Governing Body

To be held on
Thursday 1 August 2019

From 1pm until 4pm

in the Boardroom, Sovereign House,
Heavens Walk, Doncaster DN4 5HZ
## GOVERNING BODY
To be held on Thursday, 1 August 2019 at 1pm
In Boardroom, Sovereign House

### A G E N D A

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Enclosure</th>
<th>Led By</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies for Absence</td>
<td>Verbal</td>
<td>Chair</td>
<td>For noting</td>
</tr>
<tr>
<td>2.</td>
<td>Declarations of Interest</td>
<td>Verbal</td>
<td>All</td>
<td>For noting</td>
</tr>
<tr>
<td>3.</td>
<td>Minutes of the meeting held on 4 July 2019</td>
<td>Enc A</td>
<td>Chair</td>
<td>For approval</td>
</tr>
<tr>
<td>4.</td>
<td>Matters Arising not on the Agenda</td>
<td>Verbal</td>
<td>Chair</td>
<td>For discussion</td>
</tr>
<tr>
<td>5.</td>
<td>Notification of Any Other Business</td>
<td>Verbal</td>
<td>Chair</td>
<td>For discussion</td>
</tr>
<tr>
<td>6.</td>
<td>Questions from Members of the Public</td>
<td>Verbal</td>
<td>Chair</td>
<td>For discussion</td>
</tr>
<tr>
<td>7.</td>
<td>Patient Story</td>
<td>Verbal</td>
<td>Chair</td>
<td>For discussion</td>
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</tbody>
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### Strategy

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Enclosure</th>
<th>Led By</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>CCG New Model Constitution</td>
<td>Enc B</td>
<td>Chair</td>
<td>For discussion and approval</td>
</tr>
</tbody>
</table>

### Assurance

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Enclosure</th>
<th>Led By</th>
<th>Action Required</th>
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</thead>
<tbody>
<tr>
<td>9.</td>
<td>Quality &amp; Performance Report</td>
<td>Enc C</td>
<td>Director of Strategy &amp; Delivery and Deputy Chief Nurse</td>
<td>For noting</td>
</tr>
<tr>
<td></td>
<td>• Spotlight Report on Ageing Well</td>
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<tr>
<td>10.</td>
<td>Finance Report</td>
<td>Enc D</td>
<td>Chief finance Officer</td>
<td>For noting</td>
</tr>
<tr>
<td>11.</td>
<td>Governing Body Assurance Framework – Quarter 1 2019-2020</td>
<td>Enc E</td>
<td>Associate Director of HR &amp; Corporate Services</td>
<td>For approval</td>
</tr>
<tr>
<td>Ref</td>
<td>Item</td>
<td>Enclosure</td>
<td>Led By</td>
<td>Action Required</td>
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<td>12.</td>
<td>Corporate Assurance Report – Quarter 1 2019/2020</td>
<td>Enc F</td>
<td>Associate Director of HR &amp; Corporate Services</td>
<td>For noting</td>
</tr>
<tr>
<td>13.</td>
<td>Chair &amp; Chief Officer Report</td>
<td>Enc G</td>
<td>Chief Officer &amp; Chair</td>
<td>For noting</td>
</tr>
<tr>
<td>14.</td>
<td>Locality Feedback</td>
<td>Verbal</td>
<td>Locality Leads</td>
<td>For noting</td>
</tr>
</tbody>
</table>

**Items to note/Receipt of Minutes**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Enclosure</th>
<th>Led By</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Items to Note</td>
<td>Enc H</td>
<td>Deputy Chief Nurse &amp; Designated Nurse</td>
<td>For noting</td>
</tr>
<tr>
<td></td>
<td>Letters from the Care Quality Commission and Ofsted regarding the Joint Local Area SEND Inspection in Doncaster.</td>
<td></td>
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</tr>
<tr>
<td>16.</td>
<td>Safeguarding Annual Report</td>
<td>Enc I</td>
<td>Deputy Chief Nurse &amp; Designated Nurse</td>
<td>For noting</td>
</tr>
<tr>
<td>17.</td>
<td>• Integrated Care System - System Leader Update</td>
<td>Enc J</td>
<td>Chair</td>
<td>For noting</td>
</tr>
<tr>
<td></td>
<td>• Feedback from South Yorkshire and Bassetlaw Integrated Care System and Region Focus meeting on 16 May 2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Receipt of Minutes</td>
<td>Enc K</td>
<td>Chair</td>
<td>For noting</td>
</tr>
<tr>
<td></td>
<td>• Engagement &amp; Experience Committee – Minutes of the meeting held on 6 June 2019.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Joint Committee Clinical Commissioning Group – Minutes of the meeting held on 24 July 2019.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>Any Other Business</td>
<td>Verbal</td>
<td>Chair</td>
<td>For discussion</td>
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<tr>
<td>20.</td>
<td>Date and Time of Next Meeting</td>
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<td>For noting</td>
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Thursday 5 September 2019 at 1pm

Governing Body Quorum is 6
Members: Chair or Vice Chair, at least 3 Clinical Members and Chief Officer or Chief Finance Officer
### Minutes of the Governing Body

**Held on Thursday 4 July 2019 at 1pm**

**In the Boardroom, Sovereign House**

<table>
<thead>
<tr>
<th>Members</th>
<th>Present:</th>
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<tbody>
<tr>
<td>Dr Crichton</td>
<td>NHS Doncaster CCG Chairman (Chair)</td>
</tr>
<tr>
<td>J Pederson</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>H Tingle</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>L Tully</td>
<td>Lay Member</td>
</tr>
<tr>
<td>Mr Wilkin</td>
<td>Lay Member</td>
</tr>
<tr>
<td>A Russell</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>S Whittle</td>
<td>Lay Member</td>
</tr>
<tr>
<td>Dr Tupper</td>
<td>Locality Lead, Central Locality</td>
</tr>
<tr>
<td>Dr Bradley</td>
<td>Locality Lead, East Locality</td>
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<tr>
<td>Dr Pieri</td>
<td>Locality Lead, North Locality</td>
</tr>
<tr>
<td>Dr Joseph</td>
<td>Public Health Representative (Attending on behalf of Dr Suckling)</td>
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<tr>
<th>Formal Attendees</th>
<th>Present:</th>
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<tbody>
<tr>
<td>L Devanney</td>
<td>Associate Director of HR and Corporate Services</td>
</tr>
<tr>
<td>A Fitzgerald</td>
<td>Director of Strategy and Delivery</td>
</tr>
<tr>
<td>A Goodall</td>
<td>Healthwatch Representative (Attending on behalf of D Hilditch)</td>
</tr>
</tbody>
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<tr>
<th>In attendance:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>J Satterthwaite</td>
<td>PA to Chair and Chief Officer</td>
</tr>
<tr>
<td>P Hemingway</td>
<td>Head of Communications and Engagement</td>
</tr>
<tr>
<td>K Leivers</td>
<td>Head of Strategy &amp; Delivery – Planned Care (Item 9 Performance Report – Living Well)</td>
</tr>
<tr>
<td>D McKinney</td>
<td>Complex Lives (Item 9 Performance Report - Living Well)</td>
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</tbody>
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## Action

### 1. Apologies

Apologies were noted from:

- Dr Jones, Secondary Care Doctor
- Dr Singh, Locality Lead, South Locality
- Dr Suckling, Director of Public Health
- P Holmes, Doncaster Council Representative
- D Hilditch, Healthwatch Representative
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](http://www.doncasterccg.nhs.uk)

The meeting was noted as not quorate but it was agreed to continue with the meeting as there were agenda items that require progressing.

**Declarations of interest from sub committees / working groups:**

None declared.

**Declarations of interest from today’s meeting:**

None.

Dr Tupper updated the Governing Body that he is now officially the Clinical Director of 4Primary Care Network.

3. **Minutes From Previous Meeting held 6 June 2019.**

The minutes of the meeting held on 6 June 2019 were approved as a correct record subject to the following amendments:

Page 2, Item 2 Declaration of Interest, Paragraph 1, Line 4: amend ‘and’ to read ‘an’.

Page 2, Item 2 Declaration of Interest, Paragraph 2, Line 3: amend ‘contacts’ to read ‘contracts’.

4. **Matters Arising not on the Agenda**

**Quality and Performance Report**

Mr Russell reported that the issues relating to nerve conduction were as a result of staffing issues and further information is included in the performance report.

**Starting Well**

It was confirmed that the Bader school had no residential units therefore would not have any implications on GP practices.
Mr Goodall stated that he would liaise with Mrs Hilditch outside of this meeting to ascertain if the information on homelessness in young people aged 15 – 18 years had been forwarded to Mr Golze.

Mrs Whittle confirmed that she is in the process of considering representation from the Doncaster Youth Council at the Engagement & Experience Committee in the future.

5. Notification of Any other Business

There was no Notification of Any other Business received.

6. Questions from Members of the Public

The Chair welcomed a member of the public, Mr Doug Wright to the meeting. Mr Wright raised the following questions.

**Agenda Item 8 - Manual Agreement for JCCCG’s**

**Appendix 2 - JCCCG’s Terms of Reference Page 53**

During the SYB JCCCG meeting on Wednesday 26 June, the Committee decided to change their procedure for asking questions. They have reneged on a promise to the public ‘to make a statement or ask a question about items on that day’s agenda’. (see Action Summary minutes for CCG Boards Page 1 75/18 Matters Arising, where the Chair requested that the protocol statement be published on the website; see also 75/18 pages 3/4).

**Will the Doncaster CCG ask the SYB JC CCG to reverse this decision made on Wednesday 27 June 2018?**

Dr Crichton responded; Public questions received at the JCCCG were discussed in the meeting in public on 26 June 2019 as part of the review of the Terms of Reference which is on our agenda today, unfortunately Mr Wright had left the room during those conversations. As agreed at the end of the JCCCG I have subsequently clarified this by email.

It was acknowledged that the committee value the questions that they receive from the public and as a result the time on the agenda for this has been extended to 15 minutes as in Doncaster there is an ask for questions to be submitted prior to the meeting to be able to respond. There is a need to manage the time available. At the last meeting, SYN NHS Action Group submitted four pages of questions totalling 20 questions. If time permits verbal questions and or statement would still be allowed at the Chair’s discretion. Dr Crichton suggested that the Action Group gives consideration to prioritise the questions they wish to ask.
Manual Agreement and Terms of Reference of the JCCCG SYB 2019/20 Final Version 27 June 2019
Page 24 3rd Bullet Point - Electronic meetings

Does Doncaster CCG know why the SYB JCCCG has stopped having electronic meetings which commenced on 28 June 2017 and do they agree that this matter should be reconsidered?

Dr Crichton responded; The video streaming of meetings in 2017 was in relation to two specific decisions that the JCCCG had delegation for, namely Hyper Acute Stroke Units (HASU) and Children’s Anaesthetics and Surgery. The reference to electronic meetings has been considered again in reviewing the Terms of Reference and there are no plans to undertake this as a routine but the option remains for consideration.

Dr Crichton thanked Mr Wright for his attendance at the meeting and his questions.

7. Patient Story

The patient story featured Mr Robert Havenhand who suffered a fall on 22 March 2019 which was initially treated with various prescribed drugs to alleviate the pain. As they had no effect he contacted his GP practice and was given an appointment for First2physio on 3 April 2019. He was given an examination and was provided with instructions on a sheet of paper and advised to complete the exercises and if there was no improvement it was recommended that he contact his GP. Mr Havenhand had expected to be shown how to do the exercises but was not. The pain worsened and he sought other options to help with the pain at considerable financial cost to himself. As of the middle of June he is just starting to feel better however he has continued pain, burning, tingling and electric shocks in his leg affecting his positioning, functioning and mobility.

Mr Havenhand felt that there should be further awareness of the service First2Physio provides such as demonstrations of the exercises and follow up and self-management supported by a coordinated approach to signposting and advice regarding options available.

Mrs Pederson stated that we are currently trying to encourage patients to self-manage where appropriate however felt that the advice may have been to re-visit Mr Havenhand’s GP. NHS Doncaster CCG commissions the First2Physio service from Primary Care Doncaster and it does evaluate well if the patient is directed to the service appropriately however the process can be complex for some patients. It may be beneficial to review the service and the expectations of the patients and to revisit at the care navigation point and ascertain if there may be options along the process to refer patients into the Physiotherapy service at the Acute Trust.

Dr Crichton thanked Mr Havenhand for attending the meeting and sharing
his experience with the Governing Body.

8. Joint Committee Clinical Commissioning Group Terms of Reference and Manual Agreement and South Yorkshire and Bassetlaw Joint Commissioning Plan

Mrs Pederson presented the Joint Committee Clinical Commissioning Group Terms of Reference and Manual Agreement and South Yorkshire and Bassetlaw Joint Commissioning Plan. They will also be presented to the four other South Yorkshire & Bassetlaw (SY&B) CCGs Governing Bodies during July.

The pertinent points to highlight are:

- NHS Wakefield CCG is no longer an associate to the Joint Committee and this is with immediate effect.
- A further review of the Terms of Reference and the Manual Agreement will be undertaken in December.
- The workplan is more detailed and broader ranging than the table in point 6.1 of the Manual Agreement. This is because those areas in the Agreement are a subset of the broader workplan and further requests for delegation may be requested as those areas are worked up. It showcases the two areas that Doncaster is leading on; complex lives and follow up outpatient appointments.
- There is an addition of a Clinical Engagement and Assurance process.

The Governing Body was asked to:

- Agree the JCCCGs priorities and the requested areas for delegation for 2019/2020.
- Agree the revised manual Agreement and Terms of Reference and note the December 2019 review date.
- Note the ongoing development of system commissioning in SY&B and potential new areas that may be added to the list of priorities over the coming months where agreed by Governing Bodies.
- Note a quarterly JCCCG progress report will be provided for Governing Bodies.

Mrs Pederson quoted point 10.2 of the Terms of Reference as follows and asked the Governing Body if it felt it was acceptable:

‘Up to 15 minutes will be set aside at the beginning of the meeting in public to respond to written questions. Additional verbal questions and/or statements requested by members of the public are answered at the chairs discretion. Questions or statements that are not deemed appropriate to the business of the JCCCGs and agenda will not be accepted’

Dr Crichton added that if any questions are received which cannot be answered in the meeting they are either taken away by individual bodies, organisations or Trusts and a written response will be provided in due
course. If no questions are submitted prior to the meeting, the 15 minutes allotted time remains available.

It was felt by the Governing Body that 15 minutes was a sufficient amount of time to answer questions received from members of the public as business has to be concluded.

Mrs Tully highlighted that there were typing errors in the first sentence in point 8.1 of the Manual Agreement making it difficult to understand.

The Governing Body:

- Agreed the JCCCGs priorities and the requested areas for delegation for 2019/2020.
- Agreed the revised manual Agreement and Terms of Reference and note the December 2019 review date.
- Noted the ongoing development of system commissioning in SY&B and potential new areas that may be added to the list of priorities over the coming months where agreed by Governing Bodies.
- Noted a quarterly JCCCCG progress report will be provided for Governing Bodies.

9. Quality and Performance Report

Mr Fitzgerald and Mr Russell presented the Quality & Performance Report for noting by the Governing Body.

The following key areas were highlighted:

**Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT)**

- Diagnostic performance increased by 3.7% to 97.4% against the 99% target in May 2019 however there is an issue regarding nerve conduction. A tender process is underway and an external provider currently provides the service. The improvement is a result of the addition of extra sessions and more sustainability by the provider.

**Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH)**

- The Attention Deficit Hyperactivity Disorder (ADHD) incomplete pathways for children remain below target at 28.6% in April 2019 against a target of 92%. The CCG is liaising with RDaSH regarding the recovery of the trajectory and mitigating some risks with care pathways.

**Other Commissioned Services**

- Yorkshire Ambulance Service – Category 1 performance achieved the
target for March, April and May 2019

Dr Tupper queried the number of patients on the ADHD waiting list. There are currently 73 children however a quick recovery is anticipated. The Finance, Performance and Intelligence Group (FPiG) has this as a standing item on its agenda.

Dr Tupper asked how many patients were on the carpal tunnel waiting list. Mr Russell advised that an audit and ‘Deep Dive’ is being undertaken and an improvement should be seen next month.

Mr Wilkin enquired if we are to meet the 18 week target. Mrs Tingle reported that there has been significant investment to meet the 92% standard. An evaluation from DBTHFT is expected in July. There is a slight under performance in elective activity and this does not reflect the significant investment that has been put in. We are working with the Acute Trust to agree a trajectory.

Dr Crichton referred to the 52 week breach and was informed that this relates to a patient who was treated at a tertiary hospital who was initially treated privately but was subsequently referred to the NHS.

The Governing Body noted the Quality and Performance Report.

**Spotlight Report Living Well**

**Planned Care**

Mrs Leivers gave a presentation on Planned Care to the Governing Body which focussed on the following areas:

- An update on Electronic Referrals
- GP referrals, Referral to Treatment (RTT) and the Patient Tracker List
- Reducing inappropriate follow up appointments
- The financial position to Planned Care in 2019/2020
- Next steps

**Complex Lives**

The Governing Body received a presentation from Ms McKinney the Team Manager from the Doncaster Complex Lives Alliance which concentrated on an integrated care approach to supporting rough sleepers with complex needs. The Team were MJ Achievement Award winners on 26 June 2019.

Dr Crichton commented that there was a point raised last month by Healthwatch as to whether there had been an increase noted in homelessness in young people aged 15 and below? Mrs Pederson also queried how many of those homeless were Looked after Children (LAC). Ms McKinney reported that there were 25 and the team are working closely with the Doncaster Children’s Trust.
Mrs Pederson explained that she had recently attended the NHS Confederation where Mr Andy Burnham, Mayor of Greater Manchester announced a new ‘bed for the night’ system in Manchester.

Mr Russell enquired into the level of engagement with prisons in the area. Mr McKinney advised that she has met with prison leads and the team are working with prisoners when they are first sentenced and when they are released.

Dr Crichton thanked Ms McKinney for attending the Governing Body meeting.

10. Finance Report

Mrs Tingle presented the Finance Report for noting by the Governing Body. The report sets out the financial position as at the end of May 2019. At this early stage in the year NHS Doncaster CCG is forecasting to achieve all of its financial targets for 2019/2020.

The main risks identified were the achievement of the ambitious efficiency plans, increased costs associated with individual placements and prescribing.

The national guidance for the Better Care Fund has not yet been published. Once this is published, NHS Doncaster CCG and the Local Authority will work jointly to agree a plan for 2019.2020 which will then be signed off at the Health & Wellbeing Board then shared with the Governing Body.

Mr Wilkin queried if it is anticipated that an increase in pressures could emerge and we receive an additional control total. Mrs Tingle advised that we have been asked in the past if we wish to improve our financial position and more discussions will take place going forward.

The Governing Body noted the Finance Report.

11. Chair and Chief Officer Report

Mrs Pederson presented the Chair and Chief Officer Report for noting by the Governing Body however wished to highlight the following:

- NHS England, the South Yorkshire and Bassetlaw Integrated Care System (ICS) undertook a quarterly review of Doncaster place on 26 June 2019. The performance and delivery review focussed on Referral to Treatment (RTT) which poses a significant challenge.

  The outcome of the Doncaster Place Review will be reported in due course.

- The NHS Doncaster CCG Annual General Meeting is scheduled to take
place on 17 July 2019, 2.30pm – 6pm at the National High Speed Rail College. All Governing Body Members are welcome to attend.

The Governing Body noted the Chair and Chief Officer Report.

12. **Locality Feedback**

Locality Leads gave the following feedback from their Locality meetings:

**Central Locality** – Dr Tupper reported that, due to the number of apologies received, the Central Locality meeting was cancelled.

**East Locality** – Dr Bradley reported that a meeting had not taken place.

**North Locality** – Dr Pieri reported that the following items were discussed:

- A Pharmacist attended the meeting to explain their objectives.

**South Locality** – As Dr Singh had given his apologies for the meeting, Dr Crichton advised that the next meeting would be held on 5 July 2019.

The Governing Body noted the feedback from the Locality Leads.

13. **Items to Note**

**Doncaster Safeguarding Children Partnership – Local safeguarding partnership arrangements to succeed Doncaster Safeguarding Children’s Board in response to Working Together 2018.**

Mr Russell presented the report for noting by the Governing Body. It details the partnership arrangements that have been developed and has been launched locally in relation to Working Together 2018.


14. **Receipt of Minutes**

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

- Quality & Patient Safety Committee – Minutes of the meeting held on 7 March 2019.
- Primary Care Commissioning Committee – Minutes of the meeting held on 11 April 2019.
- Joint Committee Clinical Commissioning Group – Minutes of the
meeting held on 22 May 2019.

15. **Any Other Business**

   There was no further business discussed.

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

   Thursday 1 August 2019 at 1pm in the Boardroom, Sovereign House.
Meeting name | Governing Body
---|---
Meeting date | 1 August 2019
Title of paper | CCG Constitution

Executive / Clinical Lead(s) | Lisa Devanney, Associate Director of Human Resources and Corporate Services
Author(s) | Helen Harris, Head of Corporate Governance

Status of the Report
To approve | 
To consider / discuss | X
To note | 

Purpose of Paper - Executive Summary

1. Introduction
The Governing Body is asked to consider the revised NHS Doncaster Clinical Commissioning Group (CCG) Constitution and recommend to the CCG Membership for approval. The revised constitution is based upon the new model and supporting notes which was developed and published by NHS England in September 2018.

A report was presented to Strategy and Organisational Development Forum (S&OD) on 20 December 2018 detailing the background, key differences and the impact. Two workshops have been held at S&OD on 16 May and 18 July 2019 to discuss the proposed amendments. Two working groups reviewed the new model constitution, proposed amendments and standing orders.

David Crichton, Chair of the Governing Body presented the changes to the new constitution at the GP-wide event on 28 June 2019.

In preparing the draft NHS Doncaster CCG Constitution, the following documents were considered:
- Clinical Commissioning Group guidance on senior appointments, including accountable officers, NHS England, March 2017 and 2012
- Frequently asked questions: CCG Model Constitution and Supporting Notes, NHS England, February 2019
- The Handbook to the Constitution 2019, NHS England, January 2019,
- Supporting Notes to the CCG Model Constitution, September 2018
- CCG Constitution Webinar (slides), August 2018
- Procedures for Clinical Commissioning Groups to apply for constitution change, merger or dissolution, November 2016
- NHS Bristol CCG Constitution, April 2018
- NHS Portsmouth CCG Constitution, January 2019
- Rotherham Doncaster and South Humber NHS Foundation Trust, September 2016
- NHS Dorset CCG Constitution, April 2019
- NHS Derby and Derbyshire CCG Constitution, February 2019
2. CCG Constitution

The Governing Body is asked to consider the amendments to the model constitution, which are highlighted in blue text. The additions are:

1.4.2 The Accountable Officer may propose amendments to the constitution.

1.5.1b) The Scheme of Reservation and Delegation forms part of the Committee Handbook. Material changes to the constitution will be referred to the whole membership.

1.5.1e) This section provides details of what is included in the CCG Governance Handbook.

1.6.1a) Details which documents will be published alongside the constitution.

1.6.1g) Details where our duties are set out with regards to communication and engagement with the public.

1.6.1h) States how the CCG will discharge its duties fairly and non-discriminatory.

3.3 Speaking, Writing or Acting in the Name of the CCG provides Members with guidance on giving personal views.

3.4 Members’ and CCG Relationships. Sets out Members core responsibilities as a member of the CCG.

3.5 Members’ Meetings. Sets out the CCG’s responsibility for communicating with its members.

3.6.1.1 Practice Representatives Role. This section has been expanded to include: 
- ensuring patients are treated with dignity and respect,
- bringing ideas for improvement in their locality,
- supporting the CCG’s patient engagement,
- supporting service redesign and commissioning work of the CCG,
- offering constructive challenge of the Governing Body,
- holding the Governing Body to account,
- providing views and feedback from patients.

3.6.2.4 A Clinical Director for a PCN cannot be a Locality Lead or Clinical Chair.

3.6.3 Role of Clinical Leads. This is a new section and details how the leads will provide specific support to commissioning managers and support the CCG’s Executive in developing and delivering its commissioning programme, including engagement with patients.

3.6.5 Recruitment and selection of Clinical Leads and other Healthcare Professionals. A new section detailing the openness of the process for selection.

