2017 commencing at 12.30pm
In the Boardroom, Sovereign House

Voting Members
Mrs Linda Tully – Lay Member (Chair)
Mrs Sarah Whittle – Lay Member (Vice Chair)
Mrs Hayley Tingle – Chief Finance Officer
Mrs Laura Sherburn – Chief of Partnerships Commissioning and Primary Care

Non-voting Members
Dr Pat Barbour – Locality Lead, South East Locality
Dr Niki Seddon – Locality Lead, North West Locality
Mrs Carolyn Ogle – Primary Care Contract Manager, NHS England

Formal attendees present
Dr Nabeel Alsindi – Clinical Lead for Primary Care and Long Term Conditions
Dr Dean Eggitt – Medical Secretary, Doncaster Local Medical Committee
Mrs Debbie Hilditch, Health watch Doncaster Representative

In attendance:
Mrs Jayne Satterthwaite PA to Chair & Chief Officer - (Taking Minutes)
Mr Andrew Russell – Chief Nurse (Item 15)
Mrs Zara Head – Primary Care Quality Nurse (Item 15)

ACTION

1. Welcome and Introductions

Mrs Tully welcomed everyone to the Primary Care Commissioning Committee meeting.

There were 0 members of the public in attendance at the meeting and 2 members of NHS Doncaster CCG staff observing the meeting.

2. Apologies

Apologies were received from:

- Mrs Jackie Pederson – Chief Officer
- Mrs Suzannah Cookson – Deputy Chief Nurse
- Dr Rupert Suckling – Director of Public Health
- Mr Ian Carpenter, Head of Communications & Engagement

3. Declarations of Interest

The Chair reminded committee members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Doncaster Clinical
Declarations declared by members of the committee are listed in the CCG’s register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link www.doncasterccg.nhs.uk

The meeting was noted as quorate.

**Declarations of interest from sub-committee/working groups:**

None declared.

**Declarations of interest from today’s meeting:**

**Item 6 - National Primary Care Transformation Fund (Capital Infrastructure & IT)**

Dr Seddon declared a Financial interest in the National Primary Care Transformation Fund (Capital Infrastructure & IT) Update as a bid had been submitted from her practice. As this item provided an update only, Dr Seddon remained in the meeting.

**Item 9 – Extended Primary Care Pillar – Tiered Framework**

Dr Seddon declared a Financial Interest in the Extended Primary Care Pillar – Tiered Framework as Dr Seddon provides a Colposcopy service. As this item provided an update only, Dr Seddon remained in the meeting.

**Item 10 – Practice Merger Business Case proposal**

Dr Eggitt declared a Financial Interest in the Practice Merger Business Case proposal as he is a partner in the Oakwood Surgery. As this item was for discussion and the support and approval of the merger, it was agreed that Dr Eggitt leave the room until a decision is made when this item is discussed.

4. **Minutes of the Previous Meeting held on 8th December 2016**

The minutes of the meeting held on 8th December 2016 were agreed as an accurate record.

5. **Matters Arising**

  **Proactive Co-ordinated Primary Care Specification – Update on Practice Readiness – Recommendations**

Dr Eggitt reported that it had been difficult to obtain feedback from the GPC regarding any contractual levers that can be used to ensure
universal coverage of the service specification. There is one practice who has not chosen to deliver the specification, which causes an inequity for the patient population. Dr Eggitt and Mrs Sherburn will continue to hold discussions to find a solution and this action will remain 'open' on the Action Tracker.

Oakflower Merger Business Case – Estates and Technology

Mrs Hilditch confirmed that the practices had been contacted and continued support from Healthwatch will be given.

Contingency Planning

This is an agenda item in the confidential section of this meeting.

Primary Care Commissioning Committee Summary Report

Mrs Ogle confirmed that NHS England does not require sight of quarterly reports only on an annual basis.

6. National Primary Care Transformation Fund (Capital Infrastructure & IT) Update

Mrs Sherburn explained that in 2016, NHS England invited CCGs to submit bids against the ETTF on behalf of practices. NHS Doncaster CCG received 28 bids and following technical assessment against NHS England criteria, supported 27 to go forward through submission via the online portal, in June 2016. Schemes were then ranked by NHS England and the practices and the CCG were asked to re-affirm their commitment to the various schemes in October 2016. It is generally recognised by the CCG, practices and local NHS England colleagues alike that the ETTF process has been challenging to navigate thus far, and remains so going forward, due to incremental publication of the next steps in the process.

In October 2016 the CCG was informed that schemes assessed as either not directly contributing to CCG Strategic Plans, STP’s or LDR’s or considered very unlikely to be able to be delivered in timeframe of the ETTF, were not going to be taken forward. Furthermore, the remaining bids had been ranked into cohorts based on a technical assessment of the schemes’ ability to complete within the timeframe of the ETTF. (The cohorts did not take into account how the bids had been prioritised by the CCG when submitting in June.) This still left the ETTF highly oversubscribed. The cohorts were described as:

- **Cohort 1** – assessed as can be fully delivered and funded this year (2016/2017) and therefore should be prioritised to proceed (subject to CCGs confirmation) and also bidders recognition and acceptance of the funding level of 66% grant maximum funding and therefore bidders will need to contribute 34% this financial year.
- **Cohort 2** – assessed as being able to complete by March 2019. These schemes will be asked to proceed on an individual basis if and when funding allows. CCGs and practices to confirm whether schemes
should be included or not. If the schemes are not approved to go forward, or the practice does not want to proceed then the schemes will be removed. If both the CCG and the practice do agree to move forward with the scheme then the lead for the scheme should immediately commence preparing a business case/Project Initiation Document (PID).

- **Cohort 3** – these schemes require funding beyond the length of the ETTF and will be subject to a business case. Confirmation if capital resources are likely to be available beyond 2019 is needed.

Also to take into consideration is the proposed funding level from the ETTF which differs to the original guidance. NHS England decided due to the level of CCG and bidders funding requests that:

- Schemes below £1m which are improvements to existing premises will be limited to a maximum of 66% of scheme costs.
- NHS Property Services/Community Health Partnerships or LIFT premises – are likely to need to be funded going forward by those stakeholders but will also be considered for NHS Capital Contribution to help reduce future increased revenue costs of being funded through those routes: maximum capital contribution provided will be between 20-30%.
- Schemes over £1m – especially where new builds or major extension to existing premises will be considered as to whether can better be taken forward through other funding routes – LIFT or 3PD with potential for an NHS Capital Contribution of no more than 20-30% to help future revenue costs.
- Only Technology schemes are likely to be funded at or close to 100%.

In Doncaster 10 schemes have been ranked into cohort 1, 14 schemes into cohort 2, 1 into cohort 3, and 2 schemes were not ranked at all and therefore not recommended to proceed. Subsequently, 2 practices withdrew from Cohort 2, due to various reasons including lack of planning permission and affordability constraints. NHS England requested that practices in Cohorts 1 & 2 complete a PID by the end of February 2017.

There are 14 schemes in Cohort 2; made up of 5 IT schemes and 9 premises schemes. The ETTF is significantly oversubscribed and there is still no guarantee that funding for Cohort 2 schemes will be released, however in early January NHS England asked all Cohort 2 practices to complete detailed PIDs for the end of February 2017.

Initial discussions internally concluded that although the CCG has supported, and will continue to support each individual practice scheme, there is a considerable level of duplication. The affordability of revenue costs and likelihood of success with the ETTF itself, are significantly compromised by this. The CCG and the local NHS England will support practices to re-consider their schemes in this light, with the possibility of combining or amending some schemes. The CCG and NHS England met with all cohort 2 practices mid-January to discuss this further and practices are currently discussing their options together but as yet no commitments have been made by practices to alter their schemes.
Mrs Sherburn requested that the Primary Care Commissioning Committee consider and advise on the process by which revenue impact of schemes (when known) should be considered and decided upon within the CCG and the approach to supporting Cohort 2 PIDs going forward, should duplication between schemes not be resolved.

Dr Seddon raised concerns that practices have invested a considerable amount of time in the preparation of their bids and may become disheartened if the bids are not accepted. Mrs Tingle stated that NHS Doncaster CCG is keen to be as supportive as possible to practices, however the financial challenges faced by the CCG in the next 2 years reduces flexibility considerably and there is concern regarding on-going revenue consequences.

Dr Eggitt commented that to guard against practices investing time and money unnecessarily, consideration should be given to which bids have any likelihood of being accepted and which we know already cannot be taken forward, so as to inform the practices as soon as possible.