4.1.2 Good Governance. A new section providing detail of how governance will follow accepted principles.
5.1.4 The Accountable Officer may propose amendments to the constitution as set out in the Scheme of Reservation and Delegation.

5.4.2 The Governing Body role and functions include additional functions delegated from the CCG Membership to the Governing Body.

5.5.2 Lay Member for Patient and Public Involvement is Chair of the Engagement and Experience Committee and the Deputy Chair of the Governing Body.

5.5.3 Additional Members are a third lay member who is the Chair of the Primary Care Commissioning Committee and four clinical leads drawn from member practices, rather than four GPs.

5.6.2 Meeting attendees detailed by job title.

5.11.2 Provides the delegated responsibilities from the Membership to the Governing Body in relation to commissioning and health-related functions with the Local Authority.

5.12.2 Provides the delegated responsibilities from the Membership to the Governing Body in relation to joint commissioning with other CCGs.

5.13.2 Provides the delegated responsibilities from the Membership to the Governing Body in relation to joint arrangements.

3. **Terms of Reference**

   Committee terms of reference will be reviewed and presented to the respective committee meetings for consideration, following approval of the CCG Constitution by NHS England.

4. **Standing Orders**

   In conjunction with the constitution, there was a requirement to amend the Standing Orders (refer to page 68).

   The main amendments (highlighted in blue text) are:

3.1.3 Removal of a Member Practice from the CCG Membership.

4.1.1 Lay Member for Patient and Public Involvement will act as Deputy Chair of the Governing Body.

4.2.1 Appointment of Chair of the Governing Body is a new section, detailing the appointment process, terms of office, reappointment process, notice period, suspension from Governing Body and grounds for removal from office.

4.2.2 Appointment process for Locality Leads is a new section, detailing the appointment process, terms of office, reappointment process, salary, notice period, suspension from Governing Body and grounds for removal from office.

4.2.3 Lay Member appointment process is a new section, detailing the appointment process, terms of office, reappointment process, notice period, convictions, registration requirements and grounds for removal from office.
4.2.4 Registered Nurse appointment process is a new section, detailing the appointment process, terms of office, notice period, convictions and grounds for removal from office.

4.2.5 Secondary Care Doctor appointment process is a new section, detailing the appointment process, eligibility, terms of office, reappointment process, notice period, convictions, grounds for suspension and grounds for removal from office.

4.2.6 Accountable Officer appointment process is a new section, detailing the eligibility, appointment process, terms of office, reappointment process, notice period, suspension from Governing Body, convictions and grounds for removal from office.

4.2.7 Chief Finance Officer appointment process is a new section, detailing the eligibility, appointment process, terms of office, reappointment process, notice period, suspension from Governing Body, convictions and grounds for removal from office.

4.2.8 Specific role outlines is a new section and states the job descriptions for the Members of the Governing Body provide further detailed information.

4.2.9 Removal from Office of an Elected Member is a new section.

4.2.10 Removal from Office of an Appointed Individual is a new section and refers to the CCG’s human resources policies.

4.4.1 The Deputy Chair of the Governing Body will be appointed by a majority vote.

4.4.2 Specific detail related to the Lay Member with a lead role in primary care and audit cannot be the Deputy Chair.

5.6.1 Formal deputies for Chiefs of Service are required to be listed.

5. Prime Financial Policies
The prime financial policies (page 96) are part of the DCCG Constitution. Minor amendments are highlighted in blue text; references to the NHS Counter Fraud Authority and Records Management Code of Practice have been updated.

6. Scheme of Budgetary Delegation
The scheme has been reviewed by the Deputy Chief Finance Officer and forms part of the DCCG Constitution (page 113).

7. Current Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation
The current SOs, SFIs and SoRD policy will be separated. The SOs form part of the Constitution. The SFIs and SoRD will form part of the Committee Handbook. The Chief Finance Officer has agreed to this recommendation.

8. Committee Handbook
A Committee Handbook has been created, but does not form part of the DCCG Constitution. The handbook includes the Governing Body and Committee structure, roles and responsibilities of the main committees, terms of reference for the
committees that do not form part of the DCCG Constitution, Scheme of Reservation and Delegation, the Operational Delegation and the Standing Financial Instructions. The handbook will be considered by the Audit Committee in September 2019.

<table>
<thead>
<tr>
<th>Recommendation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Governing Body are asked to:</td>
</tr>
<tr>
<td>a) consider the new DCCG Constitution and Standing Orders;</td>
</tr>
<tr>
<td>b) recommend the DCCG Constitution to the CCG Membership for approval;</td>
</tr>
<tr>
<td>c) note the creation of a Governance / Committee Handbook;</td>
</tr>
<tr>
<td>d) note the SFIs and SoRD to be incorporated into the Governance / Committee Handbook.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Exempt from Public Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, detail grounds for exemption:</td>
</tr>
<tr>
<td>Yes [ ] No [X]</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Impact analysis</th>
</tr>
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<tbody>
<tr>
<td>Quality impact</td>
</tr>
<tr>
<td>Equality impact</td>
</tr>
<tr>
<td>Sustainability impact</td>
</tr>
<tr>
<td>Financial implications</td>
</tr>
<tr>
<td>Legal implications</td>
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</table>

<table>
<thead>
<tr>
<th>Management of Conflicts of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>None identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultation / Engagement (internal departments, clinical, stakeholder &amp; public/patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Wilkin, Lay Member Audit and Governance. Sarah Whittle, Lay Member Patient and Public Involvement. Hayley Tingle, Chief Finance Officer. Dr Nick Tupper, Locality Lead. Associate Director of HR and Corporate Services. Chair of the Governing Body.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report previously presented at</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details discussed at Audit Committee in September 2018, S&amp;OD in December 2018 S&amp;OD in May and July 2019.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic objectives and principal risks not identified.</td>
</tr>
</tbody>
</table>

<p>| Recommendation from the internal auditors is not achieved. |
| To ensure the Constitution meets statutory and legislative responsibilities and all other associated policies and procedures, committee terms of reference and the Group’s responsibilities are adhered to. |</p>
<table>
<thead>
<tr>
<th>Assurance Framework</th>
<th>CO1</th>
</tr>
</thead>
</table>

The new proposed changes have come from NHS England and BrowneJacobson solicitors.
NHS DONCASTER
CLINICAL COMMISSIONING GROUP
CONSTITUTION
NHS Doncaster Clinical Commissioning Group Constitution

<table>
<thead>
<tr>
<th>Version</th>
<th>Effective Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>August 2018</td>
<td>Standard model</td>
</tr>
<tr>
<td>V2</td>
<td>August 2019</td>
<td>Revised new model constitution</td>
</tr>
</tbody>
</table>

This model constitution has been prepared on behalf of NHS England by thiNKnow LTD with the support of Browne Jacobson LLP
CONTENTS

1 Introduction .................................................................................................... 5
  1.1 Name ............................................................................................................... 5
  1.2 Statutory Framework ....................................................................................... 5
  1.3 Status of this Constitution ................................................................................ 6
  1.4 Amendment and Variation of this Constitution ................................................. 6
  1.5 Related Documents ......................................................................................... 6
  1.6 Accountability and Transparency ..................................................................... 7
  1.7 Liability and Indemnity ..................................................................................... 9

2 Area Covered by the CCG ........................................................................... 10

3 Membership Matters .................................................................................... 11
  3.1 Membership of the Clinical Commissioning Group ........................................ 11
  3.2 Nature of Membership and Relationship with CCG ....................................... 13
  3.3 Speaking, Writing or Acting in the Name of the CCG .................................... 13
  3.4 Members’ Rights ............................................................................................ 13
  3.5 Members’ Meetings ....................................................................................... 15
  3.6 Practice Representatives, Locality Leads, Clinical Leads and Other Health Care Professionals ........................................................................................ 15

4 Arrangements for the Exercise of our Functions ..................................... 19
  4.1 Good Governance ......................................................................................... 19
  4.2 General .......................................................................................................... 19
  4.3 Authority to Act: the CCG .............................................................................. 20
  4.4 Authority to Act: the Governing Body ............................................................. 20

5 Procedures for Making Decisions .............................................................. 21
  5.1 Scheme of Reservation and Delegation (SoRD) ........................................... 21
  5.2 Standing Orders ............................................................................................. 21
  5.3 Standing Financial Instructions (SFIs) ........................................................... 21
  5.4 The Governing Body: Its Role and Functions ................................................ 22
  5.5 Composition of the Governing Body .............................................................. 25
  5.6 Additional Attendees at the Governing Body Meetings ............................ 25
5.7 Appointments to the Governing Body ................................................................. 26
5.8 Committees and Sub-Committees ........................................................................ 26
5.9 Committees of the Governing Body ................................................................... 26
5.10 Collaborative Commissioning Arrangements ................................................... 28
5.11 Joint Commissioning Arrangements with Local Authority Partners............... 29
5.12 Joint Commissioning Arrangements – Other CCGs ........................................ 30
5.13 Joint Commissioning Arrangements with NHS England ................................ 32

6....Provisions for Conflict of Interest Management and Standards of Business Conduct................................................................................................................... 35
6.1 Conflicts of Interest ........................................................................................ 35
6.2 Declaring and Registering Interests ............................................................... 35
6.3 Training in Relation to Conflicts of Interest .................................................... 36
6.4 Standards of Business Conduct ..................................................................... 36

Appendix 1: Definitions of Terms Used in This Constitution.............................. 38
Appendix 2: Committee Terms of Reference ....................................................... 41
Appendix 3: Standing Orders ................................................................................ 68
Appendix 4: Prime Financial and Standing Financial Instructions ....................... 101
Appendix 5 - Scheme of Budgetary Delegation and Individual Authorisation Limits .......................................................................................................... 113
1 Introduction

1.1 Name

The name of this clinical commissioning group is NHS Doncaster Clinical Commissioning Group (“the CCG”).

1.2 Statutory Framework

1.2.1 CCGs are established under the NHS Act 2006 (“the 2006 Act”), as amended by the Health and Social Care Act 2012. The CCG is a statutory body with the function of commissioning health services in England and is treated as an NHS body for the purposes of the 2006 Act. The powers and duties of the CCG to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to CCGs, as well as by regulations and directions (including, but not limited to, those issued under the 2006 Act).

1.2.2 When exercising its commissioning role, the CCG must act in a way that is consistent with its statutory functions. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to CCGs, including the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to CCGs take the form of statutory duties, which the CCG must comply with when exercising its functions. These duties include things like:

a) Acting in a way that promotes the NHS Constitution (section 14P of the 2006 Act);

b) Exercising its functions effectively, efficiently and economically (section 14Q of the 2006 Act);

c) Financial duties (under sections 223G-K of the 2006 Act);

d) Child safeguarding (under the Children Acts 2004,1989);

e) Equality, including the public-sector equality duty (under the Equality Act 2010); and

f) Information law, (for instance under data protection laws, such as the EU General Data Protection Regulation 2016/679, and the Freedom of Information Act 2000).

1.2.3 Our status as a CCG is determined by NHS England. All CCGs are required to have a constitution and to publish it.

1.2.4 The CCG is subject to an annual assessment of its performance by NHS England which has powers to provide support or to intervene where it is satisfied that a CCG is failing, or has failed, to discharge any of our functions or that there is a significant risk that it will fail to do so.
1.2.5 CCGs are clinically-led membership organisations made up of general practices. The Members of the CCG are responsible for determining the governing arrangements for the CCG, including arrangements for clinical leadership, which are set out in this Constitution.

1.3 Status of this Constitution

1.3.1 This CCG was first authorised on 1 April 2013.

1.3.2 Changes to this constitution are effective from the date of approval by NHS England.

1.3.3 The constitution is published on the CCG website at http://www.doncasterccg.nhs.uk/

1.4 Amendment and Variation of this Constitution

1.4.1 This constitution can only be varied in two circumstances.

a) where the CCG applies to NHS England and that application is granted; and
b) where in the circumstances set out in legislation NHS England varies the constitution other than on application by the CCG.

1.4.2 The Accountable Officer may periodically propose amendments to the constitution which shall be considered for approval by the Governing Body unless:

a) Changes are thought to have a material impact;
b) Changes are proposed to the reserved powers of the members;
c) At least half (50%) of all the Governing Body Members formally request that the amendments be put before the membership for approval.

1.5 Related Documents

1.5.1 This Constitution is also informed by a number of documents which provide further details on how the CCG will operate. With the exception of the Standing Orders and the Standing Financial Instructions, these documents do not form part of the Constitution for the purposes of 1.4 above. They are the CCG’s:

a) Standing Orders – which set out the arrangements for meetings and the selection and appointment processes for the CCG’s Committees, and the CCG Governing Body (including Committees).
b) **The Scheme of Reservation and Delegation** – sets out those decisions that are reserved for the membership as a whole and those decisions that have been delegated by the CCG or the Governing Body. Material changes will be referred to the whole membership and the CCG ensure the membership supports the change.

c) **Prime Financial Policies** – which set out the arrangements for managing the CCG’s financial affairs.

d) **Standing Financial Instructions** – which set out the delegated limits for financial commitments on behalf of the CCG.

e) **The CCG Governance Handbook** – includes:

- Committee terms of reference (excluding Audit Committee, Remuneration Committee and Primary Care Commissioning Committee);
- Standards of Business Conduct and Conflicts of Interest Policy;
- Scheme of Reservation and Delegation (SoRD);
- Roles and Responsibilities;
- Policies and Procedures.

### 1.6 Accountability and Transparency

#### 1.6.1

The CCG will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by being transparent. We will meet our statutory requirements to:

a) publish our constitution and other key documents including

- CCG Committee Handbook
- Joint Health and Social Care Commissioning Strategy
- Doncaster Place Plan
- South Yorkshire and Bassetlaw Integrated Care System Plan
- Joint Commissioning Management Board Terms of Reference
- Joint Committee of Clinical Commissioning Groups Terms of Reference.

b) appoint independent lay members and non-GP clinicians to our Governing Body;

c) manage actual or potential conflicts of interest in line with NHS England’s statutory guidance *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017* and expected standards of good practice (see also part 6 of this constitution);
d) hold Governing Body meetings in public (except where we believe that it would not be in the public interest);

e) publish an annual commissioning strategy that takes account of priorities in the health and wellbeing strategy;

f) procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers and publish a Procurement Strategy;

g) involve the public, in accordance with its duties under section 14Z2 of the 2006 Act, and as set out in more detail in the CCG’s Communication and Engagement Strategy.

h) when discharging its duties under section 14Z2, the CCG will ensure that it will act in an open, fair and non-discriminatory way, involving patients and stakeholders in all aspects of healthcare.

i) comply with local authority health overview and scrutiny requirements;

j) meet annually in public to present an annual report which is then published;

k) produce annual accounts which are externally audited;

l) publish a clear complaints process;

m) comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the CCG;

n) provide information to NHS England as required; and

o) be an active member of the local Health and Wellbeing Board.

1.6.2 In addition to these statutory requirements, the CCG will demonstrate its accountability by:

a) disseminating appropriate information to its members and to its local population on a regular basis;

b) holding engagement events to present and discuss service commissioning proposals with the public as appropriate; and
c) on-going engagement with stakeholders.

1.7 Liability and Indemnity

1.7.1 The CCG is a body corporate established and existing under the 2006 Act. All financial or legal liability for decisions or actions of the CCG resides with the CCG as a public statutory body and not with its Member practices.

1.7.2 No Member or former Member, nor any person who is at any time a proprietor, officer or employee of any Member or former Member, shall be liable (whether as a Member or as an individual) for the debts, liabilities, acts or omissions, howsoever caused by the CCG in discharging its statutory functions.

1.7.3 No Member or former Member, nor any person who is at any time a proprietor, officer or employee of any Member or former Member, shall be liable on any winding-up or dissolution of the CCG to contribute to the assets of the CCG, whether for the payment of its debts and liabilities or the expenses of its winding-up or otherwise.

1.7.4 The CCG may indemnify any Member practice representative or other officer or individual exercising powers or duties on behalf of the CCG in respect of any civil liability incurred in the exercise of the CCGs' business, provided that the person indemnified shall not have acted recklessly or with gross negligence.
2 Area Covered by the CCG

2.1 The geographical area covered by NHS Doncaster Clinical Commissioning Group is co-terminus with that covered by Doncaster Council, and for registered patients includes the agreed General Practice boundaries which fall outside of the Doncaster Council geographical area.

2.2 We are an NHS organisation responsible for commissioning (planning, buying, and ensuring the quality of) healthcare services in Doncaster including hospital care, primary care (provided in local GP surgeries), urgent and emergency care, and most community health services, including mental health and learning disabilities.

2.3 We commission for a population of around 320,000 people spending in excess of £500 million per annum.

2.4 We are a membership organisation, led by healthcare professionals elected to represent all the GP practices in the city.
## Membership Matters

### 3.1 Membership of the Clinical Commissioning Group

#### 3.1.1 The CCG is a membership organisation.

#### 3.1.2 All practices that provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in our area are eligible for membership of this CCG.

#### 3.1.3 The practices which make up the membership of the CCG are listed below.

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Locality</strong></td>
<td></td>
</tr>
<tr>
<td>Scawsby Health Centre</td>
<td>Scawsby Health Centre, Barnsley Road, Scawsby, Doncaster, DN5 8QE</td>
</tr>
<tr>
<td>The Ransome Practice</td>
<td>The Ransome Practice, The Health Centre, Askern Road, Bentley, Doncaster, DN5 0JX</td>
</tr>
<tr>
<td>Bentley Surgery</td>
<td>Bentley Surgery, 128 High Street, Bentley, Doncaster, DN5 0AT</td>
</tr>
<tr>
<td>Dr. Sheikh’s Surgery</td>
<td>Dr Sheikh’s Surgery, Bentley Health Centre Askern Road, Bentley, Doncaster, DN5 0JX</td>
</tr>
<tr>
<td>Petersgate Medical Centre</td>
<td>Petersgate Medical Centre, 99 Amersall Road Scawthorpe, Doncaster, DN5 9PQ</td>
</tr>
<tr>
<td>The Nelson Practice</td>
<td>The Nelson Practice, Amersall Road, Scawthorpe, Doncaster, DN5 9PQ</td>
</tr>
<tr>
<td>The Lakeside Practice</td>
<td>The Lakeside Practice, White Wings Centre Spa Pool Road, Askern, Doncaster, DN6 0HZ</td>
</tr>
<tr>
<td>The Askern Medical Practice</td>
<td>The Askern Medical Practice, White Wings Centre Spa Pool Road, Askern, Doncaster, DN6 0HZ</td>
</tr>
<tr>
<td>Conisbrough Medical Practice</td>
<td>Conisbrough Medical Practice, The Health Centre, Gardens Lane, Conisbrough, Doncaster, DN12 3JW</td>
</tr>
<tr>
<td>The Great North Medical Group</td>
<td>The Health Centre, Chestnut Avenue Carcroft, Doncaster, DN6 8AG</td>
</tr>
<tr>
<td>Denaby Medical Practice</td>
<td>Denaby Medical Practice, Denaby Springwell Centre, Church Road, Denaby Main, Doncaster, DN12 4AB</td>
</tr>
<tr>
<td><strong>South Locality</strong></td>
<td></td>
</tr>
<tr>
<td>Park View Surgery</td>
<td>Park View Surgery, Newton Medical Centre Newton Lane, Sprotbrough, Doncaster, DN5 8DA</td>
</tr>
<tr>
<td>Barnburgh Surgery</td>
<td>Barnburgh Surgery, Fox Lane, Barnburgh Doncaster, DN5 7ET</td>
</tr>
<tr>
<td>The New Surgery</td>
<td>The New Surgery, Adwick Road, Mexbrough, S64 0DB</td>
</tr>
<tr>
<td>Mexborough Health Centre</td>
<td>Mexborough Health Centre, Adwick Road, Mexbrough, S64 0BY</td>
</tr>
<tr>
<td>Edlington Practice</td>
<td>Dr Zaidi And Partners, The Martinwells Centre Thompson Avenue, Edlington, Doncaster, DN12 1JD</td>
</tr>
<tr>
<td>The Nayar Practice</td>
<td>The Nayar Practice, The Martinwells Centre Thompson Avenue, Edlington, Doncaster, DN12 1JD</td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Mayflower Medical Practice</td>
<td>The Mayflower Medical Practice, The Health Centre, Station Road, Bawtry, Doncaster, DN10 6RQ</td>
</tr>
<tr>
<td>The Rossington Practice</td>
<td>The Rossington Practice, Grange Lane, Rossington, Doncaster, DN11 0PL</td>
</tr>
<tr>
<td>Tickhill And Colliery Medical Practice</td>
<td>Tickhill And Colliery Medical Practice, 25 St Marys Road, Tickhill, Doncaster, DN11 9NA</td>
</tr>
<tr>
<td>West End Clinic</td>
<td>West End Clinic, West End Lane, Rossington Doncaster, DN11 0PQ</td>
</tr>
<tr>
<td>The Conisbrough Group Practice</td>
<td>The Conisbrough Group Practice, The Health Centre, Gardens Lane, Conisbrough, Doncaster, DN12 3JW</td>
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</table>

Central Locality

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mount Group Practice</td>
<td>The Mount Group Practice, 54 Thorne Road Doncaster, DN1 2JP</td>
</tr>
<tr>
<td>Regent Square Group Practice</td>
<td>Regent Square Group Practice, 8/9 Regent Square, Doncaster, DN1 2DS</td>
</tr>
<tr>
<td>The Burns Medical Practice</td>
<td>The Burns Medical Practice, 4 Albion Place Bennettorpe, Doncaster, DN1 2EG</td>
</tr>
<tr>
<td>Kingthorne Group Practice</td>
<td>Kingthorne Group Practice, Kingthorne House, 83a Thorne Road, Doncaster, DN1 2EU</td>
</tr>
<tr>
<td>St. Vincent Medical Centre</td>
<td>St. Vincent Medical Centre, 77 Thorne Road, Doncaster, DN1 2ET</td>
</tr>
<tr>
<td>The Flying Scotsman Health Centre</td>
<td>The Flying Scotsman Health Centre, St Sepulchre Gate West, Doncaster, DN1 3AP</td>
</tr>
<tr>
<td>The Sandringham Practice</td>
<td>The Sandringham Practice, The Sandringham Centre, Sandringham Road, Intake, Doncaster, DN2 5JH</td>
</tr>
<tr>
<td>The Oakwood Surgery</td>
<td>The Oakwood Surgery, Masham Road, Cantley, Doncaster, DN4 6BU</td>
</tr>
<tr>
<td>The Scott Practice</td>
<td>The Scott Practice, Greenfield Lane, Balby, Doncaster, DN4 0TG</td>
</tr>
<tr>
<td>St. John’s Group Practice</td>
<td>St. John’s Group Practice, Greenfield Lane Balby, Doncaster, DN4 0TH</td>
</tr>
<tr>
<td>The Medical Centre</td>
<td>The Medical Centre, 2 Frances Street, Doncaster, DN1 2JS</td>
</tr>
</tbody>
</table>

East Locality

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
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<tbody>
<tr>
<td>Field Road Surgery</td>
<td>The Surgery, Field Road, Stainforth, Doncaster, DN7 5AF</td>
</tr>
<tr>
<td>Northfield Surgery</td>
<td>Northfield Surgery, The Vermuyden Centre, Fieldside, Thorne, Doncaster, DN8 4BQ</td>
</tr>
<tr>
<td>Hatfield Health Centre</td>
<td>The Heathfield Centre, Ash Hill Road, Hatfield, Doncaster, DN7 6Jh</td>
</tr>
<tr>
<td>Dunscliffe Medical Centre</td>
<td>Dunscliffe Medical Centre, 126/128 High Street, Dunscliffe, Doncaster, DN7 4BY</td>
</tr>
<tr>
<td>Thorne Moor Practice</td>
<td>The Vermuyden Centre, Fieldside, Thorne, Doncaster, DN8 4BQ</td>
</tr>
<tr>
<td>Whitehouse Farm Medical Centre</td>
<td>Whitehouse Farm Medical Centre, Church Street, Armthorpe ,Doncaster ,DN3 3AH</td>
</tr>
<tr>
<td>The Village Group Practice</td>
<td>The Village Practice, Mere Lane, Armthorpe Doncaster, DN3 2DB</td>
</tr>
</tbody>
</table>
3.2 **Nature of Membership and Relationship with CCG**

3.2.1 The CCG’s Members are integral to the functioning of the CCG. Those exercising delegated functions on behalf of the Membership, including the Governing Body, remain accountable to the Membership.