Dr Barbour stated that thought should be given to what patients and practices need and not necessarily what they want and it is up to the CCG to determine if schemes are necessary. Mrs Sherburn stated that this had already taken place in the initial round of assessment and prioritisation, using the transformation criteria attached to the fund. Mrs Ogle re-iterated that the purpose of transformation is to do things differently; there is other funding available for building modifications.

There is still a lot of work to do on the Cohort 2 bids to get the detail needed for the next level of decision-making (where decisions can be made based on the recurrent financial impact, for example) – the challenge is that this requires a lot of work from practices with no guarantee of return on their investment.

Mrs Tingle highlighted that we must be cautious that practices are supported equally and queried the approach of other areas. Mrs Ogle reported that other areas have submitted fewer bids however would query when funding for those practices in Cohort 1 will be received.

Mrs Sherburn stated that the primary care team would continue to support all practices to progress their bids. When further detail is known regarding the timescales for agreeing Cohort 2 funding nationally, the CCG will need to have a process in place to assess local affordability. For now the message to Cohort 2 practices is the one that has already been given; that duplicative bids will not be successful, and practices may wish to give thought to working together.

Primary Care Commissioning Committee noted the update.

7. **GPFV Implementation Plan – progress update**
Mrs Sherburn stated that, when the GPFV Implementation Plan was signed off in December 2016, it was agreed that the Primary Care Commissioning Committee would remain sighted on its progress and provided the following update:

- West Wakefield has been engaged to help the CCG implement Care Navigation in Doncaster. Dr Seddon reported that some of her practice team had visited a Wakefield practice where care navigation was in place, and had expressed concern that the online training for staff was quite basic and that a reduction of only 10% in GP appointments was noted. Mrs Sherburn stated that West Wakefield online training will only be one element of the implementation package, and the plan is to work with the Advanced Training Programme (ATP) to embed the concept properly into each practice. In addition, the work on the Directory of Services (DOS) is a key part of the agenda in order to maximise the impact of care navigation; and a lot of this work is already being done by the local authority.
- We have engaged Thornfields Primary Care Training Specialists to provide training for non-clinical practice staff to manage medical correspondence. These sessions are being scheduled for April & May.
- A meeting has taken place with Federation leads to discuss the best model of GP federation for Doncaster going forward. A discussion paper has been developed, proposing the establishment of a Pan-Doncaster Federation supported by 4 groups of general practice, aligned to the Place Plan neighbourhoods. A workshop has been arranged in March to discuss further. Dr Seddon queried if a decision had been made on an overarching federation. Mrs Sherburn stated that no decision had been made; the paper is for discussion back in practices, and where she is asked to, Jayne Brown is facilitating conversations. Dr Eggitt commented that one federation would be the better option and would provide opportunities for the sustainable delivery of core general practice into the future.

The Primary Care Commissioning Committee noted the update.

8. Keeping Well Pillar of the Primary Care Strategic Model

Mrs Sherburn presented the latest draft of the specification and explained that the concept of the specification is to identify patients with multiple risk factors that are not already on a disease register or eligible for NHS healthcheck, and offer them an appointment within primary care to discuss their lifestyle choices, with the aim of preventing long-term health conditions developing. A further sense-check with the Primary Care Provider Engagement Group on the clinical and operational elements of the specification is planned for 22 February 2017, after which a timescale for implementation will be agreed.

The aim of the “Keeping Well” pillar is to move towards a wellbeing approach to disease prevention in Doncaster which is integrated with Doncaster Council’s Community Led Support Model. The specification sets out how the first steps will be taken towards this in 2017-18. A
clustered risk factor approach involves identifying individuals that have multiple risk factors that are known to cause ill health. For the Keeping Well specification this will focus on risk factors (smoking, high body mass index, alcohol intake and physical inactivity) that are known to be the leading cause of death for the population of Doncaster from cancer, circulatory disease and respiratory disease. The proposal is to target those aged 18-40 years as these individuals are not already covered by the existing NHS Health Check programme. Practices will identify people with multiple risk factors from their patient list and develop a Clustered Risk Register. It is anticipated that this may amount to circa 3000 patients.

Mrs Tingle informed the Committee that the total budget requirement is £144k; a first appointment payment would be £30 and a follow up £18.

Mrs Sherburn requested that the Primary Care Commissioning Committee note the contents and endorse the direction of travel with the specification, approve the payment schedule and advise on any further considerations prior to finalisation and implementation.