3.3 **Speaking, Writing or Acting in the Name of the CCG**

3.3.1 Members are not restricted from giving personal views on any matter. However, Members should make it clear that personal views are not necessarily the view of the CCG.

3.3.2 Nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the CCG, any member of its Governing Body, any member of any of its Committees or Sub-Committees or the Committees or Sub-Committees of its Governing Body, or any employee of the CCG or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

3.4 **Members’ and CCG Relationships**

3.4.1 Practices’ engagement, involvement and support for the CCG with the Governing Body as the mechanism for delivery are critical, as without co-operation and delivery from member practices, the CCG will fail and GP opportunities and influence in the CCG will be severely compromised.

3.4.2 The CCG will work positively with its Members. There are a number of core responsibilities which practices are expected to deliver as a member of the CCG. These include:

- understanding, monitoring and managing their individual budget at a practice level;
- participating as a member of the CCG. Members are expected to send a clinical or senior management representative to the Locality Meetings;
- participation in the development of projects and schemes, via forum attendance, such as re-designed service provision, enhanced services and incentive schemes;
- implementation and performance monitoring of agreed projects and schemes;
- nominating, or voting or agreeing for representatives to the CCG Governing Body and CCG service development working groups;
• a commitment to working in locality based arrangements and
• assisting in the development of the CCG strategy for integrated care, limited to the following:
  – improvement of quality and performance in member practices;
  – innovating local solutions to address locality problems;
  – reducing inequalities;
  – working with local health and social care professionals;
  – sharing best practice.

Where Members are participating in the development of projects and schemes, the CCG will set up a contractual funding agreement.

3.4.3 In order to ensure that Members and the CCG practices are able to meet their responsibilities under the Constitution and to ensure that the governance arrangements of the CCG and the Membership are successful, each member practice is asked to nominate a healthcare professional representative.

3.4.4 Practices will ensure that their respective practice representative attend no less than 75% of Locality meetings.

3.4.5 The CCG and its Governing Body will work with its practice members towards achieving the CCG’s mission and aims, in line with the values of the CCG.

3.4.6 The CCG will aim to deliver support to its practice members in line with achieving its aims across the borough in three areas:

a) Education – Working with member practices in Primary Care workforce development;

b) Quality – Working with member practices in supporting the delivery of formal contractual arrangements such as Quality Outcomes Framework (QOF), National Enhanced Services (NES), Local Enhanced Services (LES) and Directed Enhanced Services (DES);

c) Performance – Working with member practices to share and support good practice.

3.4.7 Rights reserved to the membership are detailed in the Scheme of Reservation and Delegation and include:

a) Calling and attending a general meeting of the Members;

b) Submitting a proposal for amendment of the Constitution;

c) Putting themselves forward for election to the Governing Body;

d) Electing the Chair (and/ or other members) of the Governing Body;
e) Removing the Chair (or other elected members) of the Governing Body.

3.5 Members’ Meetings

3.5.1 The CCG has established a range of mechanisms in order to ensure ongoing, regular communication and involvement of our membership:

a) Individual Practice or Locality Meetings / visits by the Chiefs / Executives at least annually;

b) Regular and frequent CCG Newsletters including prescribing and key messages;

c) Practice Information Portal (PIP) and IT-based system hosting a range of Primary Care information including guidelines and pathways;

d) Face-to-face events such as commissioning and prescribing events support communication and engagement, as does Time for Audit Research and General Education and Training (TARGET) which promotes cost effective primary care through education, whilst linking to our commissioning needs;

e) Using Clinical Leads as important ambassadors for the CCG working with member practices;

f) Maintaining close links with the Practice Managers Group to capture their knowledge and expertise;

g) Primary Care Engagement Team to work with practices, using Primary Care Matrix, on understanding variation in practice and provide support in activities which may reduce demand;

h) Support pharmacists work with practices to aid safe and cost effective prescribing;

i) Annual General Meeting.

3.6 Practice Representatives, Locality Leads, Clinical Leads and Other Health Care Professionals

3.6.1 Practice Representatives
3.6.1.1 Practice Representatives represent their Practice’s views and act on behalf of the Practice in matters relating to the Group. Practice Representatives are nominated by their Practice and are required to be a General Practitioner or Healthcare Professional.

A minimum 75% annual attendance rate at Locality meetings is expected by the nominated Practice Representative.

A Deputy may attend where the nominated Practice Representative is unable to attend.

Where a General Practitioner or Healthcare Professional moves to another Practice, they are automatically de-selected as a Practice Representative for their original Practice.

The role of each Practice Representative is to:

a) Represent their Practice and the needs of their Practice population at Locality meetings and relevant Group meetings and events;

b) As far as reasonably practicable, respond in a timely manner to information requests from a Locality Lead, promptly feeding back and evidencing any preparatory work completed by the Practice at Locality meetings;

c) Facilitate delivery by the Practice, as far as reasonably practicable, the clinical and cost-effective strategies agreed by the Locality;

d) Feed back to the Practice the information, updates, actions and outcomes from the Locality meetings to enable positive contributions from the Practice to the commissioning agenda.

e) Ensure the treatment of patients with dignity and respect according to need not cost, promoting equity and valuing diversity;

f) Be innovative, and bringing forward ideas for improvement in their locality and across the CCG;

g) Support the CCG’s public and patient engagement work;

h) Support service re-design and commissioning work of the CCG. This will mean committing appropriate practice representation CCG wide and in neighbouring meetings, working within the commissioning decisions of the CCG, particularly in relation to commissioned care pathways and service and prescribing policy;
i) Offer constructive challenge and scrutiny of the Governing Body’s functions;

j) Hold the Governing Body to account in asking appropriate questions; and

k) Provide the Governing Body with views from the frontline and feedback patient perspectives.

3.6.2 Locality Leads

3.6.2.1 The Group has developed a Locality structure to facilitate Member engagement. There are four Localities comprising:

a) North Locality
b) South Locality
c) East Locality
d) Central Locality

3.6.2.2 One Locality Lead shall be elected per Locality to represent and act on behalf of the Locality in matters relating to the Locality and to sit on the Governing Body and relevant Committees thereof. Where a Locality Lead moves to another Practice outside the Locality which they represent, they shall be automatically de-selected as a Locality Lead for their original Locality. The role of each Locality Lead is to maintain a balance of work as a member of the Governing Body and within the Locality in order to:

a) Contribute to the leadership and development of the Group commensurate with the delegated functions of the Governing Body, including the development and approval of a Strategic Plan and ensuring that financial controls and systems of risk management are robust and effective;

b) Undertake a portfolio of designated clinical commissioning strategic work as delegated by the Chair of the Governing Body, supported by the officers of the CCG;

c) Adhere to and contribute to the development of high standards of probity and governance within the Governing Body and the Locality and ensure that activities remain within the terms of its authorisation as agreed and as defined in this Constitution and accompanying Scheme of Delegation;

d) Represent the views of Member Practices on the Governing Body, bringing an understanding of those Member Practices to the discussion and decision making of the Governing Body;
e) Chair regular Locality meetings to ensure effective two-way communication between Member Practices and the Governing Body and any Committees of the Governing Body.

3.6.2.3 A Locality Lead may not be their Practice’s Representative within a Locality.

3.6.2.4 A Clinical Director for a Primary Care Network cannot be a Locality Lead or Clinical Chair.

3.6.3 Clinical Leads

3.6.3.1 A number of key clinical leadership roles have been identified to provide specific support to commissioning managers. These include:

a) Joint Commissioning Health and Social Care Strategy Delivery Plans (Starting Well, Living Well, Ageing Well).

3.6.3.2 Clinical Leaders have an active role in the management and operation of the CCG. They bring their unique understanding of the CCG’s member practices to the discussion and decision making of the Governing Body.

3.6.3.3 The Clinical Leaders will support the CCG’s Executive in developing and delivering its commissioning work programme, including engagement with its member GP practices.

3.6.4 Other GP and Primary Care Health Professionals

In addition to the Practice Representatives, Locality Leads and Clinical Leads identified in sections 3.6.1, 3.6.2 and 3.6.3, the Group may identify further General Practitioners / Healthcare Professionals from Member Practices to either support the work of the Group and/or to represent the Group rather than represent their own individual Practices. These General Practitioners and Healthcare Professionals may undertake relevant clinical lead roles on behalf of the Group.

3.6.5 Recruitment and Selection of Clinical Leads and other GP and Primary Care Professionals

Selection for all these roles will be based on an open and transparent process, and will be selected on the basis of interest and expertise against the business needs of the CCG.
4 Arrangements for the Exercise of our Functions

4.1 Good Governance

4.1.2 The CCG will, at all times, observe generally accepted principles of good governance, as per Section 14L(2)(b) of the 2006 Act. These include:

a) undertaking regular governance reviews;

b) use of standards and procedures that facilitate speaking out and the raising of concerns including a freedom to speak up guardian if one is appointed;

c) promoting CCG values that include standards of propriety in relation to the stewardship of public funds, impartiality, integrity and objectivity;

d) the Good Governance Standard for Public Services;

e) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the ‘Nolan Principles’;

f) the seven key principles of the NHS Constitution;

g) relevant legislation including such as the Equality Act 2010; and

h) the standards set out in the Professional Standard Authority’s guidance ‘Standards for Members of NHS Boards and CCG Governing Bodies in England’.

4.2 General

4.2.1 The CCG will:

a) comply with all relevant laws, including regulations;

b) comply with directions issued by the Secretary of State for Health or NHS England;

c) have regard to statutory guidance including that issued by NHS England; and

d) take account, as appropriate, of other documents, advice and guidance.
4.2.2 The CCG will develop and implement the necessary systems and processes to comply with (a)-(d) above, documenting them as necessary in this constitution, its scheme of reservation and delegation and other relevant policies and procedures as appropriate.

4.3 **Authority to Act: the CCG**

4.3.1 The CCG is accountable for exercising its statutory functions. It may grant authority to act on its behalf to:

a) any of its members or employees;
b) its Governing Body;
c) a Committee or Sub-Committee of the CCG.

4.4 **Authority to Act: the Governing Body**

4.4.1 The Governing Body may grant authority to act on its behalf to:

a) any Member of the Governing Body;
b) a Committee or Sub-Committee of the Governing Body;
c) a Member of the CCG who is an individual (but not a Member of the Governing Body); and
d) any other individual who may be from outside the organisation and who can provide assistance to the CCG in delivering its functions.
5 Procedures for Making Decisions

5.1 Scheme of Reservation and Delegation (SoRD)

5.1.1 The CCG has agreed a SoRD which is published in full and can be found on our website: Policies-and-procedures

5.1.2 The CCG’s SoRD sets out:

a) those decisions that are reserved for the membership as a whole;
b) those decisions that have been delegated by the CCG, the Governing Body or other individuals.

5.1.3 The CCG remains accountable for all of its functions, including those that it has delegated. All those with delegated authority, including the Governing Body, are accountable to the Members for the exercise of their delegated functions.

5.1.4 The Accountable Officer may periodically propose amendments to the constitution which shall be considered for approval by the Governing Body unless:

a) Changes are proposed to the reserved powers; or

b) At least half (50%) of all the Governing Body member practice representatives (including the Chair) formally request that the amendments be put before the membership for approval.

5.2 Standing Orders

5.2.1 The CCG has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

a) conducting the business of the CCG;
b) the appointments to key roles including Governing Body members;
c) the procedures to be followed during meetings; and
d) the process to delegate powers.

5.2.2 A full copy of the standing orders is included in appendix 3. The standing orders form part of this constitution.

5.3 Standing Financial Instructions (SFIs)
5.3.1 The CCG has agreed a set of SFiS which include the delegated limits of financial authority set out in the SoRD.

5.3.2 A copy of the Prime Financial Instructions is included at Appendix 3 and forms part of this constitution. The detailed Standing Financial Instructions can be viewed at: Policies-and-procedures.

5.4 The Governing Body: Its Role and Functions

5.4.1 The Governing Body has statutory responsibility for:

a) ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance (its main function); and for

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme established.

5.4.2 The CCG has also delegated the following additional functions to the Governing Body which are also set out in the SoRD. Any delegated functions must be exercised within the procedural framework established by the CCG and primarily set out in the Standing Orders and SFiS:

a) approve any functions of the group that are specified in regulations;

b) approve and monitor the groups plans to meet the public sector equality duty;

c) promote the involvement of all Members in the work of the CCG in securing improvements in commissioning of care and services and developing the vision, values and culture of the group in consultation with members;

d) review and monitor the arrangements for working in partnership with the local authority to develop joint strategic needs assessments and joint health and well-being strategies and monitoring the delivery of the groups responsibilities within such strategies;

e) approve and publish the groups communications and engagement strategy and annual public and patient involvement report;
f) ensure effective arrangements are in place to secure health services in such a way as promotes awareness of, and has regard to the NHS Constitution;

g) approve and monitor the implementation of the groups strategies and plans to secure continuous improvement in the safety and quality of services including safeguarding children and vulnerable adults utilising information available to help identify areas for improvement to ensure better health, better outcomes and better value for the residents of Doncaster;

h) assist the NHS Commissioning Board in its duty to improve the quality of primary medical services by continuously increasing the capability, competence and capacity of primary care, and the proportion of health and social care provided by primary and community services;

i) ensure effective plans are in place to reduce inequalities across the borough;

j) promote the involvement of patients, their carers and representatives in decisions about their healthcare;

k) ensure effective systems to enable patients to make choices are in place across its member practices and commissioned providers;

l) ensure the group in its decision making obtains advice from a wide-range of professionals;

m) engage in a collaborative approach within the local health system including but not limited to:
   - Health and Wellbeing Board
   - Local Medical Committee
   - the Local Authority
   - Healthwatch
   - Local Health & Social Care Providers
   - The voluntary sector
   - other clinicians and allied health professionals
   - Primary Care Networks
n) ensure effective systems are in place to promote innovation and modernisation;

o) ensure effective systems are in place to promote research and the use of research;

p) ensure effective systems are in place to promote education and training;

q) approve and monitor plans to support and drive the integration of health and social care services where these improve quality or reduce inequalities;

r) ensure the group has in place effective arrangements to:
   - make sure expenditure does not exceed the aggregate of its allotments for the financial year;
   - its use of resources does not exceed the amount specified by the NHS Commissioning Board for the financial year;
   - any directions from the NHS Commissioning Board in respect of specified types of resource in a financial year, to ensure the group does not exceed an amount specified

s) approve and publish a process for and an explanation of how the group utilised any payment in respect of quality;

t) manage the corporate strategic risks of the group including regularly reviewing the groups assurance framework;

u) approve the organisational development plan including the principles by which it will procure commissioning support;

v) exercise any other functions of the Group which are not otherwise reserved or delegated;

w) lead the development of vision and strategy for the CCG;

x) approve the CCG’s Commissioning Plans and its consultation arrangements;

y) approve the admission or removal of Member Practices;

z) overseeing and monitoring performance;

aa) ensuring good governance and leading a culture of good governance throughout the CCG.
The detailed procedures for the Governing Body, including voting arrangements, are set out in the standing orders.

a. **Composition of the Governing Body**

   i. This part of the constitution describes the make-up of the Governing Body roles. Further information about the individuals who fulfil these roles can be found on our website: [www.doncasterccg.nhs.uk](http://www.doncasterccg.nhs.uk).

5.5.2 The National Health Service (Clinical Commissioning Groups) Regulations 2012 set out a minimum membership requirement of the Governing Body of:

1. The Chair
2. The Accountable Officer
3. The Chief Finance Officer
4. A Secondary Care Specialist;
5. A Registered Nurse
6. Two lay members:
   - one who has qualifications expertise or experience to enable them to lead on finance and audit matters; another who
   - has knowledge about the CCG area enabling them to express an informed view about discharge of the CCG functions; who is the Chair of the Engagement and Experience Committee and Deputy Chair of the Governing Body.

5.5.3 The CCG has agreed the following additional members:

a) A third lay member who is the chair of the Primary Care Commissioning Committee

b) Four clinical leads drawn from member practices

b. **Additional Attendees at the Governing Body Meetings**

5.6.1 The CCG Governing Body may invite other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Any such person
may be invited by the chair to speak and participate in debate, but may not vote.

**5.6.2** The CCG Governing Body will regularly invite the following individuals to attend any or all of its meetings as attendees:

1. Chief Executive or Deputy, Healthwatch, Doncaster
2. Director of Public Health, Doncaster Council
3. Director of Adult Social Care, Doncaster Council
4. Associate Director of HR and Corporate Services, Doncaster CCG
5. Head of Communications and Engagement, Doncaster CCG
6. Director of Strategy and Delivery, Doncaster CCG

c. **Appointments to the Governing Body**

i. The process of appointing GPs to the Governing Body, the selection of the Chair and the appointment procedures for other Governing Body Members are set out in the standing orders.

ii. Also set out in standing orders are the details regarding the tenure of office for each role and the procedures for resignation and removal from office.

d. **Committees and Sub-Committees**

i. The CCG may establish Committees and Sub-Committees of the CCG.

ii. The Governing Body may establish Committees and Sub-Committees.

iii. Each Committee and Sub-Committee established by either the CCG or the Governing Body operates under terms of reference and membership agreed by the CCG or Governing Body as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees.

iv. With the exception of the Remuneration Committee, any Committee or Sub-Committee established in accordance with clause 5.8 may consist of or include persons other than Members or employees of the CCG.

v. All members of the Remuneration Committee will be members of the CCG Governing Body.

e. **Committees of the Governing Body**
i. The Governing Body will maintain the following statutory or mandated Committees:

ii. **Audit Committee:** This Committee is accountable to the Governing Body and provides the Governing Body with an independent and objective view of the CCG’s compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

iii. The Audit Committee will be chaired by a Lay Member who has qualifications, expertise or experience to enable them to lead on finance and audit matters and members of the Audit Committee may include people who are not Governing Body members.

iv. **Remuneration Committee:** This Committee is accountable to the Governing Body and makes recommendations to the Governing Body about the remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the CCG.

5.9.5 The Remuneration Committee will be chaired by a lay member other than the audit chair and only members of the Governing Body may be members of the Remuneration Committee.

5.9.6 **Primary Care Commissioning Committee**

This committee is required by the terms of the delegation from NHS England in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to the Governing Body and to NHS England. Membership of the Committee is determined in accordance with the requirements of *Managing Conflicts of Interest: Revised statutory Guidance for CCGs 2017*. This includes the requirement for a lay member Chair and a lay Vice Chair.

5.9.7 None of the above Committees may operate on a joint committee basis with another CCG(s).

5.9.8 The terms of reference for each of the above committees are included in Appendix 2 to this constitution and form part of the constitution.

5.9.9 The Governing Body has also established a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SoRD and further information about these Committees, including terms of reference, are published in the CCGs Committee Handbook: *Policies-and-procedures*. 
5.10 Collaborative Commissioning Arrangements

5.10.1 The CCG wishes to work collaboratively with its partner organisations in order to assist it with meeting its statutory duties, particularly those relating to integration. The following provisions set out the framework that will apply to such arrangements.

5.10.2 In addition to the formal joint working mechanisms envisaged below, the Governing Body may enter into strategic or other transformation discussions with its partner organisations, on behalf of the CCG.

5.10.3 The Governing Body must ensure that appropriate reporting and assurance mechanisms are developed as part of any partnership or other collaborative arrangements. This will include:

a) reporting arrangements to the Governing Body, at appropriate intervals;

b) engagement events or other review sessions to consider the aims, objectives, strategy and progress of the arrangements; and

c) progress reporting against identified objectives.

5.10.4 When delegated responsibilities are being discharged collaboratively, the collaborative arrangements, whether formal joint working or informal collaboration, must:

a) identify the roles and responsibilities of those CCGs or other partner organisations that have agreed to work together and, if formal joint working is being used, the legal basis for such arrangements;

b) specify how performance will be monitored and assurance provided to the Governing Body on the discharge of responsibilities, so as to enable the Governing Body to have appropriate oversight as to how system integration and strategic intentions are being implemented;

c) set out any financial arrangements that have been agreed in relation to the collaborative arrangements, including identifying any pooled budgets and how these will be managed and reported in annual accounts;

d) specify under which of the CCG’s supporting policies the collaborative working arrangements will operate;
e) specify how the risks associated with the collaborative working arrangement will be managed and apportioned between the respective parties;

f) set out how contributions from the parties, including details around assets, employees and equipment to be used, will be agreed and managed;

g) identify how disputes will be resolved and the steps required to safely terminate the working arrangements;

h) specify how decisions are communicated to the collaborative partners.

5.11 Joint Commissioning Arrangements with Local Authority Partners

5.11.1 The CCG will work in partnership with its Local Authority partners to reduce health and social inequalities and to promote greater integration of health and social care.

5.11.2 Partnership working between the CCG and its Local Authority partners might include collaborative commissioning arrangements, including joint commissioning under section 75 of the 2006 Act, where permitted by law. In this instance, and to the extent permitted by law, the CCG Membership delegates to the Governing Body the ability to enter into arrangements with one or more relevant Local Authority in respect of:

a) Delegating specified commissioning functions to the Local Authority;

b) Exercising specified commissioning functions jointly with the Local Authority;

c) Exercising any specified health-related functions on behalf of the Local Authority.

5.11.3 For purposes of the arrangements described in 5.11.2, the Governing Body may:

a) agree formal and legal arrangements to make payments to, or receive payments from, the Local Authority, or pool funds for the purpose of joint commissioning;

b) make the services of its employees or any other resources available to the Local Authority; and
c) receive the services of the employees or the resources from the Local Authority.

d) where the Governing Body makes an agreement with one or more Local Authority as described above, the agreement will set out the arrangements for joint working, including details of:

- how the parties will work together to carry out their commissioning functions;
- the duties and responsibilities of the parties, and the legal basis for such arrangements;
- how risk will be managed and apportioned between the parties;
- financial arrangements, including payments towards a pooled fund and management of that fund;
- contributions from each party, including details of any assets, employees and equipment to be used under the joint working arrangements; and
- the liability of the CCG to carry out its functions, notwithstanding any joint arrangements entered into.

5.11.4 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.11.2 above.

5.12 Joint Commissioning Arrangements – Other CCGs

5.12.1 The CCG may work together with other CCGs in the exercise of its Commissioning Functions.

5.12.2 The CCG Membership delegates its powers and duties under 5.12 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.12.3 The CCG may make arrangements with one or more other CCGs in respect of:

a) delegating any of the CCG’s commissioning functions to another CCG;
b) exercising any of the Commissioning Functions of another CCG; or

c) exercising jointly the Commissioning Functions of the CCG and another CCG.

5.12.4 For the purposes of the arrangements described at 5.12.3, the CCG may:

a) make payments to another CCG;

b) receive payments from another CCG; or

c) make the services of its employees or any other resources available to another CCG; or

d) receive the services of the employees or the resources available to another CCG.

5.12.5 Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

5.12.6 For the purposes of the arrangements described above, the CCG may establish and maintain a pooled fund made up of contributions by all of the CCGs working together jointly pursuant to paragraph 5.12.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

5.12.7 Where the CCG makes arrangements with another CCG as described at paragraph 5.12.3 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working including details of:

a) how the parties will work together to carry out their commissioning functions;

b) the duties and responsibilities of the parties, and the legal basis for such arrangements;

c) how risk will be managed and apportioned between the parties;

d) financial arrangements, including payments towards a pooled fund and management of that fund;
e) contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

5.12.8 The responsibility of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 0 above.

5.12.9 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.12.1 above.

5.12.10 Only arrangements that are safe and in the interests of patients registered with Member practices will be approved by the Governing Body.

5.12.11 The Governing Body shall require, in all joint commissioning arrangements, that the lead Governing Body Member for the joint arrangements:

a) make a quarterly written report to the Governing Body;

b) hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and

c) publish an annual report on progress made against objectives.

5.12.12 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

5.13 Joint Commissioning Arrangements with NHS England

5.13.1 The CCG may work together with NHS England. This can take the form of joint working in relation to the CCG’s functions or in relation to NHS England’s functions.

5.13.2 The CCG Membership delegates its powers and duties under 5.13 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.13.3 In terms of either the CCG’s functions or NHS England’s functions, the CCG and NHS England may make arrangements to exercise any of their specified commissioning functions jointly.
5.13.4 The arrangements referred to in paragraph 5.13.3 above may include other CCGs, a combined authority or a local authority.

5.13.5 Where joint commissioning arrangements pursuant to 5.13.3 above are entered into, the parties may establish a Joint Committee to exercise the commissioning functions in question. For the avoidance of doubt, this provision does not apply to any functions fully delegated to the CCG by NHS England, including but not limited to those relating to primary care commissioning.

5.13.6 Arrangements made pursuant to 5.13.3 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

5.13.7 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 5.13.3 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

a) how the parties will work together to carry out their commissioning functions;

b) the duties and responsibilities of the parties, and the legal basis for such arrangements;

c) how risk will be managed and apportioned between the parties;

d) financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;

e) contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

5.13.8 Where any joint arrangements entered into relate to the CCG’s functions, the liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.13.3 above. Similarly, where the arrangements relate to NHS England’s functions, the liability of NHS England to carry out its functions will not be affected where it and the CCG enter into joint arrangements pursuant to 5.13.

5.13.9 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.
5.13.10 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.

5.13.11 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the lead Governing Body Member for the joint arrangements make;

a) make a quarterly written report to the Governing Body;

b) hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and

c) publish an annual report on progress made against objectives.

5.13.12 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement but has to give six months’ notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.
6 Provisions for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14O of the 2006 Act, the CCG has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without being unduly influenced by external or private interest.

6.1.2 The CCG has agreed policies and procedures for the identification and management of conflicts of interest.

6.1.3 Employees, Members, Committee and Sub-Committee members of the CCG and members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will comply with the CCG policy on conflicts of interest. Where an individual, including any individual directly involved with the business or decision-making of the CCG and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the Standards of Business Conduct Policy.

6.1.4 The CCG has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the CCG’s governance lead, their role is to:

   a) Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
   b) Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to conflicts of interest;
   c) Support the rigorous application of conflict of interest principles and policies;
   d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
   e) Provide advice on minimising the risks of conflicts of interest.

6.2 Declaring and Registering Interests

6.2.1 The CCG will maintain registers of the interests of those individuals listed in the CCG’s policy.
6.2.2 The CCG will, as a minimum, publish the registers of conflicts of interest and gifts and hospitality of decision making staff at least annually on the CCG website and make them available at our headquarters upon request.

6.2.3 All relevant persons for the purposes of NHS England’s statutory guidance Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017 must declare any interests. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.2.4 The CCG will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually. All persons required to, must declare any interests as soon as reasonable practicable and by law within 28 days after the interest arises.

6.2.5 Interests (including gifts and hospitality) of decision making staff will remain on the public register for a minimum of six months. In addition, the CCG will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The CCG’s published register of interests states that historic interests are retained by the CCG for the specified timeframe and details of whom to contact to submit a request for this information.

6.2.6 Activities funded in whole or in part by 3rd parties who may have an interest in CCG business such as sponsored events, posts and research will be managed in accordance with the CCG policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.3 Training in Relation to Conflicts of Interest

6.3.1 The CCG ensures that relevant staff and all Governing Body members receive training on the identification and management of conflicts of interest and that relevant staff undertake the NHS England Mandatory training.

6.4 Standards of Business Conduct

6.4.1 Employees, Members, Committee and Sub-Committee members of the CCG and members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
a) act in good faith and in the interests of the CCG;

b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the standards set out in the Professional Standards Authority guidance - *Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England*; and

d) comply with the CCG’s Standards of Business Conduct, including the requirements set out in the policy for managing conflicts of interest which is available on the CCG’s website and will be made available on request.

6.4.2 Individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the CCG’s Standards of Business Conduct policy.
### Appendix 1: Definitions of Terms Used in This Constitution

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 Act</td>
<td>National Health Service Act 2006</td>
</tr>
</tbody>
</table>
| Accountable Officer (AO)                  | an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England, with responsibility for ensuring the group:  
complies with its obligations under:  
sections 14Q and 14R of the 2006 Act,  
sections 223H to 223J of the 2006 Act,  
paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and  
any other provision of the 2006 Act specified in a document published by the Board for that purpose;  
exercises its functions in a way which provides good value for money. |
<p>| Area                                      | The geographical area that the CCG has responsibility for, as defined in part 2 of this constitution                                                                                                     |
| Chair of the CCG Governing Body           | The individual appointed by the CCG to act as chair of the Governing Body and who is usually either a GP member or a lay member of the Governing Body.                                                        |
| Chief Finance Officer (CFO)               | A qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance and who is a member of the Governing Body.                                |
| Clinical Commissioning Groups (CCG)       | A body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act.                                                                                                       |
| Committee                                 | A Committee created and appointed by the membership of the CCG or the Governing Body.                                                                                                                        |
| Sub-Committee                             | A Committee created by and reporting to a Committee.                                                                                                                                                    |</p>
<table>
<thead>
<tr>
<th><strong>Governing Body</strong></th>
<th>The body appointed under section 14L of the NHS Act 2006, with the main function of ensuring that a Clinical Commissioning Group has made appropriate arrangements for ensuring that it complies with its obligations under section 14Q under the NHS Act 2006, and such generally accepted principles of good governance as are relevant to it.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governing Body Member</strong></td>
<td>Any individual appointed to the Governing Body of the CCG</td>
</tr>
</tbody>
</table>
| **Healthcare Professional** | A Member of a profession that is regulated by one of the following bodies:  
  the General Medical Council (GMC)  
  the General Dental Council (GDC)  
  the General Optical Council;  
  the General Osteopathic Council  
  the General Chiropractic Council  
  the General Pharmaceutical Council  
  the Pharmaceutical Society of Northern Ireland  
  the Nursing and Midwifery Council  
  the Health and Care Professions Council  
  any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999 |
<p>| <strong>Lay Member</strong> | A lay Member of the CCG Governing Body, appointed by the CCG. A lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law. |
| <strong>Primary Care Commissioning Committee</strong> | A Committee required by the terms of the delegation from NHS England in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to NHS England and the Governing Body |
| <strong>Professional Standards Authority</strong> | An independent body accountable to the UK Parliament which help Parliament monitor and improve the protection of the public. Published <em>Standards for Members of NHS Boards</em> |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member/ Member Practice</td>
<td>A provider of primary medical services to a registered patient list, who is a Member of this CCG.</td>
</tr>
<tr>
<td>Member practice representative</td>
<td>Member practices appoint a healthcare professional to act as their practice representative in dealings between it and the CCG, under regulations made under section 89 or 94 of the 2006 Act or directions under section 98A of the 2006 Act.</td>
</tr>
<tr>
<td>NHS England</td>
<td>The operational name for the National Health Service Commissioning Board.</td>
</tr>
</tbody>
</table>
| Registers of interests | Registers a group is required to maintain and make publicly available under section 14O of the 2006 Act and the statutory guidance issues by NHS England, of the interests of:  
- the Members of the group;  
- the Members of its CCG Governing Body;  
- the Members of its Committees or Sub-Committees and Committees or Sub-Committees of its CCG Governing Body;  
- and Its employees. |
| STP | Sustainability and Transformation Partnerships – the framework within which the NHS and local authorities have come together to plan to improve health and social care over the next few years. STP can also refer to the formal proposals agreed between the NHS and local councils – a “Sustainability and Transformation Plan”. |
| Joint Committee | Committees from two or more organisations that work together with delegated authority from both organisations to enable joint decision-making |
Appendix 2: Committee Terms of Reference

Appendix 2a - Audit Committee
Appendix 2b - Remuneration Committee
Appendix 2c - Primary Care Commissioning Committee
1. **Introduction**

   1.1. The Audit Committee (the Committee) is established in accordance with NHS Doncaster Clinical Commissioning Group’s (CCG) Constitution, Standing Orders, Scheme of Delegation and Prime Financial Policies.

   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 is responsible for providing assurance to the Governing Body on the processes operating within the organisation for risk, control and governance. It assesses the adequacy of assurances that are available with respect to financial, corporate, clinical and information governance.

   1.4. The Committee is able to direct further scrutiny, both internally and externally where appropriate, for those functions or areas where it believes insufficient assurance is being provided to the CCG Board.

2. **Accountability**

   2.1. The Committee is directly accountable to the CCG Constitution for overseeing and providing assurance on the matters detailed under Section 4 (Role).

3. **Authority**

   3.1. The Committee is authorised by the CCGC to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

   3.2. Subject to such directions as may be given by the Governing Body, it may establish subcommittees as appropriate and determine the membership and terms of reference of such. The Standing Orders and Prime Financial Policies of the CCG, as far as they are applicable, shall apply to the Committee and its sub-committees.

   3.3. The Committee is authorised by the CCG Board to obtain outside legal or other independent professional advice and to secure the attendance of

Appendix 2a
outsiders with relevant experience and expertise if it considers this necessary.

4. **Role of the Committee**
The Governing Body has delegated the following functions to the Audit Committee.

4.1. **Integrated Governance, Risk Management and Internal Control**
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control (both clinical and non-clinical), across the whole of the CCG’s activities that support the achievement of the CCG’s objectives.

The Committee’s work will dovetail with that of the Quality & Patient Safety Committee which the CCG has established to seek assurance that robust clinical quality is in place.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement (or its equivalent)), together with any appropriate independent assurances, prior to endorsement by the Governing Body of the CCG.

- The underlying assurance processes that indicate the degree of achievement of CCG objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

- The policies and procedures for all work related to fraud, bribery and corruption to ensure compliance with NHS Counter Fraud Authority (NHSCFA) formerly NHS Protect’s Standards for Commissioners: fraud, bribery and corruption.

- The Assurance Framework and Corporate Risk Register on a periodic basis as decided by the Committee.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter Fraud Specialist, NHSCFA and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Senior Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with
indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

4.2. Internal Audit
The Committee shall ensure that there is an effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Governing Body of the CCG. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management’s response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the CCG.
- An annual review of the effectiveness of Internal Audit.

4.3. External Audit
The Committee shall review the work and findings of the External Auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Consideration of the performance of the External Auditors.
- Discussion and agreement with the External Auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee.
- Review of all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter
before submission to the Governing Body of the CCG and any work undertaken outside the Annual Audit plan, together with the appropriateness of management responses.

4.4. Other Assurance Functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the CCG. These will include, but will not be limited to, any reviews by Department of Health, arms’ length bodies or regulators/inspectors (for example, the Care Quality Commission (CQC) and NHS Litigation Authority (LA) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee’s own scope of work. In reviewing the work of the Quality and Safety Committee, the Committee will wish to satisfy itself on issues around clinical risk management and the assurance gained from clinical audit.

Where a Member who has raised an issue with the Governing Body under the Local Dispute Resolution process is not satisfied by the response, the matter will be delegated to the Committee to advise on the appropriateness of the process followed and the Committee will provide a report back to the Governing Body within one month.

The Committee shall review and approve corporate policies and procedures relevant to the functions of the Committee.

The Committee shall establish and be advised on operational corporate governance issues (including Information Governance and Health & Safety, Fire and Security) by an Information Governance Group.

4.5. Counter Fraud, Bribery and Corruption
The Committee shall provide assurance and advice to the Governing Body on the proper stewardship of resources and assets, including value for money, financial reporting, the effectiveness of audit arrangements (internal and external), compliance with NHSCFA for Commissioners: fraud, bribery and corruption, risk management, and on control and integrated governance arrangements within the CCG.

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of counter fraud, bribery and corruption work. The Committee will seek assurance regarding the organisation’s compliance with NHSCFA for Commissioners: fraud, bribery and
corruption by means including reports from the Counter Fraud Specialist, the CCG’s annual self-assessment (Self Review Tool) submissions to NHSCFA and from NHSCFA inspection reports.

4.6. **Oversight of Management Reporting**
The Committee shall request and review reports and positive assurances from Senior Managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the CCG as they may be appropriate to the overall arrangements.

4.7. **Financial Reporting**
The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG’s financial performance.

The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.

The Committee shall review schedules of debtor and creditor balances over six months old and over £5,000 and consider explanations and action plans.

The Committee shall review the annual report and financial statements before submission to the Governing Body of the CCG, focusing particularly on:

- The wording in the Annual Governance Statement (or its equivalent) and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of Representation; and
- Qualitative aspects of financial reporting.

4.8. **Conflict of Interest and Whistleblowing**
The Committee shall have oversight and challenge of the management of conflict of interest and whistleblowing procedures by:

- Reviewing the Standards of Business Conduct and Conflict of Interest Policy and Procedures.
- Reviewing the Whistleblowing procedures and the management of confidential whistleblowing in the CCG.
- Supporting the Conflict of Interest Guardian in carrying out their role.

4.9. Risk

The Committee shall:

- Ensure effective risk management systems are in place including, but not limited to, the Board Assurance Framework (BAF); complaints; claims; incidents (including Serious Untoward Incidents (SUIs)); statutory and mandatory training; staff experience; risk assessments and registers, and inspections accreditations;
- Provide a process for scrutiny of high risks identified on the Board Assurance Framework (BAF) and Risk Register;
- Develop and monitor governance policies;
- Oversee and monitor the development of Research Governance structures, systems and processes;
- Monitor health, safety and security systems and processes required in order to deliver sound health, safety and security;
- Oversee and monitor the development of information governance structures, systems and processes required in order to deliver sound information governance;
- Monitor the use of the CCG seal;
- Ensure a sound governance process is in place to monitor standards in relation to independent contractors and providers of healthcare, and
- Ensure effective safeguarding systems are in place.

5. Membership

5.1. Members
The Committee shall be appointed by the NHS CCG from amongst those members of the Governing Body who are, or are deemed to be, independent. The Chair of the Group shall not be a member of the Committee. The members of the Committee shall comprise:

- Lay Member – Audit & Governance (Chair)
- Lay Member – Patient & Public Involvement
- Locality Lead x 2
- Governing Body Secondary Care Doctor Member (Vice-Chair)

5.2. Members are required to attend four out of six of scheduled meetings. Attendance will be monitored throughout the year and any concerns raised with the Chair and relevant Member.

5.3. **Attendees**
Other individuals may be invited to attend for all or part of any meeting as appropriate. The Committee shall include the following formal attendees:

- Chief Finance Officer
- External Audit representative
- Internal Audit representative
- Local Counter Fraud representative
- Associate Director of HR and Corporate Services
- Head of Corporate Governance

5.4. At least once a year the Committee shall meet privately with the External and Internal Auditors.

5.5. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Audit Committee.

5.6. The Accountable Officer (Chief Officer) has an open invitation to attend meetings, but at least once a year the Accountable Officer will be invited to attend and discuss with the Committee the process for assurance that supports the Annual Governance Statement (or its equivalent) and when the Committee considers the draft Internal Audit Plan and the Annual Accounts.

5.7. Any other Senior Manager may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Senior Manager.

5.8. The Chair of the Governing Body will also be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee’s operations.
6. **Appointment of Chair**

The Lay Member – Audit and Governance shall be the Chair of the Audit Committee.

The Vice Chair is appointed by members of the Audit Committee.

7. **Meetings and Conduct of Business**

7.1. **Secretary**

The Board Secretary shall 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.

7.2. **Quorum**

A Quorum shall be two members. One member must be a Lay Member.

If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal Minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

7.3. **Frequency**

The Committee will aim to meet at least five times a year at times which are consistent with the audit and reporting cycle and which enable it to efficiently discharge its duties. Extraordinary meetings may be called at the discretion of the Chair. The External Auditors, Head of Internal Audit or Counter Fraud Specialist may request a meeting if they consider that one is necessary.

7.4. **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 six working days before the meeting takes place. The agenda and supporting papers shall be circulated to all Committee members and attendees at least three working days before the date the meeting will take place.

7.5. **An Annual Schedule of Meetings**

An Annual Schedule of Meetings shall be agreed at, or before, the last meeting each year in order to circulate the schedule for the following year.

8. **Decisions**
8.1. The Committee will apply best practice in its decision making processes and effectively declare and manage all conflicts of interest.

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

8.3. Decisions will aim to be reached by a process of consensus decision-making.

8.4. The Committee has full authority to commission any reports it deems necessary to help it fulfil its obligations.

8.5. The Committee may establish Sub-Groups to assist it in discharging responsibilities of the Committee as set out in its Terms of Reference.

9 Confidentiality and Conflicts of Interest / Standards of Business Conduct

9.1 All Members are expected to adhere to the CCG Constitution and Standards of Business Conduct and Conflicts of Interest Policy.

9.2 In circumstances where a potential conflict is identified the Chair of the Committee will determine the appropriate steps to take in accordance with the CCG’s Conflicts of Interest decision-making matrix. This action may include, but is not restricted to, withdrawal from the meeting for the conflicted item or remaining in the meeting but not voting on the conflicted item.

9.3 All Members shall respect confidentiality requirements as set out in the CCG Constitution.

9.4 The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice including the Nolan Principles\(^1\).

10 Reporting Arrangements

10.1 The minutes of the Committee meetings shall be formally recorded and submitted to the Governing Body. The Chair shall also provide a brief written report following each formal Committee meeting drawing to the attention of the Governing Body significant issues of concern that require disclosure and/or senior management action. The report will also contain examples of good practice or positive assurance which are evidenced by the Committee.

\(^1\) Available at http://www.public-standards.gov.uk/
10.2 The Committee will report to the Governing Body annually on its work in support of the Annual Governance Statement (or its equivalent), specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and “embeddedness” of risk management in the organisation and the integration of governance arrangements.

10.3 The Committee will annually review and assess its effectiveness and report its findings to the Governing Body. It will do this by:

- Reviewing its terms of reference;
- Reviewing the attendance rate of Committee members;
- Reviewing its work plan;
- Reviewing its performance.

10.4 Any resulting changes to the terms of reference or membership shall be submitted to the Governing Body for approval.

11 Disclosure/Freedom of Information Act (FOI)
The senior officer with responsibility for corporate governance will be responsible for ensuring that FOI requirements in relation to the Committee’s minutes and reports are met. The chair of the committee will seek the advice of the senior officer with responsibility for corporate governance in relation to any matters where an exemption as defined within the Freedom of Information Act 2000 is believed to apply.

12 Links and Interdependencies
The Committee is the primary committee for all strategic risk, control and governance matters of the organisation. It will seek suitable information and assurance from independent sources, such as internal / external audit, as well as from internal sources, such as executive officers / senior managers and other committees of the board, in particular:

- Quality and Patient Safety Committee.
- Executive Committee,
- Engagement and Experience Committee, and
- Remuneration Committee

13 Review of the Terms of Reference
The Terms of Reference will be reviewed not less than annually and submitted to the governing body for approval as necessary.

Last reviewed: November 2018
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 CCG and on determinations about allowances under any pension scheme that the CCG 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 non-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. 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.

2.5. Advising the Governing Body on the remuneration, allowances and terms of service for the Chairs and Members of the CCG.
2.6. Reporting to the Governing Body that it has met and performed its function, within recognised national guidelines and for discharging the CCG’s statutory duties as an employer.

2.7. Establishing Sub-Groups to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference.

2.8. Determining and recommending the terms and conditions, remuneration and travelling or other allowances for Governing Body members.

2.9. Reviewing and recommending the terms and conditions of employment for all employees of the CCG who are not on the Agenda for Change national terms and conditions including pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the CCG.

2.10. Determining and recommending pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG.

2.11. Approve non-contractual payments to staff to ensure value for money and probity.

3. Membership

3.1. Members: The members of the Committee shall comprise:

- Lay Member – Patient & Public Involvement (Chair)
- Lay Member – Audit & Governance
- Locality Lead x 2 (1 x Vice Chair)
- Governing Body Secondary Care Doctor Member

Other attendees requested to attend shall comprise:

- Accountable Officer
- Associate Director of Human Resources and Corporate Services
- Chair of the Governing Body

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.

3.2. The Vice Chair of the Committee shall be a Locality Lead.

3.3. Members are required to attend the scheduled ad hoc meetings. Attendance will be monitored throughout the year and any concerns raised by the Chair with the relevant Member.
3.4. Any changes to the membership of the Committee must be approved by the CCG Governing Body.

4. Appointment Of Chair
   The Lay Member – Patient and Public Involvement shall be the Chair of the Remuneration Committee.

5. Meetings and Conduct of Business

5.1. The Committee will operate in accordance with the CCG’s Standing Orders.

5.2. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

5.3. 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.

5.4. Quorum
   A quorum shall be three 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.

   If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

5.5. 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.
5.6. **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.

6. **Decisions**

6.1. The Committee will apply best practice in its decision making processes and effectively declare and manage all conflicts of interest.

6.2. 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.

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

6.4. Decisions will aim to be reached by a process of consensus decision-making.

6.5. The Committee has full authority to commission any reports it deems necessary to help it fulfil its obligations.

6.6. The Committee may establish Sub-Groups to assist it in discharging responsibilities of the Committee as set out in its Terms of Reference.

7. **Reporting Arrangements**

7.1. The minutes of the Committee meetings shall be formally recorded and submitted to the confidential session of the Governing Body.

7.2. The reporting arrangements to the CCG governing body shall be through the submission of a written Chair’s Report on the progress made and opinion of confidence provided to the next CCG governing body meeting. The report shall, where necessary, include details of any recommendations requiring ratification by the CCG governing body.

7.3. Recommendations and decisions arising from the work of the Committee will be reported to the CCG Governing Body as required.
7.4. The Committee will annually review and assess its effectiveness and report its findings to the Governing Body. It will do this by:
- Reviewing its terms of reference;
- Reviewing the attendance rate of Committee members;
- Reviewing its work plan;
- Reviewing its performance.

8. Confidentiality and Conflicts of Interest / Standards of Business Conduct

8.1. All Members are expected to adhere to the CCG Constitution and Standards of Business Conduct and Conflicts of Interest Policy.

8.2. In circumstances where a potential conflict is identified the Chair of the Committee will determine the appropriate steps to take in accordance with the CCG’s Conflicts of Interest decision-making matrix. This action may include, but is not restricted to, withdrawal from the meeting for the conflicted item or remaining in the meeting but not voting on the conflicted item.

8.3. All Members shall respect confidentiality requirements as set out in the CCG Constitution.

8.4. The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice including the Nolan Principles.

9. Disclosure / Freedom of Information Act (FOI)
The CCG senior officer with responsibility for corporate governance will be responsible for ensuring that FOI requirements in relation to the Committee are met. The chair of the committee will seek the advice of the senior officer with responsibility for corporate governance in relation to any matters where an exemption as defined within the Freedom of Information Act 2000 is believed to apply.

10. Review of the Terms of Reference
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 2019

2 Available at http://www.public-standards.gov.uk/
1. Introduction

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

1.2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHSE has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Doncaster CCG. The delegation is set out in Schedule 1.

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

1.4. It is a committee comprising representatives of the following organisations:
   - NHS Doncaster CCG
   - NHS England

2. Statutory Framework

2.1. NHSE has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

2.2. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

2.3. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
a) Management of conflicts of interest (section 14O);  
b) Duty to promote the NHS Constitution (section 14P);  
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);  
d) Duty as to improvement in quality of services (section 14R);  
e) Duty in relation to quality of primary medical services (section 14S);  
f) Duties as to reducing inequalities (section 14T);  
g) Duty to promote the involvement of each patient (section 14U);  
h) Duty as to patient choice (section 14V);  
i) Duty as to promoting integration (section 14Z1);  
j) Public involvement and consultation (section 14Z2).

2.4. The CCG will also need to specifically, in respect of the delegated functions from NHSE, exercise those set out below:  
• Duty to have regard to impact on services in certain areas (section 13O);  
• Duty as respects variation in provision of health services (section 13P).

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

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

3. Accountability of the Committee

3.1. Budgetary and resource accountability is in line with the CCG Scheme of Delegation and Standing Orders.

3.2. For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.

4. Role of the Committee

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

4.2. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Doncaster CCG, which will sit alongside the delegation and terms of reference.
4.3. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

4.4. Establishing Sub-Groups to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference.

4.5. 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.

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

4.7. 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;

4.8 The Executive Committee will review, consider and recommend to the Primary Care Commissioning Committee on all service changes to primary care medical services, ensuring the services are in line with the CCG Corporate Objectives, Five Year Commissioning for Strategy, Doncaster Place Plan and the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

5. Sub Groups
The Primary Care Commissioning Committee has established the following sub-groups:
- Primary Care Delivery Group
- Provider Engagement Group
6. **Geographical Coverage**
The Committee will cover the geographical area of NHS Doncaster CCG.