The Committee gave the following comments and suggestions:

- Dr Eggitt requested that there was further clinical input on the relevant aspects prior to finalising the specification. It was agreed that Dr Alsindi, Mrs Sherburn and Dr Eggitt would meet to review these aspects.
- There should be equality for patients.
- Other Healthcare professionals could deliver the service it does not have to be a GP.

Mrs Hilditch highlighted that the expectation is that consultations with the public regarding the Doncaster Place Plan which includes an emphasis on a more self-management approach will take place over the next 3 – 6 months.

The Primary Care Commissioning Committee endorsed the specification and approved the payment schedule.

9. **Extended Primary Care Pillar – Tiered Framework**

Dr Alsindi presented the Extended Primary Care Pillar Tiered Framework to the Committee and explained that the Extended Primary Care Pillar is one of the four pillars of the Primary Care Strategic Model for Doncaster, concerned with supporting the delivery of services closer to the patient’s home. Doncaster’s practices already provide a number of services beyond those contracted through the existing GMS and PMS contracts. Some of these are commissioned nationally as Direct Enhanced Services (DES’s) or through the existing Local Enhanced Services (LES’s). The CCG also commissions LES’s from primary care via
contracts with opticians and pharmacies.

The Extended Primary Care Pillar framework has been worked up over the last 6 months, with input from the Primary Care Provider Engagement Group and the Local Medical Committee (LMC) amongst others, with the aims of:

- Reducing inequity of services available to patients outside of secondary care, currently almost completely dependent on whether a practice chooses to sign up for each individual LES.
- Supporting the future transfer of services traditionally provided in secondary care into primary care, where there is sufficient expertise and resource, to help address pressures in Planned Care.
- Creating new opportunities for practices, individually or working at scale, to expand and diversify the services they receive defined funding for.

The framework classifies the existing LES’s, and any new LES’s that may be created in-year, into 3 tiers:

- Tier 1 Enhanced Services – a group of current individual LES’s which all practices are expected to deliver, or put in place an agreement for another practice to provide part or all of the LES on their behalf for an agreed reimbursement. Practices will not be able to pick and choose between these in contrast to the current approach.
- Tier 2 Enhanced Services – the existing and future LES’s which, for various reasons including clinical expertise or maintenance of sufficient activity to keep up skills and quality, could be delivered by a practice on behalf of a group of practices.
- Tier 3 Enhanced Services – those LES’s delivered at scale by only one or two approved practices to populations across a larger multiple practice area or potential the whole of Doncaster.

These changes were communicated to all practices in the Primary Care Commissioning Intentions 2017/18 and the new Service Specification for Tier 1 Local Enhanced Service Group has been sent out to practices along with confirmation that the Tier 2 LES’s will remain unchanged as of 1 April 2017 but will be worked up in the months after resulting in new specifications to better support primary care innovation and patient choice. The planned next steps are:

- Tier 1 Enhanced Services – practices have until 28 February 2017 to indicate if they will be delivering each LES themselves or have arranged another practice to do so on their behalf. The CCG will work with any practices who have not arranged provision of these LES’s from 1 April 2017.
- Tier 2 Enhanced Services – practices have until 28 February 2017 to confirm which Tier 2 LES’s they will continue or begin to provide for their patients from 1 April 2017, and if they are intending to provide that service to non-registered patients when the new specifications are issued. Between April and September 2017 there will be testing and rolling out of the group/non-registered aspects of the current Tier 2 LES’s along with the issuing of the new Complex Dressings LES and
working up any other potential new LES’s/pathways.
• Tier 3 Enhanced Services – subject to approval of the approach, the proposal for expansion of the Colposcopy LES (previously discussed at the Committee in September) will be worked up against this and an update brought to the March Committee for a decision.

Mrs Tingle reported that the 2017/18 indicative budgets have been allocated into tiers to reflect the new proposed framework as follows:

• Tier 1 services have an indicative budget of £2,734,785.
• Tier 2 services have an indicative budget of £49,702.
• Tier 3 services have an indicative budget of £119,519.

A number of changes were factored in when setting the budgets as follows:

• The Enhances Services ceasing on 31 March 2017.
• The addition of the Flying Scotsman practice.
• The adjustment to reflect changes in practice list sizes to the 1 January 2017 relating to the Treatment LES.

A standardised ‘top up’ fee to reflect non-registered patients for those practices who provide a service to others is yet to be determined. The Finance team is working with Practice Managers on a number of options.