7. **Membership**

7.1. **Members**
The Committee shall consist of:

- **Voting Members:**
  - Lay Member with a responsibility for Primary Care Commissioning (Chair)
  - Lay Member (Vice Chair)
  - Chief Officer
  - Chief Finance Officer
  - Director of Strategy and Delivery
  - Chief Nurse

- **Non-Voting Members:**
  - Locality Lead clinical leader from the Governing Body
  - NHS England representative
  - CCG Deputy Chief Nurse
  - Healthwatch Doncaster representative
  - Doncaster Health and Wellbeing Board representative
  - Local Medical Committee representative
  - CCG-employed Clinical Lead for Primary Care
  - CCG Primary Care Support Manager
  - CCG Head of Contracting
  - Primary Care Quality Nurse
  - Associate Director of Primary Care

7.2. The Chair of the Committee shall be the Lay Member with the responsibility for Primary Care Commissioning.

7.3. The Vice Chair of the Committee shall be a Lay Member.

7.4. Members are required to attend five out of seven scheduled meetings. Attendance will be monitored throughout the year and any concerns raised by the Chair with the relevant Member.

7.5. Any changes to the membership of the Committee must be approved by the CCG Governing Body.

7.6. The Committee may include attendees and may call additional experts to attend meetings on an ad hoc basis to inform discussions.

8. **Appointment Of Chair**
The Chair shall be the Lay Member for Primary Care Commissioning.

The Vice-Chair shall be a Lay Member.
9. Meetings and Conduct of Business

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

9.2. Quorum

9.2.1. The quorum for meetings shall be four members including a minimum of one Lay Member inclusive of the Chair (or Vice Chair in the Chair’s absence).

9.2.2. If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal minutes, and no decisions may be taken by the non-quorate meeting of the Committee.

9.3. Frequency

9.3.1. The Committee will aim to meet formally on a monthly basis initially, and this will be reviewed during the establishment year to ensure that meetings are scheduled at appropriate intervals which are consistent with the commissioning cycle and which enable it to efficiently discharge its duties.

9.3.2. Meetings of the Committee shall:
   a) be held in public, subject to the application of 12.6;
   b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

8.3.1 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
8.3.2 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

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

8.4 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. 

10. Decisions
10.1 The Committee will make decisions within the bounds of its remit.

10.2 The decisions of the Committee shall be binding on NHS England and NHS Doncaster CCG.

10.3 The Committee will produce an executive summary report which will be presented to Yorkshire and Humber Area Team of NHS England and the governing body of NHS Doncaster CCG each quarter for information.

11. Voting
11.1 Each voting member of the Committee shall have one vote.

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

11.3 The Committee will produce an executive summary report which will be presented to Yorkshire and Humber Area Team of NHS England and the governing body of NHS Doncaster CCG each quarter for information.

12. Confidentiality and Conflicts of Interest / Standards of Business Conduct
12.1. All Members are expected to adhere to the CCG Constitution and Standards of Business Conduct and Conflicts of Interest Policy.

12.2. In circumstances where a potential conflict is identified the Chair of the Committee will determine the appropriate steps to take in accordance with the CCG’s Conflicts of Interest decision-making matrix. This action may include, but is not restricted to, withdrawal from the meeting for the conflicted item or remaining in the meeting but not voting on the conflicted item.

12.3. All Members shall respect confidentiality requirements as set out in the CCG Constitution.

13. Reporting Arrangements

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

13.2. All meetings shall be formally minuted and a record kept of all reports / documents considered.

13.3. The Committee will present its minutes to the Yorkshire and Humber Area Team of NHS England and the governing body of NHS Doncaster CCG each quarter for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

13.4. The Committee will provide an Annual Workplan to the CCG Governing Body for approval and an Annual Report.

13.5. The meetings of the Committee shall normally be held in public, save for where 8.3.2 applies.

13.6. The Committee will annually review and assess its effectiveness and report its findings to the Governing Body. It will do this by;
- Reviewing its terms of reference;
- Reviewing the attendance rate of Committee members;
- Reviewing its work plan;
- Reviewing its performance.

14. Disclosure / Freedom of Information Act (FOI)
The CCG senior officer with responsibility for corporate governance will be responsible for ensuring that FOI requirements in relation to the Committee are met. The chair of the committee will seek the advice of the senior officer with responsibility for corporate governance in relation to any matters where an exemption as defined within the Freedom of Information Act 2000 is believed to apply.
15. **Links and Interdependencies**
The Primary Care Commissioning Committee will link, in particular, to the following forums:
- Primary Care Delivery Group
- CCG Governing Body (Board)
- CCG Quality and Patient Safety Committee
- Engagement and Experience Committee
- Primary Care Matrix Evaluation Group
- Executive Committee

16. **Procurement of Agreed Services**
The detailed arrangements regarding procurement will be set out in the delegation agreement.

17. **Review of the Terms Of Reference**
The Terms of Reference will be reviewed not less than annually and submitted to the Governing Body for approval as necessary.

Last reviewed: October 2018
Schedule 2 – Delegated functions

a) decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) decisions in relation to Enhanced Services;
ii) decisions in relation to Local Incentive Schemes (including the design of such schemes);
iii) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
iv) decisions about ‘discretionary’ payments;
v) decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

b) the approval of practice mergers;

c) planning primary medical care services in the Area, including carrying out needs assessments;

d) undertaking reviews of primary medical care services in the Area;

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

f) management of the Delegated Funds in the Area;

g) Premises Costs Directions functions;

h) co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and

i) such other ancillary activities that are necessary in order to exercise the Delegated Functions.
Schedule 3 – List of Members

Voting Members:

Lay Member with a responsibility for Primary Care Commissioning (Chair)  Mrs Linda Tully
Lay Member (Vice Chair)  Mrs Sarah Whittle
Chief Officer  Mrs Jackie Pederson
Chief Finance Officer  Mrs Hayley Tingle
Director of Strategy and Delivery  Mr Anthony Fitzgerald
Chief Nurse  Mr Andrew Russell

Non-Voting Members: Attendees

Locality Lead clinical leaders from the Governing Body  Dr Khaimraj Singh

Associate Director of Primary Care  Carolyn Ogle
NHS England representative  Vacancy
Deputy Chief Nurse  Ian Boldy
Healthwatch Doncaster representative  Mrs Debbie Hilditch
Doncaster Health and Wellbeing Board representative  Dr Rupert Suckling
Local Medical Committee representative  Dr Dean Eggitt
CCG-employed Clinical Lead for Primary Care  Dr Nabeel Alsindi
CCG Primary Care Support Manager  Mr Karl Roberts
CCG Head of Contracting  Mrs Claire Hudson
Primary Care Quality Nurse  Mrs Zara Head
Appendix 3: 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:

NHS Doncaster Clinical Commissioning Group
Sovereign House
Heavens Walk
Doncaster
South Yorkshire
DN4 5HZ
Telephone: 01302 566300
Email: Donccg.enquiries@nhs.net

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 the CCG 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 (SOs) have been drawn up to regulate the proceedings of the CCG so that the Group can fulfil its obligations, as set our 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 SOs, together with the CCG’s Prime Financial Policies / Standing Financial Instructions (SFIs), 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, 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, 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: Policies-and-procedures.

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 Prime 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;
- Standing Financial Instructions
- Code of Conduct for NHS Managers 2004;
- ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical / external industry;
- CCG staff Expenses Policy
- Procurement Strategy.

2.4 Specific guidance
2.4.1 Notwithstanding the application of Standing Order 2.1.1 above, these Standing Orders 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 Admission and Eligibility for CCG Membership
3.1.1 CCGs 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 CCG comprises all the providers, (as set out in 3.2.1 of the Constitution), based in the geographic area of Doncaster Council. Providers that are based outside of that area but have branch surgeries within it, are not members of the NHS Doncaster CCG.

3.1.3 Removal of a Member Practice from the CCG Membership

Members Practices are required to comply with the CCG Constitution and any rules and regulations stipulated by the Membership and / or delegated to the Governing Body. Any Member Practice that falls outside these requirements will be subject to formal proceedings as determined by the Governing Body.
a) Grounds for removal: If a Member Practice ceases to hold a NHS Primary Care contract.

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 12 members and comprises of:

a) the Chair;
b) four representatives of Member Practices otherwise called "Locality Leads";
c) three Lay Members:
   - one to lead on audit and conflict of interest matters
   - one to lead on patient and public participation matters and will act as Deputy Chair of the Governing Body,
   - 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 of the Governing Body

4.2.1 The appointment process for the Chair is subject to the following:

a) Expressions of Interest from a clinician working within a GP practice within the Doncaster borough.
b) Appointment process: Appointments will be made through a selection process approved by the Governing Body.
c) Term of office: Successful candidates will normally serve for a three year term.
d) Eligibility for reappointment: Serving Chairs may be considered for further terms, subject to consistently good performance and the needs of the organisation. This must be confirmed at a meeting of the CCG Members.
e) Grounds for removal from office:
   i) A person who within the period of five years immediately preceding the date of the proposed appointment has been dismissed (other than because of redundancy), from paid employment or during their current appointment, has been convicted of any bankruptcy offence
   ii) No longer meets eligibility for role (refer to Membership Matters, section 3, page 11 of the CCG Constitution)
   iii) Exclusion from GMC or NHS England
   iv) Breach of Nolan Principles (as determined by majority vote by
Governing Body members)

v) Significant reputational damage to CCG (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

vi) Majority vote of no-confidence by the Membership

vi) Has become ineligible to stand as a result of the declaration of any overriding conflict of interest

vii) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

f) Notice period: Three months.

g) Suspension from Governing Body: Suspension from the GMC or NHS England will result in an immediate review of the post holder’s position on the Governing Body.

They may also be removed from office by the Accountable Officer of the CCG under circumstances described in the CCG’s HR policies in line with their terms and conditions of appointment or as set out within their secondment agreement with their main employer (as applicable).

4.2.2 The appointment process for the Members of the Governing Body (Locality Leads) is subject to the following:

a) Nominations: Invited by application.

b) Applications from a clinician working within a GP practice within the Doncaster borough.

c) Appointment process: Appointments will be made through a selection process approved by the Governing Body.

e) Term of office: Successful candidates will normally serve for a two and a half year term.

f) Salary: determined by Remuneration Committee.

g) Eligibility for reappointment: Serving Locality Leads may be considered for further terms, subject to consistently good performance and the needs of the organisation.

h) Grounds for removal from office:

i) A person who within the period of five years immediately preceding the date of the proposed appointment has been dismissed (other than because of redundancy), from paid employment or during their current appointment, has been convicted of any bankruptcy offence

ii) No longer meets eligibility for role (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

iii) Exclusion from GMC or NHS England

iv) Breach of Nolan Principles (as determined by majority vote by Governing Body members)

v) Significant reputational damage to CCG (refer to Membership
Matters, section 3, page 11 of the CCG Constitution)
vii) Majority vote of no-confidence by the Membership
viii) Has become ineligible to stand as a result of the declaration of any overriding conflict of interest
ix) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

i) Notice period: Three months.
j) Suspension from Governing Body: Suspension from the GMC or NHS England will result in an immediate review of the post holder’s position on the Governing Body.

They may also be removed from office by the Accountable Officer of the CCG under circumstances described in the CCG’s HR policies in line with their terms and conditions of appointment or as set out within their secondment agreement with their main employer (as applicable).

4.2.3 The Lay Members are subject to the following appointment process:

a) Nominations: Invited by application via open advertisement.
b) Eligibility: Not disqualified from membership of a CCG under current regulations. Meets person specification and criteria for role. Preference will be given to applicants who live or work in the Doncaster area.
c) Appointment process: Appointments will be made through a selection process approved by the Chair.
d) Term of office: Successful candidates will serve a three year term, and no more than a maximum of six to ten years.
e) Grounds for removal from office:
   i) A person who within the period of five years immediately preceding the date of the proposed appointment has been dismissed (other than because of redundancy), from paid employment or during their current appointment, has been convicted of any bankruptcy offence
   ii) No longer meets eligibility for role (refer to Membership Matters, section 3, page 11 of the CCG Constitution)
   iii) Exclusion from a relevant professional body
   iv) Breach of Nolan Principles (as determined by majority vote by Governing Body members)
   v) Significant reputational damage to CCG (refer to Membership Matters, section 3, page 11 of the CCG Constitution)
   vi) Majority vote of no-confidence by Governing Body
   vii) Has become ineligible to stand as a result of the declaration of any overriding conflict of interest
   viii) a serving civil servant within the Department of Health, or
members /employees of the Care Quality Commission;
ix) serving as a Chair or non-executive of another NHS body beyond the formal establishment of the relevant CCG
x) not eligible to work in the UK
xi) in the last five years been dismissed from employment by a health service body otherwise than because of redundancy
xii) a person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine
xiii) a person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last five years
xiv) a health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings
xv) a person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual)
xvi) a person who has at any time been removed from the management or control of a charity
f) Notice period: Three months.

They may also be removed from office by the Chair of the CCG under circumstances described in the CCG’s HR policies in line with their terms and conditions of appointment or as set out within their secondment agreement with their main employer (as applicable).

The Lay Member leading on audit and governance must have appropriate financial and audit experience sufficient to enable them to competently engage with financial management and reporting in the organisation and associated assurances.

4.2.4 The Registered Nurse is subject to the following appointment process:

a) Nominations: Invited by application via open advertisement.
b) The Registered Nurse will be the Chief Nurse.
c) Term of office: As per contract of employment.
d) Grounds for removal from office:
i) A person who within the period of five years immediately preceding the date of the proposed appointment has been dismissed (other than because of redundancy), from paid
employment or during their current appointment, has been convicted of any bankruptcy offence

ii) In accordance with human resource policies and procedures

iii) Suspended by the NMC or NHS England

iv) The individual becomes employed in an organisation from which the CCG commissions

v) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

e) Notice period: Three months.

They may also be removed from office by the Accountable Officer f the CCG under circumstances described in the CCG’s HR policies in line with their terms and conditions of appointment.

4.2.5 The Secondary Care Doctor is subject to the following appointment process:

a) Nominations: Invited by application via open advertisement.

b) Eligibility: a doctor who is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting. Whilst the individual may no longer practise medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting. The individual should have no conflicts of interest i.e. they should not be employed by any organisation from which the CCG secures any significant volume of provision. The candidate must be a medical practitioner who (or within the last ten years) fulfils (or fulfilled) all the following:

i) the individual’s name is included in the Specialist Register kept by the General Medical Council under section 34D of the Medical Act 1983(c), or the individual is eligible to be included in that Register by virtue of the scheme referred to in subsection (2)(b) of that section;

ii) the individual holds a post as an NHS consultant or in a medical specialty in the armed forces;

iii) the individual’s name is not included in the General Practitioner Register kept by the General Medical Council under section 34C of the Medical Act 1983(d).

c) Appointment process: Appointments will be made through a selection process approved by the Governing Body.

d) Term of office: Successful candidates will serve for a three year term.

e) Eligibility for reappointment: Application process.

f) Grounds for removal from office:

i) a person who within the period of five years immediately preceding the date of the proposed appointment has been
dismissed (other than because of redundancy), from paid employment or during their current appointment, has been convicted of any bankruptcy offence

ii) no longer meets eligibility for role (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

iii) exclusion from the GMC or NHS England

iv) breach of Nolan Principles (as determined by majority vote by Governing Body members)

v) significant reputational damage to CCG (as determined by a majority vote by Governing Body members) (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

vi) majority vote of no-confidence by Governing Body

vii) has become ineligible to stand as a result of the declaration of any overriding conflict of interest

viii) a person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

g) Notice period: Three months.

h) Suspension from Governing Body: Suspension from the registered professional body will result in an immediate review of the post holder’s position on the Governing Body.

They may also be removed from office by the Chair of the CCG under circumstances described in the CCG’s HR policies in line with their terms and conditions of appointment or as set out within their secondment agreement with their main employer (as applicable).

4.2.6 The Accountable Officer is subject to the following appointment process:

a) Invited by application via open advertisement.

b) Eligibility: Is eligible to be the Accountable Officer under the 2006 Act, as amended by the 2012 Act. Not disqualified from membership of a CCG under current regulations. Approved/accredited by any national assessments process stipulated for the role. Meets person specification and criteria for role approved by the Governing Body.

c) Appointment process: selection and appointment by the Governing Board and approval by NHS England. Should no appointment be made that meets the eligibility requirements then the Workforce and Remuneration Committee would consider appropriate alternative arrangements;

d) Term of office: As per contract of employment.

e) Eligibility for reappointment: Application process.

f) Grounds for removal from office:

i) No longer eligible to be the Accountable Officer under the 2006 Act, as amended by the 2012 Act. Disqualified from membership
of a CCG Governing Body under current regulations and/or in accordance with his/her contract of employment

ii) No longer meets eligibility for role (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

iii) Breach of Nolan Principles (as determined by majority vote by Governing Body members)

iv) Significant reputational damage to CCG (as determined by majority vote by Governing Body members) (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

v) Has become ineligible to stand for the position as a result of the declaration of any overriding conflict of interest

vi) Has their employment terminated by resignation, redundancy or as a result of disciplinary proceedings

vii) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

g) Notice period: Immediately if removed from office on any of the ground set out above but otherwise the notice period shall be in accordance with his or her contract of employment and/or statutory employment rights.

4.2.7 The Chief Finance Officer is subject to the following appointment process:

a) Invited by application via open advertisement.

b) Eligibility: Not disqualified from membership of a CCG under current Regulations. Holds a qualification of the CCAB body. Approved/accredited by any national assessments process stipulated for the role. Meets person specification and criteria for role approved by the Governing Body.

c) Appointment process: Appointments will be made through a selection process approved by the Governing Body.

d) Term of office: As per contract of employment.

e) Eligibility for reappointment: Eligibility criteria must continue to be met.

f) Grounds for removal from office:

i) Disqualified from membership of a CCG Governing Body under current regulations and/or in accordance with his/her contract of employment

ii) No longer holds qualification of the CCAB body; and /or in accordance with his/her contract of employment

iii) Breach of Nolan Principles (as determined by majority vote by Governing Body members)

iv) Significant reputational damage to CCG (as determined by majority vote by Governing Body members) (refer to Membership Matters, section 3, page 11 of the CCG Constitution)

v) Has become ineligible to stand for the position as a result of the
vi) Has their employment terminated by resignation, redundancy or as a result of disciplinary proceedings

vii) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months, without the option of a fine.

g) Notice period: Immediately if removed from office on any of the ground set out above but otherwise the notice period shall be in accordance with his or her contract of employment and/or statutory employment rights.

4.2.8 Detailed information on specific role outlines will be found in the job descriptions for the Clinical Chair, GP leads, lay members, registered nurse, secondary care specialist doctor, chief officer\accountable officer, chief finance officer.

4.2.9 Removal from Office of an Elected Individual

The Governing Body will ensure that a robust process is in place for the removal from office of those individuals who are elected into specific roles.

4.2.10 Removal from Office of an Appointed Individual

Individuals who are appointed into specific roles will, where necessary, be removed from office in accordance with the CCG’s human resources policies.

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 Standing Order section 4.2.

4.4 Appointment and Powers of Deputy Chair of the Governing Body

4.4.1 The Deputy Chair will be appointed by a majority vote of the Members of the Governing Body. The Deputy Chair must be a Lay Member.

4.4.2 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 and the Lay Members with a lead role in
primary care and audit cannot be the Deputy Chair to the Governing Body

4.4.3 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, Prime Financial Instructions, 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 Reservation and Delegation as detailed in the Committee Handbook.

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 and 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 six working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least three 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](http://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 12. Quorum is six members including at least four clinical members.

e) A Deputy is permitted to attend for a member and be included in the quorum if they have formal acting-up status.

f) Formal deputies who are able to vote:
   • Deputy Chief Nurse
   • Deputy Chief Finance Officer (only if the Chief Finance Officer is absent from the meeting).

g) If quorum is lost due to a member or members being disqualified from taking part is a vote or discussion due to a declared interest, the minimum quorum for decision-making is four 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 Section 4 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 5.5.2 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 and 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 and Patient Safety Committee, which includes information on the membership of the Quality and Patient 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 and Patient 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 and Experience Committee

6.12.1 The Engagement and 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 and Experience Committee, which includes information on the membership of the Engagement and 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 Executive 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) Undertaking regular scrutiny of financial risks of the organisation.

ix) Taking decisions and action on any other appropriate matter within the delegated authority of its individual members.

x) Ensuring the development and performance management of delivery plans to reduce health inequalities.

xi) Ensuring the principle of patients’ rights to choice under the NHS Constitution is maintained by commissioners and providers.

xii) Developing and approving policies and procedures relating to CCG operations within the functions of the Committee as set out in its Terms of Reference.
xiii) Establishing Sub-Groups to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference.

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 Clinical Commissioning Groups (South Yorkshire and Bassetlaw Integrated Care System)

• Joint Committee Management Board (Doncaster CCG and Doncaster Local Authority)
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.

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.

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.

8.4.2 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.

8.5 Publication of Declared Interests in Annual Report

8.5.1 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.

8.6 Conflicts of Interest Which Arise During the Course of a Meeting

8.6.1 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.

8.7 Register of Interests

8.7.1 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).
8.7.2 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.

8.7.3 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.

8.8 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

8.8.1 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.
Appendix 4: Prime Financial and Standing Financial Instructions

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the Group’s Constitution.

1.1.2. The prime financial policies are part of the Group’s control environment for managing the organisation’s financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found: Policies-and-procedures.

1.1.3. In support of these prime financial policies, the Group has prepared more detailed policies, approved by the Chief Finance Officer, known as detailed financial policies. The Group refers to these prime and detailed financial policies together as the Group’s financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Chief Finance Officer is responsible for approving all detailed financial policies.

1.1.5. A list of the Group’s detailed financial policies will be published and maintained on the Group’s website at www.doncasterccg.nhs.uk/ and is also available upon application to our Headquarters.

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the Group’s Constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies
1.2.1. If for any reason these prime financial policies 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 Governing Body’s Audit Committee for referring action or ratification. All of the Group’s Members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and Delegation

1.3.1. The roles and responsibilities of Group’s Members, employees, members of the Governing Body, members of the Governing Body’s Committees and Sub-Committees, members of the Group’s Committee and Sub-Committee (if any) and persons working on behalf of the Group are set out in the CCG Committee Handbook: Policies-and-procedures.

1.3.2. The financial decisions delegated by Members of the Group are set out in the Group’s scheme of reservation and delegation in the Committee Handbook: Policies-and-procedures.

1.4. Contractors and their Employees

1.4.1. Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body’s Audit Committee, the Chief Finance Officer will recommend amendments, as fitting, to the Governing Body for approval. As these prime financial policies are an integral part of the Group’s Constitution, any amendment will not come into force until the Group applies to the NHS Commissioning Board and that application is granted.

2. INTERNAL CONTROL

**POLICY** – the Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.
2.1. The Governing Body is required to establish an Audit Committee with terms of reference agreed by the Governing Body (see Appendix 2a, page 43, of the Group’s Constitution for further information).

2.2. The Accountable Officer has overall responsibility for the Group’s systems of internal control.

2.3. The Chief Finance Officer will ensure that:

a) financial policies are considered for review and update annually;

b) a system is in place for proper checking and reporting of all breaches of financial policies; and

c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. **AUDIT**

**POLICY** – the Group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1. In line with the terms of reference for the Governing Body’s Audit Committee, the person appointed by the Group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to Audit Committee members and the Chair of the Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the Group to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Finance Officer will ensure that:

a) the Group has a professional and technically competent internal audit function; and

b) the Chief Finance Officer approves any changes to the provision or delivery of assurance services to the Group.

4. **FRAUD AND CORRUPTION**
4.1. The Governing Body’s Audit Committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2. The Governing Body’s Audit Committee will ensure that the Group has arrangements in place to work effectively with NHS Counter Fraud Authority.

5. EXPENDITURE CONTROL

5.1. The Group is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allotments from the NHS Commissioning Board and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Finance Officer will:

a) provide reports in the form required by the NHS Commissioning Board;

b) ensure money drawn from the NHS Commissioning Board is required for approved expenditure only is drawn down only at the time of need and follows best practice;

c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of the NHS Commissioning Board.

6. ALLOTMENTS

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4 See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act
5 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
6.1. The Group’s Chief Finance Officer will:

a) periodically review the basis and assumptions used by the NHS Commissioning Board for distributing allotments and ensure that these are reasonable and realistic and secure the Group’s entitlement to funds;

b) prior to the start of each financial year submit to the Governing Body 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 Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

**POLICY** – the Group will produce and publish an annual commissioning plan\(^6\) that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets.