Dr Alsindi requested that the Primary Care Commissioning Committee note the contents of the framework, provide feedback on the proposed schedule for the Tier 2 Enhanced Services, approve the approach for the new/expanded Tier 3 Enhanced Services, including bringing an update on the Colposcopy LES expansion proposal to March Committee meeting to consider against the approved process.

Dr Seddon requested that she be consulted on the development of Colposcopy LES prior to a decision being made at the Committee meeting in March 2017.

The Primary Care Commissioning Committee noted the contents of the framework and approved the approach for the new/expanded Tier 3 Enhanced Services, including an update on the Colposcopy LES expansion proposal to the March Committee meeting for consideration. Further updates on the implementation of the changes over the coming months will be presented to the Primary Care Commissioning Committee and will be included as a standing agenda item going forward.

10. **Practice Merger Business Case proposal**

Dr Eggitt had declared a Financial Interest in this item and he left the meeting at this point until a decision was made. Mrs Hilditch left the meeting at this point.
In November 2016 the Committee was asked to consider an outline
business case from the Oakwood Surgery and the Mayflower Medical Practices and to accept their formal notification of their intent to merge in 2017. The Committee discussed the outline business case and agreed to support the merger in principle.

As part of the merger the CCG would be liable to fund from core IT budgets the clinical system migration and merger as the two practices are currently operating on different clinical systems. Details of this are within the application to merge. Mrs Sherburn presented the application for consideration of a contractual merger to the Primary Care Commissioning Committee for the support and approval of the merger and that NHS Doncaster CCG will fund the clinical system migration.

The Primary Care Commissioning Committee held a detailed discussion and highlighted the following points:

- Dr Barbour commented that one of the maps detailing the areas covered by the practices and the cross boundaries is very unclear and that it would be beneficial to have a map which showed the area which will be covered by the merged practice.
- Dr Barbour queried if consideration had been given to extended hours. Mrs Wastnage, Primary Care Support Manager, stated that patients would be able to access sites at any time and extended hours will be operational from one site. Mrs Ogle queried whether the business case reflected patients’ thoughts on this proposal. However it was noted that as currently the Mayflower Practice does not offer extended hours, it is a reasonable assumption therefore that for their patients this would be an improvement.
- It was not explicitly articulated in the business case exactly how a reduction in locum doctors will be achieved; however it was agreed that the Committee would not necessarily require this level of detail.
- Mrs Ogle queried if the Committee is satisfied that there is equity for patients to access a single service and there is adequate assurance for the provision of home visits. Mrs Sherburn agreed to check this back with the practices.

Dr Seddon left the meeting at this point.

- Mrs Tingle raised the wider question of the funding of the clinical system migration and merger. The GP IT budget is £790k and System migration is accounted for within the budget. Practices may request system migration after a period of 3 years and the CCG will provide funding. As Primary Care moves towards Federations, and working more at scale with potentially more mergers, NHS Doncaster CCG will require an equitable process in order to prioritise limited funding. Currently, the GP IT team maintains a forward planner, which includes requests from practices to migrate to a different system, on a first come first served basis. Mrs Ogle reported that historically the practice would not fund a merger unless it had been recorded on the forward plan.

The Primary Care Commissioning Committee approved the practice
merger in principle subject to the following:

- Assurance is gained that the merged practices will have one single operating model, and there will be no inequity for patients.
- A conjoined map of the areas will be produced and that there are no geographical gaps identified.
- The migration of the Oakwood system to TPP is added to the GP IT forward planner, and funded by the CCG. Any additional costs of merging the 2 TPP systems will then be funded by the practices.

Mrs Sherburn agreed to write to the practices to communicate the Committee’s decision.

Dr Eggitt and Mrs Hilditch re-joined the meeting.

11. Primary Care Budgets 2017/18

Mrs Tingle presented the Primary Care Budgets for 2017/18 to the Committee for noting. It was the first time the budgets had been presented and Mrs Tingle requested that the Committee feedback any suggestions on the format to her after the meeting.

The total delegated budget for Primary Care Medical Services is £41m and includes the cost of providing General Practice services to the population of Doncaster including GMS, PMS and APMS contracts, reimbursable costs including rent and rates as per national guidelines, national LES’s and Quality and Outcomes Framework (QOF). The year to date position reflects an under spend of £282k and a forecast underspend of £240k. There are no particular areas of concern to be highlighted at present.