7.1. The Accountable Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.

7.3. The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Accountable Officer is responsible for ensuring that information relating to the Group’s accounts or to its income or expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

7.5. The Governing Body will approve consultation arrangements for the Group’s commissioning plan\(^7\).

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\(^7\) See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act.
8. **ANNUAL ACCOUNTS AND REPORTS**

**POLICY** – the Group will produce and submit to the NHS Commissioning Board accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS Commissioning Board.

8.1. The Chief Finance Officer will ensure the Group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body’s Audit Committee;

b) prepares the accounts according to the timetable approved by the Governing Body’s Audit Committee;

c) complies with statutory requirements and relevant directions for the publication of annual report;

d) considers the external auditor’s management letter and fully address all issues within agreed timescales; and

e) publishes the external auditor’s management letter on the Group’s website at [www.doncasterccg.nhs.uk](http://www.doncasterccg.nhs.uk) and also available upon application to the Group's Headquarters.

9. **INFORMATION TECHNOLOGY**

**POLICY** – the Group will ensure the accuracy and security of the Group’s computerised financial data

9.1. The Chief Finance Officer is responsible for the accuracy and security of the Group’s computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Group’s data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security.

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8. See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
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 Chief Finance Officer may consider necessary are being carried out.

9.2. In addition the Chief Finance Officer shall 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.

10. ACCOUNTING SYSTEMS

| POLICY – the Group will run an accounting system that creates management and financial accounts |

10.1. The Chief Finance Officer will ensure:

a) the Group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS Commissioning Board;

b) 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.

10.2. 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.

11. BANK ACCOUNTS

| POLICY – the Group will keep enough liquidity to meet its current commitments |

11.1. The Chief Finance Officer will:
a) review the banking arrangements of the Group at regular intervals to ensure they are in accordance with Secretary of State directions, best practice and represent best value for money;

b) manage the Group's banking arrangements and advise the Group on the provision of banking services and operation of accounts;

c) prepare detailed instructions on the operation of bank accounts.

11.2. The Governing Body’s Audit Committee shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

POLICY – the Group will

- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the Group or its functions
- ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Financial Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;

b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

c) approving and regularly reviewing the level of all fees and charges other than those determined by the NHS Commissioning Board or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

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9. See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act


POLICY – the Group:

- will ensure proper competition that is legally compliant within all purchasing to ensure the Group incurs only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for
  - the supply of goods, materials and manufactured articles;
  - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
  - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1. The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the Group’s Governing Body’s Audit Committee.

13.2. The Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the Group’s standing orders;

b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

c) take into account as appropriate any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (NHS Improvement) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders, the Group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The Group will coordinate its work with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, Local
Authority(ies), including through Health and Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the Group will put arrangements in place for evaluation and management of its risks

15.1. The Group will set out in its Risk Management Strategy (Risk-Management-Framework-Strategy-and-Policy) the arrangements that it will make to effectively evaluate and manage risk. This will include the development of an Assurance Framework by the Governing Body and regular review and updating of this document.

15.2. A Risk Management Policy will be available to all staff which outlines the roles and responsibilities of all members of the organisation.

15.3. The management of insurance claims will be set out in the Policy for Claims.

16. PAYROLL

POLICY – the Group will put arrangements in place for an effective payroll service

16.1. The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions;

b) has adequate internal controls and audit review processes;

c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.
17. **NON-PAY EXPENDITURE**

**POLICY** – the Group will seek to obtain the best value for money goods and services received

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers (Appendix 5).

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

   a) advise the Governing Body on 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 the scheme of reservation and delegation;

   b) be responsible for the prompt payment of all properly authorised accounts and claims;

   c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. **CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**

**POLICY** – the Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the Group’s fixed assets

18.1. The Accountable Officer will

   a) 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) be 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;
d) be 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.

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. **RETENTION OF RECORDS**

   **POLICY** – the Group will put arrangements in place to retain all records in accordance with *Records Management Code of Practice for Health and Social Care 2016* and other relevant notified guidance

19.1. The Accountable Officer shall:

   a) be responsible for maintaining all records required to be retained in accordance with *Records Management Code of Practice for Health and Social Care 2016* and other relevant notified guidance;

   b) ensure that arrangements are in place for effective responses to Freedom of Information requests;

   c) publish and maintain a Freedom of Information Publication Scheme.

20. **TRUST FUNDS AND TRUSTEES**

   **POLICY** – the Group will put arrangements in place to provide for the appointment of trustees if the Group holds property on trust

20.1. The Chief Finance Officer shall ensure that each trust fund which the Group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
Appendix 5 - Scheme of Budgetary Delegation and Individual Authorisation Limits

The following Scheme of Delegation applies to nominated officers working on behalf of the Doncaster Clinical Commissioning Group.

<table>
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<tr>
<th>Post/Committee</th>
<th>Current Postholder</th>
<th>Healthcare Expenditure Up to £20m</th>
<th>Healthcare Expenditure Up to £7m plus DBTH monthly contract value (Approx £15M)</th>
<th>Healthcare Expenditure Up to £100k</th>
<th>Non Healthcare Expenditure Up to £20m</th>
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This report sets out the key quality and performance issues to be noted by the NHS Doncaster Clinical Commissioning Group (DCCG) Governing Body on an exception basis. This report reflects 2019/20 performance and delivery areas and shows a summary of national measures, provider performance, the Improvement and Assessment Framework and the South Yorkshire and Bassetlaw Integrated Care System Chief Executive Officer Report. Ageing Well is the life stage in focus this month and the updates on actions and outcome measures are also included in this report.

Please note all data is validated and quality checked internally within DCCG and with Providers as necessary. Where there is a data quality concern on any of the data or metrics presented in the following report, this will be stated in the narrative accompanying the data.

The key areas of change, both positive and negative, to note since the last report are:

**NHS Doncaster Clinical Commissioning Group (DCCG)**
Doncaster CCG has been rated ‘Outstanding’ for 2018-19. Only 24 of the 195 CCGs achieved this rating. This is the third consecutive year that Doncaster CCG has been rated as ‘Outstanding’. Only 9 CCGs have been rated ‘Outstanding’ for each of the last 3 years.

- The proportion of people waiting less than 18 weeks in June 2019 decreased to 86.8% (Page 4).
- The number of patients on an incomplete referral to treatment pathway increased to 23803 at the end of June 2019, remaining within the CCG’s target (Page 7).
- Diagnostics performance improved to 98.7% against the 99% target in June 2019 (Page 9).
- Cancer measures – The following are for May 2019 (Page 12 onwards):
  - 2 week wait – 93.0%, against the 93% target
• 31 day wait – 97.7%, above the 96% target
• Overall 62 days – 80.3% below the target of 85%
• Improving Access to Psychological Therapies referral to treatment within 6 weeks – 87.0% of people accessed treatment in March against a target of 75% (Page 22).
• Improving Access to Psychological Therapies referral to treatment within 18 weeks – 100% of people accessed treatment in March against a target of 95% (Page 22).
• MRSA – No cases during 2019/20 as at May 2019 (Page 22).
• Clostridium Difficile – There have been 7 cases recorded as at May 2019 against a threshold of fewer than 14 (Page 23).

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT)
• Diagnostics performance improved to 98.7% against the 99% target in June 2019 (Page 9).
• A&E performance decreased to 90.7% in June 2019, remaining below the 95% target (Page 10).
• Cancer measures – The following are for May 2019 (Page 12 onwards):
  • 2 week wait – 93.0%, against the 93% target
  • 31 day wait – 100%, above the 96% target
  • Overall 62 days – 82.3% below the target of 85%
• Stroke (Page 26/27):
  • Percentage of patients admitted directly to stroke unit within 4 hours – 53.6% of patients were admitted directly to a unit in April 2019 against a 75% target
  • Percentage of eligible patients given thrombolysis – 75% of eligible patients were given thrombolysis against a target of 90%

Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH)
• Care Programme Approach (CPA) – Percentage of people followed up within 7 days of discharge – 100% of people were followed up in timeframe during May 2019
• Attention Deficit Hyperactivity Disorder (ADHD) - children’s service – Further capacity agreed for the service

Other Commissioned Services
• Yorkshire Ambulance Service – Category 2 performance for average and 90th centiles failed to meet target as did Category 4 90th centile (Page 18).

Recommendation(s)
The Governing Body is asked to:
Note the key quality performance areas for attention.

Report Exempt from Public Disclosure
If yes, detail grounds for exemption:  Yes  No  

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<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
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<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
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Section 1: National Frameworks and Measures

1.1: NHS Constitution Measures

1.1.1 Referral To Treatment (RTT) Performance

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Performance for DCCG patients at all Trusts remains below target and decreased further to 86.8% in June 2019 and remains outside of the normal variation of the service. The longest waiting Doncaster patient at the end of May is a 52 week wait in Gynaecology at University College London. This is currently being investigated as described below (section 1.1.3).

The chart above shows that RTT performance has deteriorated over the last 2 years with 2 clear stages of continual deterioration. Performance did however improve each month from December 18 to March 19 given the focus from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT) and the financial incentive offered. The DBTHFT waiting list has been validated down to 12 weeks during April and May, which may have had a negative impact on reported performance. Thirteen specialties are failing to meet the 92% standard for DCCG:

- Cardiology (88.4%)
- Cardiotoracic Surgery (90.0%)
- Ear, Nose and Throat (ENT) (82.0%)
- General Medicine (77.43%)
- General Surgery (83.5%)
- Geriatric Medicine (81.5%)
- Neurology (78.7%)
DBTHFT position for June is 86.6% which is below the Provider Sustainability Fund trajectory of 89.3%. The trajectory in place for 2019 is to achieve the 92% target by October 2019. 12 specialities failed to meet the standard at DBTHFT in June:

- Neurosurgery (88.9%)
- Ophthalmology (91.9%)
- Other (90.9%)
- Rheumatology (78.7%)
- Trauma and Orthopaedics (T&O) (85.7%)
- Urology (81.1%)

Weekly Patient Tracking List (PTL) meetings continue at the Trust and weekly information from DBTHFT is sent to DCCG to monitor and analyse waits over 38 weeks, in particular those without a ‘To Come In’ date, for them to be dated by the Trust. Patients at risk of breaching 52 weeks are followed up and the expectation is that there should be no further breaches over 52 weeks.

The Trusts Information, finance and operations teams have been working closely to complete capacity and demand modelling to demonstrate the trajectories required to reach 92%. A set of delivery plans by specialty have been developed to increase capacity and improve performance and a set of confirm and challenge events will be held with specialties to help strengthen these plans.
Included within these are an update and relaunch of the Access Policy, the recruitment of 2 consultants to General Surgery (due by October 2019), 2 additional consultants in Cardiology (Due by November 2019) and additional clinics in other specialties.

1.1.2 Waiting List Size

![Doncaster registered patients on incomplete RTT pathways](image)

Following the achievement of the waiting list size in March 19, the expectation remains to hold the waiting list size to the same level or less by March 2020. The number of DCCG patients on incomplete RTT pathways has increased in June 2019 to 23,803 patients. The Trust is aiming to maintain validation of patients at 12 weeks on the PTL going forwards.

1.1.3 52 Week Breaches

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There was 1 DCCG patient waiting over 52 weeks at the end of June in Gynaecology. This is the same patient who was awaiting surgery at University College London NHS Foundation Trust at the end of May. The patient has a ‘To Come In’ date in July so is not expected to breach at the end of July. The choice of provider was taken by the patient and in other locations they would have been seen in less time.

For DBTHFT, breach reports, including harm assessments, are provided for every 52 week breach for DCCG patients for analysis, along with an action plan. One of the main actions is that the joint Access Policy is implemented; ensuring compliance with the policy is part of the training programme for the administrative and clinical teams on how to appropriately manage patient pathways in regards to RTT.

### 1.1.4 Diagnostics

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Performance for DCCG during June 2019 improved to 98.7%, but remains below the 99% target. Performance is now within control limits on the chart above which indicates performance is within normal variation expected within the service.
There were 72 breaches, with 66 of those at DBTHFT. The longest waiting patients at the end of June were waiting over 13 weeks at DBTHFT; 5 for Audiology assessments and 1 within echocardiography.

DBTHFT performance also improved to 98.7% with 111 breaches (the majority of which were within Nerve Conduction – 44).

The trust will be going through a tender process in the near future to try and secure additional nerve conduction pathway capacity on a permanent basis which will return performance to at least 99% sustainably.

### 1.1.5 A&E attendance to admission, transfer or discharge

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Performance deteriorated in June to 90.7% (1423 breaches) below the 95% national constitution target, and also the 94.8% Sustainability Fund trajectory. June’s performance also falls below of Statistical Process control limits suggesting that this performance is within outside of normal parameters for the service. Historically this service does show quite unstable performance therefore further observations will take place over the coming months whilst understanding the particular issues occurring.

Recent patterns of high attendance and acuity have continued during June. 16.9% of Emergency Department attendances were streamed to alternative, more appropriate services during the month aided by a trial Navigation Nurse based at the front door. The Trust is using this trial and a wider review of pathways to increase the amount of early decisions which can made for patients ensuring that they are not waiting unnecessarily and achieve optimal outcomes.

Bed pressures remain within DBTHFT with around 20 escalation beds (above normal number of beds within the hospital) open throughout the month to help ensure flow from A&E for people who need admission to hospital. Weekly Surge and Operation Group continue to focus on longer term actions such as ensuring that extended opening hours in GP Practices are utilised to their best ability.
### 1.1.6 Cancer Measures

Cancer standards nationally are reviewed on a quarterly basis.

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Performance improved during May 2019 to 93.0% against the target of 93.0%. This is within the control limits of normal variation and above the average performance for the specified timeframe.

There were 67 breaches during the month: Twenty nine of these breaches were due to Administrative delays, 25 were due to patient choice, 8 due to clinic cancellations and 5 due to Out-Patient capacity. The longest waiter for a two week wait appointment was 55 days due to an administrative delay.

Urology and Head and Neck tumour groups are the only groups out of the 15 specified that are not meeting the required 93% performance for two week waits with performance of 73% and 75% respectively. Recovery plans are going to be produced in quarter two for both tumour groups following a breach reason audit of sub-tumour groups which was presented at Cancer Programme Board. For Urology, the service has had 2 consults with unexpected time off. A locum has been assigned for cover for both on-call and clinic sessions resulting in a lack of flexibility within the service. In relation to the Head and Neck service, the administrative delays are a result of the booking clerks not being able to contact the patients. Training is going to be provided from the original team with a start date yet to be determined. A process is in place where a referral will be sent straight over to Sheffield Teaching Hospital if there are no direct booking slots available for two week wait referrals.
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Performance for DCCG in May 2019 decreased to 97.7% however remained above the 96% target and is within normal variation for Doncaster. There were 3 breaches; 2 related to elective capacity within Urology and 1 within Head and Neck (other reason, not listed). The longest delay was a total of 49 days in Urology.

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Performance for both Surgery and Radiotherapy achieved the 94% target during May at 94.4% and 96.0% respectively. Performance for drug regimen fell slightly below the 98% target at 97.9%.

There were 2 breaches within Radiotherapy due to ‘other reasons’, 1 breach in Surgery due to elective capacity and 1 breach for drug treatments (71 days) for a Health Care Provider initiated delay for diagnostic tests/treatment planning.

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Performance for DCCG deteriorated in May to 80.3%, below the 85% target, but remains within normal variation for the service. There were a total of 12 breaches; 5 due to ‘other reasons’, 2 due to outpatient capacity, 2 due to diagnosis or treatment being delayed due to medical fitness, 1 health care provided initiated delay for tests or planning, 1 patient choice and 1 appointment the patient did not attend.

4 of the 5 ‘other reasons’ were associated with Urology breaches. This reason is due to the consultant at Sheffield Teaching Hospital being away on ‘robotics’ training which is forecasted to be completed in September 2019. This is impacting the urology pathway at current by 7-10 days waiting to see an available consultant at Doncaster Royal Infirmary rather than following the usual pathway through to Sheffield. The Trust is liaising with Sheffield Teaching Hospital to put in appropriate steps whilst the Surgeon is unavailable to limit further breaches.
62-day wait from referral from an NHS screening service or Consultant Upgrade to first definitive treatment for all cancers

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There was 1 breach of 66 days for consultant upgrades during May due to a complex diagnostic pathway.

1.1.7 Cancelled Operations – those not rearranged within 28 days

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There was 1 breach of the 28 day standard during June 2019 in Ophthalmology.
1.2 NHS National Contract Key Performance Indicators

1.2.1 Yorkshire Ambulance Service (YAS)

<table>
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<th>Category 1 (Life threatening injuries and illness) target of average time less than 7min</th>
<th>Oct 18</th>
<th>Nov 18</th>
<th>Dec 18</th>
<th>Jan 19</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>June 19</th>
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<tr>
<td>Category 1 target 90% of times less than 15min</td>
<td>00:07:10</td>
<td>00:07:01</td>
<td>00:07:04</td>
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<td>00:07:02</td>
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<td>00:12:13</td>
<td>00:12:16</td>
<td>00:12:09</td>
<td>00:12:04</td>
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<td>00:19:49</td>
<td>00:20:03</td>
<td>00:17:42</td>
<td>00:19:41</td>
<td>00:18:39</td>
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<tr>
<td>Category 3 (Urgent) target 90% of times below 2 hours</td>
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<td>02:15:18</td>
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<td>01:53:12</td>
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<td>01:49:54</td>
<td>01:42:57</td>
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<tr>
<td>Category 4 (Less urgent) target 90% of times below 3 hours</td>
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<td>03:41:42</td>
<td>03:38:30</td>
<td>03:52:26</td>
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<td>03:51:12</td>
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Performance targets were met for Category 1, Category 2 90th centile and Category 3 with the other areas failing to meet target. All areas deteriorated during the month with the exception of Category 1 which remained at 6 minutes and 48 seconds.

Representatives from YAS continue to attend meetings around joint pathways within Doncaster to ensure that any issues can be addressed and continue to work closely with DBTHFT.
### 1.2.2 Ambulance Handovers (DBTHFT reported information)

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A Provider Sustainability Fund trajectory has been set for 2019/20 for handovers between 30 and 60 minutes to reduce these to 0 by March 2020 in line with national guidance. The number in May was 75 and above the trajectory of 45 for the month.

A new handover process has been introduced within Doncaster Royal Infirmary during June 2019 with feedback from the service and DBTHFT staff indicating it has been successful in improving times and has received positive feedback from patients.
1.2.3 Following handover, ambulance crew should be ready to accept new calls within 15 minutes

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1.2.4 Mixed Sex Accommodation

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1.2.5 Care Programme Approach (CPA) – Percentage of people followed up within 7 days of discharge

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1.2.6 Improving Access to Psychological Therapies (IAPT) Waiting Times

### IAPT referral to treatment within 6 weeks

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<td>85.0%</td>
<td>80.0%</td>
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<td>84.0%</td>
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<tr>
<td>Target</td>
<td>75%</td>
<td>75%</td>
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### IAPT referral to treatment within 18 weeks

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</thead>
<tbody>
<tr>
<td>DCCG</td>
<td>100%</td>
<td>100%</td>
<td>99.0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Target</td>
<td>95%</td>
<td>95%</td>
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1.2.7 Zero tolerance of methicillin- resistant Staphylococcus aureus (MRSA)

### Cases of MRSA

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>DCCG</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Target</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
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</table>
1.2.8 Incidents of Clostridium Difficile (C-Diff)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>DCCG (cumulative total)</td>
<td>13</td>
<td>26</td>
<td>36</td>
<td>44</td>
<td>47</td>
<td>54</td>
<td>59</td>
<td>65</td>
<td>71</td>
<td>76</td>
<td>80</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Cumulative Threshold (84 for 2019/20)</td>
<td>14</td>
<td>21</td>
<td>28</td>
<td>35</td>
<td>42</td>
<td>49</td>
<td>56</td>
<td>63</td>
<td>70</td>
<td>75</td>
<td>80</td>
<td>7</td>
<td>14</td>
</tr>
</tbody>
</table>

1.2.9 Venous thromboembolism (VTE) risk assessment data

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adult inpatients undergoing risk assessment (DBTHFT)</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
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<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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</tr>
</tbody>
</table>

DBTHFT undertake a manual audit of records to enable reporting and therefore cease auditing once sufficient records are reached to achieve target. May figures were still being validated at the time of writing.

1.2.10 Doncaster and Bassetlaw Length of Stay (LOS) Trajectory

As a requirement of the 2019/20 Longer LOS Patient Reduction Delivery Plan guidance, the below trajectory for DBTHFT has been agreed and signed off by the A&E Delivery Board.
The weekly position is as at Monday morning and in line with the Trust’s daily A&E sitrep submission for that day. Whilst there are no formal targets for reducing numbers of patients with a 7+ and 14+ LOS, national planning guidance states that systems should put local targets in place. These have yet to be agreed however trusts will not be held to account against these metrics nationally. As at 8th July the LOS position was 68 occupied bed days against a trajectory of 92.

**Weekly average of occupied beds by adult patients in an acute hospital for 21+ days**

- **44 (38%)** Bed reduction required by March 2020
- **49 (43%)** Occupied beds reduced as of 24 June 2019 (weekly average)
- **0 (0%)** Bed reduction remaining as of 24 June 2019 (weekly average)
Section 2: Provider Exception Report

The following section of the report details performance by exception (those measures either rated Red or have deteriorated outside of normal range) for each main local provider, namely DBTHFT and RDASH and other commissioned services. Performance is across a range of agreed 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 provided to DCCG. The following includes a summary of provider measures and exceptions, which are those causing concern either cumulatively for the year, quarter or in month.
### 2.1 Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTHFT)

This section only includes measures in the DBTHFT contract currently not meeting target which are not included in the constitution measures in Section 1.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Month</th>
<th>Latest performance</th>
<th>Target</th>
<th>Trend</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke: Proportion of patients directly admitted to a stroke unit under 4 hours</td>
<td>April</td>
<td>53.6%</td>
<td>75%</td>
<td><img src="image" alt="Graph" /></td>
<td>Trust level performance for direct admission to the Stroke Unit within 4 hours has improved from the March position to 53.6% against the 75% target (26 breaches). From the 1st July 2019 the trust became a Hyper Acute Stroke Unit (HASU) and has started to accept patients from Rotherham. This service will be rolled in October to Barnsley patients.</td>
</tr>
</tbody>
</table>
Stroke Benchmarking data was presented to the Finance, Performance and Information Group (FPIG) on 25th June 2019, where it was agreed to continue monitoring the performance of an updated list of key performance indicators, alongside the measures supporting the HASU work.

The trust are working on increasing the beds on the Stroke Ward and the appointment of 2 Stroke Nurse Practitioners, and the continual review of the pathway from the emergency department and trialling the ring fencing of beds.

Only small proportions of patients are eligible for thrombolysis, and in April 3 out of 4 patients who were eligible received thrombolysis, resulting in 75% performance. The only breach related to a Bassetlaw patient who was not transferred in time.
2.2 Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH)

This section only includes measures in the RDASH contract currently not meeting target which are not included in the constitution measures in Section 1.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Month</th>
<th>Latest performance</th>
<th>Target</th>
<th>Trend</th>
<th>Update</th>
</tr>
</thead>
</table>
| Memory Service: (from April movement from treatment to initial assessment) | May   | 69.8%              | 95%    |       | Performance improved during May 2019 to 69.8% against the 95% target (26 breaches)  
Regular meetings are taking place between RDASH and DBTHFT to review the current pathway and it has been agreed that the service will have an upgrade of the current Integrated Clinical Environment system. This will enable RDASH staff to directly refer people for Computed Tomography scans and electrocardiograms. This should reduce the waits by around 4 days.  
In addition a deep dive is being undertaken across the whole dementia pathway to understand any issues within systems and where improvements can be made. This in part will focus on assessment and diagnosis and will run from July to October 2019. |
The percentage of eligible people receiving RDASH services receiving a 12 month Section 117 (S117) Review

<table>
<thead>
<tr>
<th>Month</th>
<th>%</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>87.9%</td>
<td>95%</td>
</tr>
</tbody>
</table>

There was a slight fall in performance during May 2019 to 87.9% as the result of 73 patients waiting over timescale.

DCCG has requested a full understanding of performance which was noted over a period of time for individual pathways during 2018/19 and 2019/20. Detailed actions and a recovery time frame have been included within this request.