Dr Barbour queried if the amount under spent would be ring fenced for General Practice. Mrs Tingle informed the Committee that it would not be ring fenced, as this is not the way we treat underspends for any other contractor.

The Primary Care Commissioning Committee noted the Primary Care budgets for 2017/18

12. Prescribing LES update

Mrs Tingle reported that in August 2016 all GP practices in Doncaster signed up to the Prescribing Gain Share LES. The Gain Share was designed to incentivise practices to reduce their prescribing spend across 6 key categories that had been highlighted as part of the national Right Care information. Data on actual expenditure is received from the Business Services Authority (BSA) and is two months in arrears. Information is now available up to the end of October 2016. The actual spend for August – October 2016 has been compared to the same period in 2015 adjusted for both price and population changes. The information
shows an overall increase in costs of £464k with the biggest increases in Cardiology and Endocrine. Some practices have seen a slight reduction in costs which will result in gain share payments of approximately £18k at this stage. A forecast position will be calculated for year-end as more information becomes available. Detailed information for each practice has been shared in January 2016 and this will continue to be updated as more information is received from the BSA.

Mrs Tingle reported that NHS Doncaster CCG is an outlier in respect of Prescribing expenditure resulting in major financial risk for the CCG. There is potential for savings to be made in the Rightcare areas however we must explore ways to influence General Practice to achieve necessary savings.

Mr Russell stated that the introduction of OptimiseRx should result in some savings. Dr Eggitt emphasised the difficulty to recruit GPs in Doncaster; this has made it difficult to deliver the manpower to help with savings, there is limited capacity to make the necessary changes. Mrs Whittle commented that we need to look at the best way to optimize the Medicines Management resource we have at our disposal in the CCG.

Mrs Tingle reported that an update will be presented to the Committee in 3 months.

The Primary Care Commissioning Committee noted the update.

13. Proactive Co-ordinated Primary Care Specification Q1 progress

Mrs Sherburn informed the Committee that the reports received in January 2017 will be presented at the next meeting on 9 March 2017.

14. Informal or temporary list closures

Mrs Sherburn presented the Commissioner Guidelines for Responding to Requests from Practices to Temporarily Suspend Patient Registration to the Committee for information and to discuss an approach on the grounds upon which a practice may refuse a patient.

The Committee gave the following suggestions:

- Practices should keep an up to date written record.
- The CCG should receive notification from practices when making refusals and the reason(s) why.
- The level of occurrences should be monitored.
- Contractual action may be required.

The Primary Care Commissioning Committee noted the guidelines.

15. Quality Update
Mrs Head presented the Quality update for noting by the Committee.

Mrs Sherburn stated that the Quality Dashboard content is to be discussed in detail at the Primary Care Delivery Group. Exception reports only will then feed up to this Committee and Quality & Patient Safety Committee as necessary.

The Primary Care Commissioning Committee noted the update.

16. Receipt of Minutes

The following minutes were received and noted by the Primary Care Commissioning Committee:

- Primary Care Delivery Group – Draft minutes from the meeting held on 13 January 2017.
- Provider Engagement Group – Draft minutes from the meeting held on 25 November 2016.

17. Any Other Business

QOF

Mrs Sherburn informed the Committee that Leeds CCG has offered practices the opportunity to suspend QOF delivery, in recognition of the severe pressure currently faced by general practice. Mrs Sherburn and Dr Eggitt have discussed and there may be benefits to adopting the same approach in Doncaster, such as the release of vital capacity. Mrs Sherburn proposed that this be discussed at the meeting in March.

Dr Barbour remarked that March may be too late and that a more timely decision is required. Mrs Tully proposed that voting members receive a paper and a virtual decision be made.

Primary Care Commissioning Committee Paperwork

Mrs Tully raised the late circulation of the paperwork for today’s meeting to members of the Committee. Mrs Tully acknowledged that some papers are more complex in their preparation however requested that members endeavour to complete their papers in a timely manner. Any papers which are received late will be declined and the item removed from the agenda.

18. Date and Time of Next Meeting

Thursday 9 March 2017, Boardroom, Sovereign House at 12.30pm
Terms of Reference
Remuneration Committee

1. Introduction

1.1. The Remuneration Committee (the Committee) is established in accordance with NHS Doncaster Clinical Commissioning Group’s Constitution.

1.2. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

1.3. The Committee’s remit is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme.

2. Role of the Committee

The Governing Body has delegated the following functions to the Remuneration Committee:

2.1. Advising the Governing Body on all aspects of salary (including performance related pay elements, bonuses and allowances), provision for other benefits including pensions and lease cars (where applicable) not covered by Agenda for Change.

2.2. Advising the Governing Body on arrangements for termination of employment (including compulsory and voluntary redundancy payments and mutually agreed severance payments) and other contractual terms and conditions.

2.3. Advising the Governing Body on the remuneration, allowances and terms of service of senior managers covered by the Very Senior Managers pay framework ensuring that the terms and conditions of service, remuneration and pay awards are in line with nationally agreed guidance.

2.4. Reviewing recommendations from the Chair and Chief Officer in relation to the performance of individual Governing Body Members where relevant to their rate of remuneration.

2.5. Advising and overseeing appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance as appropriate.

2.6. Advising the Governing Body on the remuneration, allowances and terms of service for the Chairs and Members of the Group.
2.7. Reporting to the Governing Body that it has met and performed its function, within recognised national guidelines.

2.8. Establishing Sub-Groups to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference.

2.9. Determining the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.

2.10. Determining terms and conditions of employment for all employees of the Group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.

2.11. Determining pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.

3. Membership

3.1. **Members:** The members of the Committee shall comprise:

- Lay Member – Audit & Governance (Chair)
- Lay Member – Patient & Public Involvement
- Locality Lead x2 (1 x Vice Chair)
- Governing Body Secondary Care Doctor Member

3.2. **Attendees:** Other individuals may be invited to attend for all or part of any meeting as appropriate, however should not be in attendance for discussions about their own remuneration and terms of service. Attendees may include but are not restricted to:

- Accountable Officer
- Human Resources Advisor
- External Advisors

4. Meetings and conduct of business

4.1. **Secretary:** The Board Secretary shall attend to provide appropriate advice to the Chair and Committee members and shall make arrangements for the Committee to have an administrator who will arrange meetings, collate and distribute papers, take minutes and keep a record of issues to be carried forward. The Board Secretary will be responsible for supporting the Chair in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.

4.2. **Quorum:** A quorum shall be two members. Where the Committee is making a decision or recommendation regarding the remuneration of Governing Body
clinical members, the clinical members of the Committee shall declare a conflict of interest and withdraw from the meeting. Where the Committee is making a decision or recommendation regarding the remuneration of Governing Body Lay members, the Lay members of the Committee shall declare a conflict of interest and withdraw from the meeting.

4.3. **Frequency:** The Committee will aim to meet at least once a year at times which are consistent with the remuneration and terms of service cycle and which enable it to efficiently discharge its duties. Extraordinary meetings may be called at the discretion of the Chair.

4.4. **Notice of meetings:** Items of business for inclusion on the agenda of a meeting shall be notified to the Chair of the meeting at least 10 working days before the meeting takes place. Supporting papers for such items shall be submitted at least 6 working days before the meeting takes place. The agenda and supporting papers shall be circulated to all Committee members and attendees at least 3 working days before the date the meeting will take place.

4.5. **Conduct:** The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice including the Nolan Principles.

5. **Decisions**

5.1. The Committee will apply best practice in its decision making processes and effectively declare and manage all conflicts of interest.

5.2. When considering individual remuneration the Committee will:
  - Comply with current disclosure requirements for remuneration;
  - Where necessary seek independent advice about remuneration for individuals;
  - Ensure that decisions are based on clear and transparent criteria.

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

5.4. Decisions will aim to be reached by a process of consensus decision-making.

5.5. The Committee has full authority to commission any reports it deems necessary to help it fulfil its obligations.

5.6. The Committee may establish Sub-Groups to assist it in discharging responsibilities of the Committee as set out in its Terms of Reference.

6. **Reporting arrangements**

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1 Available at http://www.public-standards.gov.uk/
6.1. The minutes of the Committee meetings shall be formally recorded and submitted to the confidential session of the Governing Body.

6.2. The Committee will annually review its terms of reference and the attendance rate of Committee members. Any resulting changes to the terms of reference or membership shall be submitted to the Governing Body for approval.

Last reviewed: March 2017
Verbal

Item 16

Any Other Business
Verbal

Item 17

Date & Time of Next Meeting

Thursday 20th April 2017 at 1pm