<table>
<thead>
<tr>
<th>Month</th>
<th>%</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>82.4%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Performance deteriorated to 82.4% during May 2019 as a result of 3 breaches due to service capacity. The longest breach was 3 weeks beyond target.

There have been an increased number of children placed within Doncaster from other authorities, along with an increase of Doncaster residents which has resulted in capacity issues.

These reviews are routine and triaged so should a child require urgent care this would be provided via General Practice/Out of Hours services. This issue has been raised through the joint Clinical Quality review Group with DCCG and impact of this will be monitored.

A full time Band 6 nurse is now in post replacing a part time Band 5 nurse, although there remains some long term sickness within the service. There is a capacity and demand exercise underway; any issues will be raised by contracting as part of any contract re-negotiation. The capacity issues are highlighted via the Trust's performance escalation process and DCCG are aware of the issues.
<table>
<thead>
<tr>
<th>Service</th>
<th>May</th>
<th>Target</th>
<th>Performance</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked After Children (LAC) – The percentage of children aged 5-18 who have had a completed annual health reviews completed within timeframe</td>
<td>52.4%</td>
<td>95%</td>
<td>Performance has deteriorated to 52.4% during May as a result of 10 breaches. These breaches were 2-3 weeks beyond targeted timescale. Please see above for narrative.</td>
<td></td>
</tr>
<tr>
<td>Referral to diagnosis for Attention Deficit Hyperactivity Disorder (ADHD) – Incomplete Pathways for Children</td>
<td>To be confirmed</td>
<td>92%</td>
<td>Data currently not available.</td>
<td>RDASH have completed a refresh of the recording and reporting processes around this measure, now linking it to the Neurodevelopment pathway. This reporting will re-start from June 2019 data onwards though it has been confirmed that this service is still not meeting the 92% target. An options paper has been produced and submitted to the DCCG’s Executive Committee and it has been agreed to increase the capacity of the service through Saturday clinics and additional staffing within the core service until March 2020 and a fixed term of 12 months respectively. A meeting is to be arranged to discuss longer term resolutions for capacity issues across this specialty including options for an all age service.</td>
</tr>
<tr>
<td>Community Nursing - emergency referrals seen within 2 hours</td>
<td>90.4%</td>
<td>98%</td>
<td>Performance deteriorated slightly to 90.4% as a result of 26 breaches. Fifteen of these were seen within 5 minutes of the 2 hour target with 11 due to capacity of the service at peak times (both night and day shifts). There has been an increase in demand on the service during May which RDASH have fully informed DCCG on through weekly Surge and Escalation Group meetings. This will be monitored on an ongoing basis.</td>
<td></td>
</tr>
</tbody>
</table>
Community Nursing - percentage of reviews for complexity completed within the relevant timeframes (annually for lower level complexity at Level 1 to every visit for Level 5) - May

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage</th>
<th>Total (Reviews)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>89.3%</td>
<td>(50/56)</td>
</tr>
<tr>
<td>2</td>
<td>93.3%</td>
<td>(2096/2247)</td>
</tr>
<tr>
<td>3</td>
<td>90.0%</td>
<td>(1094/1216)</td>
</tr>
<tr>
<td>4</td>
<td>78.3%</td>
<td>(137/175)</td>
</tr>
<tr>
<td>5</td>
<td>100%</td>
<td>(4/4)</td>
</tr>
</tbody>
</table>

All 5 areas of complexity reviews for Community Nursing demonstrated improvement during May 2019 with 100% attainment for Level 5 reviews. These areas have been raised through the DCCG and RDASH FPIG with the Trust and confirmation received that this issue relates to the recording of information rather than no review being undertaken.

2.3 Other Areas
2.3.1 Nursing / Care Homes / Domiciliary Care Providers

There continue to be two homes with formal embargoes in place. One care home that has received a poor review from the Care Quality Commission (CQC); DCCG and Doncaster Council are working with the home around the areas identified by the CQC.

2.3.2 Serious Case Reviews / Lesson Learnt Reviews

No new Safeguarding Adults Reviews have been commissioned since the last Governing Body Report.

2.3.3 Domestic Homicide Reviews

There are currently three Domestic Homicide Reviews taking place within Doncaster. These reviews remain ongoing.

2.3.4 Complaints and Concerns (DBTHFT)

There were a total of 99 complaints and concerns received by DBTHFT during April 2019, with the percentage of resolutions within agreed timescales at 74%.
There are two main themes for April 2019 relating to diagnosis, which breaks down to Time taken to make diagnosis and allegation of missed diagnosis. The second main complaint theme is around admissions/transfers/discharge procedures/sleeper out, which breaks down into unacceptable time to wait for an appointment and Other.

### 2.3.5 CCG Complaints 2018 / 19

**Complaint Acknowledgement Time Scales 2018/19**

<table>
<thead>
<tr>
<th>Day of Receipt</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Over 3 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day of Receipt</td>
<td>73%</td>
<td>12%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Day 1</td>
<td>6%</td>
<td>7%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Day 2</td>
<td>6%</td>
<td>7%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Day 3</td>
<td>6%</td>
<td>7%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Over 3 days</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

94% of complaints were acknowledged within the specified time scale. 6% (5 cases) were +3 working days as a result of:
- Incomplete contact information
- Staff annual leave
Currently 53% were investigated and completed within the specified time scale. 47% (41 cases) were +25 working days as a result of:

- Some complaints being complex and multi-faceted, which require further investigation in order to provide a robust and detailed response.
- Face to face meetings take place before investigations can be instigated as the request of individuals.
- Complaints that are linked to other health care providers often go over the CCG’s time scales, as they work to their own individual time frames for example DBHFT work on a 40 working day time scale.
The CCG does not separate complaint feedback in relation to this outcome, as it believes that learning should and can take place from all complaints. It continues to liaise directly with individual and their families to ensure that patient experience is heard and acted upon.
Section 3: Improvement and Assessment Framework Dashboard

NHS England has a statutory duty to conduct an annual performance assessment of every CCG. The annual assessment will be a judgement reached by taking into account the CCG’s performance in each of the indicator areas over the full year balanced against the financial management and a qualitative assessment of the leadership of the CCG.

To ensure that the framework is being applied consistently, regional and national moderation takes place.

The Improvement and Assessment Framework for 2018-19 covers the following four domains:

1. Better Health: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve.
2. Better Care: this focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas.
3. Sustainability: this section looks at how the CCG is remaining in financial balance and securing good value for patients and the public from the money it spends.
4. Leadership: this domain assesses the quality of the CCG’s leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

The possible ratings are: Outstanding, Good, Requires Improvement and Inadequate.

Doncaster CCG was rated ‘Outstanding’ for 2018-19 – one of only 24 of the 195 CCGs to have achieved this rating. This is the third consecutive year that Doncaster CCG has been rated as ‘Outstanding’.

Underpinning the four domains in 2018-19 are 58 indicators which are used to inform the ratings. According to data provided by NHS England on 9th July Doncaster CCG is in the worst performing quartile in England for the following indicators:
The following work is being undertaken to address performance against these indicators:

**Injuries from falls in people aged 65 and over**
As part of the system transformation of Intermediate Care a new Rapid Response Service was launched in January 2017. Ambulance staff assess patients who have fallen and those who require short term health or social care support to stay at home will be referred to this service rather than conveyed to A&E.

Falls risk assessment is being embedded across all providers. The specialist falls service within Intermediate Care is being re-specified and will clearly identify requirements for strength and balance. Falls prevention and falls training is being rolled out to all Care Homes including the use of falls risk assessment.

In the 12 months ending 31st May 2019 there were 6.9% fewer hospital admissions for people aged 65+ due to injuries from falls than in the previous 12 months.
Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions
The Doncaster Health and Wellbeing Board have established a Health Inequalities Steering Group which has developed an Action Plan to address health inequalities in Doncaster. The Steering Group includes representation from DMBC, DCCG, Primary Care Doncaster and Doncaster Healthwatch.

DCCG and DMBC are establishing joint commissioning teams for 3 life stages (Starting Well, Living Well and Ageing Well). A key theme of the Living Well agenda is the establishment of a community led support model focusing on resilience and prevention which will contribute to a reduction in emergency admissions from these conditions in the most deprived communities.

In the 12 months ending 31st May 2019 there were 1.6% fewer emergency admissions for chronic ambulatory care sensitive conditions and 4.7% fewer emergency admissions for urgent care sensitive conditions than in the previous 12 months. Doncaster CCG and Doncaster MBC are currently analyzing admission rates for these conditions for the 194 Lower Super Output Areas in Doncaster as part of the population health management work.

Antimicrobial resistance: appropriate prescribing of antibiotics in primary care
DCCG’s prescribing rate of antibacterial items per STAR-PU for the 12 months ending 31st March was 1.076 which is above the national target for 2018-19 (0.965).

One of the key milestones of the Medicines Management Delivery Plan is to “Contribute towards the national agenda of reducing resistance to antibiotics through the quality care premium using Optimise Rx and quality premium dashboard”

Quality of life for carers
This metric assesses the amount of support given to carers who have one or more long term condition(s).
One of the key milestones in the joint DCCG / DMBC Ageing Well Delivery Plan is to “Improve recognition of and support for carers”

The current Better Care Fund Plan includes a scheme to embed prevention approaches across the health and social care system and provide more support to areas with greatest need especially carers of patients with complex needs.

Utilisation of the NHS e-referral
Performance improved significantly in 2018-19:
<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>2018</td>
<td>60%</td>
</tr>
<tr>
<td>June</td>
<td>2018</td>
<td>82.43%</td>
</tr>
<tr>
<td>Sept</td>
<td>2018</td>
<td>84.98%</td>
</tr>
<tr>
<td>Dec</td>
<td>2018</td>
<td>88.85%</td>
</tr>
<tr>
<td>March</td>
<td>2019</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

England performance for March 2019 was 99.8%

Staff Engagement Index
This indicator is derived from the results of the 2018 NHS Staff Survey for DBTHT and RDaSH. DBTHT have developed a Staff Survey Action Plan which contains five key elements:

- Communicating with staff
- Listening to staff
- Involving staff
- Supporting and engaging with managers
- A program of staff experience

Cancers diagnosed at an early stage
Cancers diagnosed at Stages 1 and 2 increased from 47.7% in 2016 to 48.9% in 2017 (England performance was 52.2%)
The Cancer Delivery Plan includes a target of improving the proportion diagnosed in Stages 1 and 2 to 62%.

One year survival from all cancers
The survival rate improved from 70.3% in 2015 to 70.5% in 2016.
One of the quality outcomes of the Cancer Delivery Plan is to “Improve to 75% of patients with cancer reaching 1 year survival by March 2020”.

The Delivery Plan aims to achieve above national average uptake for the National Screening Programmes (Cervical, Bowel and Breast Screening)
**Learning Disability annual health checks**
The Health Action Team are providing in-reach to practices to identify areas of concern and low uptake of annual health checks and screening (for cancer and other illnesses) through health action plans for people with learning disabilities. This team will also work with Primary Care to offer support and training to reinforce ease of access for this cohort of people.

Primary Health Passports have been developed and were rolled out during the Learning Disabilities Awareness Week (week commencing 17th June 2019). These passports will travel with the service user when accessing general practice and will help communicate consistent approaches and reasonable adjustments to support access to health appointments and ensure the best outcomes for the people involved.

**Maternal smoking at delivery**
One of the key milestones of the joint DCCG / DMBC Starting Well Delivery Plan is to “increase Carbon Monoxide verified 4 week quits for pregnant smokers”. Doncaster Council commissions a smoking in pregnancy service from RDaSH which engages with women from booking throughout pregnancy.

The service uses a host of tools to encourage and maintain smoking cessation including motivational interviewing, education, nicotine replacement therapy and cognitive behavioral therapy. The service is exploring the use of incentives for service users to maintain quits up to and beyond 4 weeks. DMBC Public Health is working with the wider children, young people and families workforce to offer advice on smoking cessation, signpost to other services and are also exploring improving midwifery interventions with families where there is smoking.

**Dementia care planning and post-diagnostic support**
This is the General Medical Services Quality and Outcomes Framework (QOF) indicator DEM004 which is the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face meeting in the preceding 12 months.

A key milestone of the joint DCCG / DMBC Ageing Well Delivery Plan is:
“Post Diagnostic Dementia Support (including Admiral Nursing) will be refined by an Accountable Care Partnership Approach to better focus available resource, improve access and service capacity, and better integration with the broader care system”

The Delivery Plan aims to increase the proportion of people with dementia whose care plan has been reviewed in primary care in the last 12 months to 80%.
Emergency admissions for urgent care sensitive conditions
There were 4.7% fewer emergency admissions for these conditions in the 12 months ending 31st May 2019 than in the previous 12 months.

The Rapid Response service now includes respiratory patients from YAS and this is to be extended to patients referred by GPs. The Doncaster Place Plan aims to reduce emergency admissions for older people with these conditions by developing out of hospital services and fostering community resilience to improve support and provide services closer to home.

Deaths with 3 or more emergency admissions in the last 3 months of life
The joint DCCG / DMBC Ageing Well Delivery Plan includes a quality outcome to reduce the percentage of people who died and had 3 or more emergency admissions in the 90 days prior to death below the 2017 baseline (7.05%). The Delivery Plan aims to reduce the number of people aged 65+ re-admitted to an acute hospital as an emergency within 30 days from the 2018-19 baseline.

Doncaster CCG is in the best performing quartile in England for the following indicators:
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>DCCG</th>
<th>Rank (out of 195)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes patients who achieved NICE targets</td>
<td>2017-18</td>
<td>48.4%</td>
<td>12</td>
</tr>
<tr>
<td>AMR: Broad spectrum prescribing</td>
<td>Feb-19</td>
<td>5.7%</td>
<td>8</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress against Workforce Race Equality Standard</td>
<td>Jul-05</td>
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<tr>
<td><strong>Better Care</strong></td>
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<td>High quality care - primary care</td>
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<tr>
<td>Mental Health - health checks</td>
<td>q4 2018-19</td>
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<td>A&amp;E admission, transfer, discharge within 4 hours</td>
<td>Mar-19</td>
<td>92.5%</td>
<td>25</td>
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<tr>
<td>Cancer 62 days of referral to treatment</td>
<td>q4 2018-19</td>
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<td>Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting</td>
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<td>% 10-11 classified overweight /obese</td>
<td>15/16 to 17/18</td>
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<td>103a</td>
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<td>103b</td>
<td>Better Health</td>
<td>Attendance of structured education course</td>
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<td>104a</td>
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<td>Injuries from falls in people 65yrs +</td>
<td>18-19 Q3</td>
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<tr>
<td>105b</td>
<td>Better Health</td>
<td>Personal health budgets</td>
<td>18-19 Q3</td>
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<td>18-19 Q2</td>
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<td>107a</td>
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<td>AMR: appropriate prescribing</td>
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<tr>
<td>107b</td>
<td>Better Health</td>
<td>AMR: Broad spectrum prescribing</td>
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<td>108a</td>
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<td>Quality of life of carers</td>
<td>2018</td>
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<tr>
<td>141b</td>
<td>Sustainability</td>
<td>In-year financial performance</td>
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<td>144a</td>
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<td>Utilisation of the NHS e-referral</td>
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<td>145a</td>
<td>Sustainability</td>
<td>Expenditure in areas with identified scope for improvement</td>
<td>18-19 Q3</td>
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<tr>
<td>162a</td>
<td>Leadership</td>
<td>Probit and corporate governance</td>
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<td>Progress against WRES</td>
<td>2018</td>
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<td>2018-19</td>
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<td>Leadership</td>
<td>CCG compliance with standards of public and patient participation (not available)</td>
<td>2018</td>
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<tr>
<td>165a</td>
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<td>Quality of CCG leadership</td>
<td>18-19 Q4</td>
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<td>18-19 Q3</td>
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<td>18-19 Q3</td>
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<td>121c</td>
<td>Better Care</td>
<td>High quality care - adult social care</td>
<td>18-19 Q1</td>
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<tr>
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<td>Cancers diagnosed at early stage</td>
<td>2017</td>
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<td>18-19 Q4</td>
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<td>One-year survival from all cancers</td>
<td>2016</td>
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<td>122d</td>
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<td>Cancer patient experience</td>
<td>2017</td>
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<td>IAPT recovery rate</td>
<td>18-19 Q3</td>
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<td>IAPT Access</td>
<td>18-19 Q3</td>
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<tr>
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<td>EIP 2 week referral</td>
<td>Mar-19</td>
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<td>MH - Crisis team provision</td>
<td>18-19 Q3</td>
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<tr>
<td>123f</td>
<td>Better Care</td>
<td>MH - OAP</td>
<td>Feb-19</td>
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<tr>
<td>123g</td>
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<td>MH - Health checks</td>
<td>18-19 Q4</td>
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<tr>
<td>123i</td>
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<td>MH - Investment standard</td>
<td>18-19 Q3</td>
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<td>2018</td>
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<td>Choices in maternity services</td>
<td>2018</td>
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<td>126a</td>
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<td>Maternal smoking at delivery</td>
<td>18-19 Q3</td>
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<td>Dementia diagnosis rate</td>
<td>Mar-19</td>
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<td>Emergency admissions for UCS conditions</td>
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<td>A&amp;E admission, transfer, discharge within 4 hours</td>
<td>Mar-19</td>
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<tr>
<td>127e</td>
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<td>Delayed transfers of care per 100,000 population</td>
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<td>127f</td>
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<td>Hospital bed use following emergency admission</td>
<td>18-19 Q2</td>
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<td>Patient experience of GP services</td>
<td>2018</td>
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<td>Sep-18</td>
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<td>Primary care transformation investment</td>
<td>18-19 Q4</td>
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<tr>
<td>130a</td>
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<td>7 DS - achievement of standards</td>
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<tr>
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<td>% NHS CHC full assessments taking place in acute hospital setting</td>
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<tr>
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**CCG in best performing quartile in England**

**CCG in worst performing quartile in England**
# 3.2 South Yorkshire and Bassetlaw Integrated Care System Assurance Report June 2019

<table>
<thead>
<tr>
<th>Description</th>
<th>Time Period</th>
<th>NHS Constitution / National Standard</th>
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<th>ALB Oversight</th>
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<tr>
<td></td>
<td></td>
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<td>By exception</td>
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<tr>
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<tr>
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<tr>
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<td>(monthly)</td>
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44
## Ageing Well Strategic Delivery Plan Updates

<table>
<thead>
<tr>
<th>Action Title</th>
<th>Due</th>
<th>% Complete</th>
<th>Latest Update</th>
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<tbody>
<tr>
<td>Refresh of the Doncaster Dementia Action Plan and continue to raise awareness and reduce stigma across Doncaster.</td>
<td>31/03/20</td>
<td>50%</td>
<td>01-Jul-2019 The Doncaster Dementia Action Plan has now become part of the actions detailed in the ageing well delivery plan. This was agreed by the Doncaster Dementia Strategic Partnership in March 2019. Public Health continues to deliver dementia awareness campaigns and reduce stigma. The Dementia Friends initiative is due to be re-launched across Doncaster again in Q2.</td>
</tr>
<tr>
<td>Further embed falls risk assessment documentation with core offer, across all providers and align ongoing developments in line with the wider prevention agenda.</td>
<td>31/08/19</td>
<td>16%</td>
<td>05-Jul-2019 mapping of existing utilisation still being undertaken to understand future requirements. Domiciliary Care providers identified as the first cohort</td>
</tr>
<tr>
<td>Raise public awareness of the importance of the last year of life across Doncaster, including awareness of dying, death loss and bereavement and improving conversations.</td>
<td>31/03/20</td>
<td>20%</td>
<td>03-Jul-2019 Awareness raised during Dying Matters week. Meeting arranged with public health colleagues to develop a plan. Public Health are only just linking into this area of work but a joint meeting is in the pipeline to discuss this further very soon.</td>
</tr>
<tr>
<td>Increase uptake in direct payment and utilisation of Personal Health Budgets</td>
<td>31/03/20</td>
<td>32%</td>
<td>05-Jul-2019 This is being managed through the Your Life Doncaster (YLD) Programme and has a work package which is purely focused on increasing the uptake in direct payments and the utilisation of Personal Health Budgets. Progress to date is as follows: Work has commenced on the production of a recognised provider list for residents wishing to take a Direct Payment (DP). A communications and engagement strategy is being developed to raise awareness of direct payments A monthly DP e-bulletin is now produced and circulated to staff and DP recipients. Discussions have taken place around how the Recognised Provider List (RPL) will be included on the YLD website. During the next month the project team will look to define the criteria for the RPL, design a logo and start to identify best practice across the country in implementing an RPL</td>
</tr>
<tr>
<td>Ensure that all services adopt an asset based approach and promotion of self management and support</td>
<td>31/03/20</td>
<td>0%</td>
<td>No update received.</td>
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<tr>
<td>Explore the future delivery of contracts and consideration of other local priorities to establish provision that meets the requirements of commissioners.</td>
<td>31/03/20</td>
<td>10%</td>
<td>List of contracts due to expire in 2019/2020 collated and reviews being completed where required. Joint Ageing Well Commissioning Strategy being drafted which will include future requirements and current provision.</td>
</tr>
<tr>
<td>Develop commissioning intentions for day opportunities and ensuring links to Your Life Doncaster and neighbourhood</td>
<td>31/03/20</td>
<td>25%</td>
<td>Review currently being completed of day services - engagement events planned – intentions to be drafted by August 2019</td>
</tr>
<tr>
<td>Development of an ageing well prevention agenda to include but not limited to social isolation, loneliness, improving vaccination and screening uptake, falls prevention, self management and increased use in technology, (further prevention aligned to the NHS Long Term Plan (LTP))</td>
<td>31/03/20</td>
<td>25%</td>
<td>03-Jul-2019 • Public Health commissions the NHS health checks service (40-74 year olds) across the borough and co-ordinates a number of awareness campaigns including dementia and cancer awareness across a number of settings. Joint presentations/updates (as requested) have been delivered with CCG leads to key Boards including Doncaster Health and Wellbeing Board and Overview and scrutiny and a separate presentation to the Parish Council Joint Consultative Committee around dementia prevention and awareness was delivered in March 2019. • Public Health are exploring the relaunch and co-ordination of dementia friends/champions initiatives through a recently formed task and finish group and are developing an action plan. The team have also refreshed the dementia directory for 2019/20 and recently co-ordinated the annual dementia action week 20th -26th May 2019 as well as supporting the dementia awards. • Ongoing dementia awareness campaigns and wider prevention work through the Public health team continue around risk factors including diet/physical activity, alcohol and smoking and use of the Making Every Contact Count tool across frontline services • The team are supporting the CCG dementia deep dive to commence in summer 2019 and also conducting our own stakeholder analysis to identify gaps and new areas for development in our ageing well prevention offer. • Public health have supported the development of the Doncaster Social Isolation and loneliness Alliance and are currently exploring links with Sheffield University centre for loneliness around potential research as well as York university • Public health are planning an age friendly members’ seminar for early 2020 and will be working with Age UK and key partners to explore an age friendly approach. • Public health have met with Barnsley Council colleagues and regularly attend the regional Public Health England healthy ageing leads meeting to share good practice and look at new ideas around loneliness, falls prevention/frailty and other key areas including age friendly environments and sight loss. • Public health also contribute to the housing and older people agenda; the older people and alcohol group; oral health improvement group and the Well Doncaster lead in public health is initiating a pilot in the east around frailty (Vanessa Powell Hoyland)</td>
</tr>
<tr>
<td>Improve recognition of and support for carers</td>
<td>31/03/20</td>
<td>0%</td>
<td>No update received.</td>
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<tr>
<td>Continue to embed previously agreed community model with wider care stakeholders of the neighbourhood model for community based multi-professional teams in partnership with mental health and social care teams in line with Doncaster Place plan and emerging Primary Care Networks (PCN).</td>
<td>31/03/20</td>
<td>20%</td>
<td>05-Jul-2019 Community services continue to link to the emerging PCN’s and the wider neighbourhood work. Wound care development with the Provider Alliance has been extended to support training requirements.</td>
</tr>
<tr>
<td>Holistic Elderly Care planning to include but not limited to identification of, robust co-ordinated management and crisis response. With a focus on admission avoidance and proactive advanced care planning.</td>
<td>31/03/20</td>
<td>30%</td>
<td>05-Jul-2019 Work continues as part of the Doncaster Innovates project to look at prototyping a frailty pathway in Thorne. This work is well underway and the project team are in the process of pulling together a single assessment document for testing how the model will work. The project team are also looking at what the make up of the Frailty Multi Disciplinary Team will look like with the first iteration of the model being tested in September 2019.</td>
</tr>
<tr>
<td>Task Description</td>
<td>Start Date</td>
<td>Percentage Complete</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
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<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Explore the opportunities of a joint community therapy offer in particular</td>
<td>30/09/20</td>
<td>0%</td>
<td>05-Jul-2019 No resource identified to undertake this work stream.</td>
</tr>
<tr>
<td>Occupational therapy to provide practical support to empower people to facilitate</td>
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<tr>
<td>recovery and overcome barriers preventing them from doing the activities to increase people's independence.</td>
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</tr>
<tr>
<td>Intermediate out of hospital pathways will be improved for people diagnosed with</td>
<td>31/03/20</td>
<td>25%</td>
<td>04-Jul-2019 An audit of inpatient (jointly by RDASH &amp; DBTHFT) has been agreed by the Transformation Board of all patients with dementia or and delirium on the frailty and Acute Medical Unit. The audit will commence in Q1 and finding presented in Q2.</td>
</tr>
<tr>
<td>dementia. In particular, dementia patients with an urgent physical presentation will be supported by better integration of the intermediate and care home Mental Health liaison offers</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Post Diagnostic Dementia Support (including Admiral Nursing) will be refined by an</td>
<td>31/03/20</td>
<td>40%</td>
<td>04-Jul-2019 The ACP are working together to develop the PDS service</td>
</tr>
<tr>
<td>Accountable Care Partnership (ACP) Approach to better focus available resource,</td>
<td></td>
<td></td>
<td>model. A new pathway and model has been proposed and this will be</td>
</tr>
<tr>
<td>improve access and service capacity, and better integration with the broader care</td>
<td></td>
<td></td>
<td>implemented by Q2. The evaluation of the service and next steps will</td>
</tr>
<tr>
<td>system.</td>
<td></td>
<td></td>
<td>be presented to Joint Commissioning Operational Group (JCOG) and</td>
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<td></td>
<td>Commissioning Management Board (JCMB) in August/September 2019.</td>
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<td>Linkage to Dementia Deep Dive with primary and community care, in</td>
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<td></td>
<td>terms of a potential consolidate post diagnostic support offer in</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>primary care</td>
</tr>
<tr>
<td>Ensure that a local primary care strategy develops that the requirements for our</td>
<td>30/04/19</td>
<td>100%</td>
<td>09-Jul-2019 The Primary Care Strategy published in April 2019 includes an ageing well section which recognises the role that proactive care plays in avoiding unnecessary admissions to hospital. It also includes plans for a deep dive into dementia diagnosis and the development of a community care model for care homes. There is also a theme of the role of primary care and integrated neighbourhood working in addressing social isolation within the strategy. Primary care networks went live on 1 July 2019 and each will be considering its priorities over the next year. Work on frailty is already underway in Thorne and the Northfield practice in the East Primary Care Network is engaged in this work.</td>
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<tr>
<td>Ageing population are addressed along with ensuring that General Practice is a key</td>
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<td>part of the neighbourhood approach to delivering holistic care</td>
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<tr>
<td>Deliver the Community Care &amp; Support at Home (CCaSH) action plan. Test the</td>
<td>31/03/20</td>
<td>50%</td>
<td>Action Plan in place and all areas on track. Trusted Reviewer in</td>
</tr>
<tr>
<td>Trusted Reviewer model with the CCaSH Strategic Lead Provider’s (SLP) trusting</td>
<td></td>
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<td>place within 1 SLP and costs/savings tracked through the Home Care</td>
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<tr>
<td>them to flex packages of care dependent on changing levels of need and identifying</td>
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<td>Project Board.</td>
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<tr>
<td>other resources within the community to support the persons independence.</td>
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<tr>
<td>Ensure continued suitable provision of community</td>
<td>30/08/19</td>
<td>100%</td>
<td>01-Jul-2019 The integrated community equipment service has been in</td>
</tr>
<tr>
<td>for nearly 5 years and a 1 year extension to 05/09/20 has been agreed. The</td>
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</table>
equipment is available to support the “Home First” approach and align these changes across the system.

| Review of CCaSH Contract and begin planning for the future commissioning of Domiciliary Care | 31/03/20 | 0% | Review to be commenced September 2019. |
| Development of a new Care Home action plan and a robust market position statement | 31/03/20 | 0% | 01-Jul-2019 Following advice from NHS England an internal paper has been produced for discussion with Chief Finance Officer on the options to take this forward. |
| Continue to explore opportunities and risks around joint contracting for Care Homes | 31/12/19 | 50% | 05-Jul-2019 Contracts and legal teams are still exploring use of the NHS standard contract. |
| Evaluate Extension of Community Led Outcomes (ECHO) and financial impacts of training and consider utilisation across a wide range across all independent sector provision. | 31/12/19 | 45% | 05-Jul-2019 A successful ECHO Launch took place at the end of June. It launched the programme with care home staff and subject matter experts. The facilitator and IT admin support are engaging with all care homes and Prison services to identify numbers of staff who will attend the sessions, work through issues, identify IT support, equipment and training requirements. Curriculum planning continues with subject matter experts. ECHO team continue to establish new ways to provide learning via the ECHO institute and will feedback into the ECHO project board to enable future sustainability of the learning platform. |
| Ensure Admission and discharge processes into Acute hospitals are efficient and seamless ensuring a ‘home first’ approach for continuous care with robust direct pathways and signposting to alternative where appropriate. | 31/03/20 | 20% | 05-Jul-2019 A High Impact Change Model workshop took place on the 3rd July 2019 to look at how this piece of work will be taken forward across the health and social care system. It was agreed that a presentation/briefing paper be taken to the Systems Resilience Group and A&E Delivery Board in August 2019 to outline some of the challenges and to discuss what the Home First approach will look like in Doncaster. |
| Continue to work with providers to implement the specified Intermediate Care service model. | 31/03/20 | 10% | 05-Jul-2019 Provider Alliance to present their implementation plan (including financial and operational risks) to the DICDG. Timelines of proposed gateway model will need to be amended post meeting |
| Focus on maximising independence, health and well being, tailoring care and support to build on individual strengths and local community assets and ensuring that the intermediate care offer is the best it can be when people need it | 31/03/20 | 25% | 05-Jul-2019 This action has now been superseded with the commissioning approach. This action needs to be closed or removed |
Total number of measures = 17
Number rated as Green = 6
Number rated as Red = 2
Number yet to be developed/rated = 9

The average length of stay in hospital for people aged 65 and over will be maintained or reduced compared to 2018/19 outturn of 10 days (excluding 0 and 1 day LOS)

There will be fewer delayed discharges of care for people aged 65 and over from Windermere and Coniston wards from the 18-19 baseline of 1026 days (Cumulative)

Fewer people aged 65 and over will be re-admitted to an acute hospital as an emergency within 30 days Baseline requested from Contracting

There will be an Increase in people aged 65 and over being discharged to their usual place of residence in 2019-20 from 18-19 baseline 92% acute
There will be an increase in people aged 65 and over being discharged to their usual place of residence in 2019-20 from 18-19 baseline 68% Intermediate Care

The percentage of people recorded on the end of life pathway as dying in their preferred place of death will increase in 2019-20 - RDASH 18-19 baseline 92.6% - this baseline may be reviewed in year as reporting from other services comes on line

There will be a 5% reduction in people aged 65 and over attending A&E, including those from care homes from 18-19 (Cumulative)

There will be a reduction in people aged 65 and over being admitted to hospital as an emergency, including those from care homes from 18-19 (Cumulative)
At least 67% of people with Dementia will be diagnosed in line with the national standard in 19-20 (IAF 126a)

There will be an increase in people with Dementia whose care plan has been reviewed in primary care in the last 12 months to 80% (IAF 126b)

There will be a reduction in the percentage of people who died and had 3 or more emergency admissions in the 90 days prior to death (IAF 105c) Baseline of 7.05% in 2017

The following measures are under development and will be included in future reports as information becomes available.

- People aged 65 and over requiring a crisis response (physical health) will receive it within 2 hours - to set a baseline during 19-20
- People aged 65 and over requiring an urgent response (physical health) will receive it within 4 hours - to set a baseline during 19-20
- People aged 65 and over requiring Intermediate Care Services will have a service in place within 48 hrs - to set a baseline during 19-20
- Fewer people aged 65 and over per 100,000 population will be permanently admitted to long term care. Baseline & target tbc
- People aged 65 and over will report an improvement in their functioning and quality of life following the episode of care in the Intermediate Care patient outcomes tool (Baseline to be developed in 19-20).
- More people aged 65 and over will report that they would be likely to recommend community services to friends and family. Baseline to be developed in 19-20
<table>
<thead>
<tr>
<th>Meeting name</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting date</td>
<td>1 August 2019</td>
</tr>
<tr>
<td>Title of paper</td>
<td>Finance Report June 2019 (Month 3)</td>
</tr>
</tbody>
</table>

| Executive / Clinical Lead(s) | Hayley Tingle, Chief Finance Officer |
| Author(s) | Tracy Wyatt, Deputy Chief Finance Officer |

**Status of the Report**

- To approve [ ]
- To consider / discuss [X]
- To note [ ]

**Purpose of Paper - Executive Summary**

This report sets out the financial position as at the end of June 2019 for consideration by the Governing Body.

At this early stage in the year the CCG is forecasting to achieve all of its financial targets for 2019/20.

The report also outlines:

- The key risk areas identified for 2019/20
- The CCG’s Operating Cost Statement (Appendix 1)
- A summary of the CCG Efficiency Savings for 2019/20 (Appendix 2)
- A summary of the CCG’s Resource Allocation (Appendix 3)
- A summary of the CCG’s Reserve position (Appendix 4)

**Recommendation(s)**

The Governing Body is asked to:

- Receive the report and consider/discuss any risks and issues as highlighted in the report.

**Report Exempt from Public Disclosure**

- Yes [ ]
- No [X]

If yes, detail grounds for exemption:
## Impact analysis

<table>
<thead>
<tr>
<th>Quality impact</th>
<th>N/A</th>
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</thead>
</table>

### Equality impact

An Equality Impact Analysis/Assessment is not required for this report.  

An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.

An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.

<table>
<thead>
<tr>
<th>Sustainability impact</th>
<th>NIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial implications</td>
<td>As outlined in the report</td>
</tr>
<tr>
<td>Legal implications</td>
<td>NIL</td>
</tr>
<tr>
<td>Management of Conflicts of Interest</td>
<td>N/A</td>
</tr>
<tr>
<td>Consultation / Engagement (internal departments, clinical, stakeholder and public/patient)</td>
<td>N/A</td>
</tr>
<tr>
<td>Report previously presented at</td>
<td>None</td>
</tr>
<tr>
<td>Risk analysis</td>
<td>As outlined in the report</td>
</tr>
<tr>
<td>Corporate Objective / Assurance Framework</td>
<td>Achievement of CCG statutory duties to deliver a break even position, maintain spend within the allocated resources for Delegated commissioning and Running Costs and achieve BPPC targets.</td>
</tr>
</tbody>
</table>
NHS DONCASTER CCG

2019/20 FINANCE REPORT MONTH 3 – JUNE 2019

1. Introduction

This report provides the financial position for NHS Doncaster CCG for 2019/20 as at the end of June 2019 (Month 3). The CCG is forecasting to achieve all of its financial targets for 2019/20.

2. Current Position

The following table shows the CCG’s current and forecast position for the key financial targets and statutory duties -

<table>
<thead>
<tr>
<th>Key Duty</th>
<th>Target</th>
<th>Month 3</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Position</td>
<td>NHSE In year reporting - breakeven</td>
<td>B/E</td>
<td>B/E</td>
</tr>
<tr>
<td></td>
<td>Achieve cumulative underspend annual target of £13,348k surplus (£3,336k M3)</td>
<td></td>
<td>£3,337k</td>
</tr>
<tr>
<td></td>
<td>QIPP Achievement Annual Plan £10,121k (£1,803 Month 3)</td>
<td></td>
<td>£10,121K</td>
</tr>
<tr>
<td>BPPC</td>
<td>95% + invoices paid within 30 days (NHS)</td>
<td>99.21%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoices paid within 30 days (non NHS)</td>
<td>99.15%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoice values paid within 30 days (NHS)</td>
<td>99.46%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>95% + invoice values paid within 30 days (Non NHS)</td>
<td>99.33%</td>
<td>98%</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>1.25% of monthly drawdown remaining at period end</td>
<td>1.11%</td>
<td>1.25%</td>
</tr>
<tr>
<td>Running Costs</td>
<td>Maintain spend within annual target of £6,900k (£1,491k M3)</td>
<td>£1,337k</td>
<td>£6,849k</td>
</tr>
<tr>
<td>Delegated Co-Commissioning</td>
<td>Maintain spend within annual target of £44,571 (£10,528k M3)</td>
<td>£10,418K</td>
<td>£44,803K</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>

Key

- **Red**: Not achieving and unlikely to be met
- **Amber**: Not currently achieving but could be recovered or under-performing
- **Green**: Achieving and on target to be met
At this early stage in the year the position reflects break-even which is in line with the target set by NHS England. The CCG is forecast to achieve a cumulative surplus of £13,348k which is also in line with expectations.

The QIPP achievement is reported as slightly under target at Month 3 by £75k.

There is an expectation that all organisations within the SYB footprint will meet their individual control totals and therefore meet the SYB control total.

The current and forecast position is summarised in the Operating Cost Statement included at Appendix 1.

3. Key Messages and Risks

As part of the 2019/20 Financial Plans, £7.1m of potential risks were identified. The main risk identified was the achievement of the ambitious efficiency plans £2.7m, acute contract over performance £1m, increased costs associated with individual placements £1.4m (including Continuing Healthcare, Specialist Placement and Section 117 packages) and prescribing £2m.

At this early stage in the year it is difficult to say if these risks will materialise but this will be closely monitored in year and mitigating action taken early.

In order to mitigate the risks identified, the CCG has set aside 0.5% of its allocation as a contingency fund, as required by the business rules. This equates to £2.6m, plus there is a small value of funding remaining in the contracting reserve. However, this will not mitigate the full risk identified and therefore further actions may be required including extending the already ambitious QIPP Programme.

3.1 DBTH Contract

As part of the contract negotiation agreements significant additional funding was agreed in the DBTH contract in order to improve waiting times, reduce the waiting list size and achieve 92% RTT targets. The CCG has been working closely with the Trust to agree a robust and phased activity plan to ensure delivery by October 2019 and this is now nearing completion. The CCG are now awaiting assurance and confirmation from the Trust in relation to capacity and demand modelling and are expecting a detailed trajectory to be provided for ongoing monthly monitoring of performance through the Contract Board meetings. Until the additional activity is reflected in the contract monitoring the CCG cannot be assured that the Trust is on plan to meet this target. It is assumed that if the additional activity is reflected in the plan for the first three months of the year then we would be seeing an under performance against plan.

Once the capacity and trajectory information is received this will be formalised through the contract and Governing Body will be updated on this issue each month and progress will be monitored and discussed at the Monthly Contract Board meeting with DBTH.
4. Efficiency Savings Programme

The CCG has set an ambitious efficiency plan equating to £10.1m. The main contracts with Doncaster and Bassetlaw Teaching Hospitals NHS FT and Rotherham, Doncaster and South Humber NHS FT were negotiated net of the agreed efficiency targets of £3.4m and £0.5m respectively.

Each scheme has been RAG rated in terms of the risk to overall delivery and will be closely monitored through the QIPP board in year. Information for the majority of schemes is now available and there is a slight under-performance of £75k however this is not deemed a risk at this stage. Further schemes are being identified through the QIPP board to mitigate against any slippage and any other cost pressures that may arise in year. A summary of progress so far can be found at Appendix 2.

5. Further Allocations

The CCG has received the following new allocations in June –

<table>
<thead>
<tr>
<th>Detail</th>
<th>£000</th>
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</thead>
<tbody>
<tr>
<td>IR changes</td>
<td>-14</td>
</tr>
<tr>
<td>Excess Treatment Costs transfer to NHSE</td>
<td>-19</td>
</tr>
<tr>
<td>Diab Trans: DTCN08 MDFT</td>
<td>29</td>
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<tr>
<td>Diab Trans: DTCN08 DISN</td>
<td>18</td>
</tr>
<tr>
<td>Challenged TCP Funding 19/20</td>
<td>150</td>
</tr>
<tr>
<td>CYP Green Paper Project Initiation Funds</td>
<td>125</td>
</tr>
<tr>
<td>CYP Green Paper MH Support Teams</td>
<td>403</td>
</tr>
<tr>
<td>CYP Green Paper Four week waiting pilot</td>
<td>122</td>
</tr>
<tr>
<td>Improving Access Allocations 19/20</td>
<td>1,958</td>
</tr>
<tr>
<td>19/20 Prior Year FTA Transfer</td>
<td>2,340</td>
</tr>
</tbody>
</table>

6. Capital Resource

The CCG has not received any capital funding in 2019/20.

7. Better Care Fund

The national guidance for the Better Care Fund has been published in mid-July and the CCG and Local Authority are now working to jointly agree a plan for 2019/20 which will be signed off at the Health and Well Being Board and then shared with the Governing Body. The first draft plan is due to be submitted in September 2019. The guidance is being reviewed but there are no major changes to previous years.

8. Conclusion and Recommendations

The committee is asked to receive the Finance Report for June (Month 3) and consider any risks or issues as outlined in the report.
# OPERATING COST STATEMENT

<table>
<thead>
<tr>
<th></th>
<th>Recurrent Budget</th>
<th>Non Rec Budget</th>
<th>Total Budget</th>
<th>Recurrent Budget</th>
<th>Non Rec Budget</th>
<th>Total Budget</th>
<th>Forecast</th>
<th>Variance (Under/ Over)</th>
<th>Opening Budget</th>
<th>Non Rec Budget</th>
<th>Total Budget</th>
<th>Recurrent Budget</th>
<th>Non Rec Budget</th>
<th>Total Budget</th>
<th>YTD Actual</th>
<th>Variance (Under/ Over)</th>
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<td><strong>Baseline Allocation</strong></td>
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<td>-475,786</td>
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<td><strong>Running Cost Incidence</strong></td>
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<td>5,600</td>
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<td><strong>Co-commissioning</strong></td>
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<td><strong>In year drawdown of prior year surplus</strong></td>
<td>0</td>
<td>0</td>
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<td><strong>Historic Drawdown</strong></td>
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<tr>
<td><strong>In Year Changes</strong></td>
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# TOTAL ALLOCATIONS

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<th>Recurrent Budget</th>
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<th>Total Budget</th>
<th>Forecast</th>
<th>Variance (Under/ Over)</th>
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# CUMULATIVE SURPLUS REQUIREMENT

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<th>Variance (Under/ Over)</th>
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<td>Risk of Slippage £000</td>
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<td>32</td>
<td>May need review as part of overall contract agreement</td>
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<td>9</td>
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<td>14</td>
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<td>50% of ICS reduction assumed</td>
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<td>Referral reductions/ follow up reductions</td>
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<td>570</td>
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<td>855</td>
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<td>Primary care</td>
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<td>100</td>
<td>Phased Q3 onwards</td>
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<tr>
<td>Other minor schemes</td>
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**RAG ratings**
- Green: Likely to achieve in full
- Yellow: May be some slippage but likely to achieve > 50%
- Red: High Risk, may achieve less than 50% of target

In Financial Plans risk of non achievement of QIPP has been estimated at £2.9m as above. This has been mitigated in plans with reserves and contingency.
### Summary of Resource Allocations as at Month 3 June 2019

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<th>Non Recurrent</th>
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<td>In year drawdown of prior year surplus</td>
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<td>Historic Drawdown</td>
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<td><strong>Total Resources Available at Plan Stage</strong></td>
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#### Adjustments to the Resource Limit:

**Month 01 April**

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**Month 02 May**

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**Month 03 June**

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<tr>
<td>IR changes</td>
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<td>CYP Green Paper MH Support Teams</td>
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<td>CYP Green Paper Four week waiting pilot</td>
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<td><strong>Total</strong></td>
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**Revised Resources available as at Month 3 June 2019**

-527,243 | -21,474 | -548,717
## RESERVES

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<tr>
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<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
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<tr>
<td>RISK RESERVES AND CONTINGENCIES</td>
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1. Introduction
This report presents the current position of the Governing Body Board Assurance Framework (BAF) for Quarter 1 2019/20 (Appendix 1).

The Audit Committee received the BAF at its meeting on 11 July 2019 for consideration and discussed the new layout, the updated corporate objectives, high level risks, measurable indicators and the updates to all the risks with the exception of CO2 – 2.2.

A full review of the corporate objectives, high level risks and measurable indicators / outcomes was undertaken at Strategy and Organisational Development Forum in May 2019. Meetings with Senior Risk Owners have taken place at the end of June / beginning of July.

Amendments to the BAF are marked as follows:
- Wording in red = item to be removed
- Wording in blue = item added / amended.

2. Corporate Objectives
The corporate objectives were reviewed at the Strategy and Organisational Development Forum in May 2019 and are for approval by the Governing Body. The amendments are detailed in Appendix 1, first page, in blue text.

| CO 1 | Ensure an effective, well led, and well governed organisation and its statutory obligations are met. |
| CO 2 | Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population. |
| CO 3 | Ensure that the healthcare system in Doncaster is sustainable. |
3. **Measurable Indicators / Outcomes**
Members of the Strategy and Organisational Development Forum in May 2019 discussed the addition of measurable indicators / outcomes in the BAF. The Governing Body are recommended to approve the indicators / outcomes, which are highlighted in blue text in Appendix 1, third page, first column.

4. **Board Assurance Framework – Key Highlights**
   - A full review of the BAF has been undertaken by Senior Risk Owners.
   - Measurable indicators / outcomes have been added to the BAF.
   - High level risk description (Appendix 1, page 2), full risk descriptions, causes and consequences have been updated throughout.
   - Initial, current and target scoring reviewed.
   - Controls, assurances, gaps, actions and progress have been updated.
   - Corporate objective 4 – 4.3 has been recommended by Audit Committee to be removed from the BAF. This is due to the risk being: Integrated Care System non-delivery. The removal of this risk was discussed at the Strategy and Organisational Development Forum in May 2019.

5. **Board Assurance Framework – Dashboard**
The dashboard can be viewed in Appendix 1, page 2. The outturn for quarter 1 2019-20 illustrates seven risks have achieved against their target score.

6. **Next Steps**
The Board Assurance Framework will continue to be reviewed by the Head of Corporate Governance and Senior Risk Owners on a quarterly basis.

Corporate objective 2 - 2.2 requires further review with the Senior Risk Owner which will be undertaken during quarter 2.

**Recommendation(s)**

The Governing Body are asked to:

a) Approve the amendments to the Corporate Objectives,
b) Approve the revised format and layout of the BAF,
c) Approve the revisions to the high level risks,
d) Approve the measurable indicators / outcomes,
e) Note the current position and updates to the BAF,
f) Approve the removal of risk Corporate Objective 4 – 4.3 (ICS Non-Delivery).
### Report Exempt from Public Disclosure

If yes, detail grounds for exemption:

Yes [ ]  No [X]

### Impact analysis

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<thead>
<tr>
<th>Impact</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality impact</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An Equality Impact Analysis/Assessment is not required for this report.</td>
</tr>
<tr>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
</tr>
<tr>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong> (internal departments, clinical, stakeholder &amp; public/patient)</td>
<td>Consultation with Chiefs of Service (Senior Risk Owners)</td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>Captured throughout the Assurance Framework</td>
</tr>
<tr>
<td><strong>Assurance Framework</strong></td>
<td>All Assurance Framework risks</td>
</tr>
</tbody>
</table>
Board Assurance Framework, 2019-20, Quarter 1

1. Introduction
This report presents the current position of the Governing Body Board Assurance Framework (BAF) for Quarter 1 2019/20. (Refer to Appendix 1 for the full BAF).

A full review of the corporate objectives, high level risks and measurable indicators / outcomes was undertaken at Strategy and Organisational Development Forum in May 2019. Meetings with Senior Risk Owners have taken place at the end of June / beginning of July.

Amendments to the BAF are marked as follows:
- Wording in red = item to be removed
- Wording in blue = item added / amended.

2. Corporate Objectives
The corporate objectives were reviewed at the Strategy and Organisational Development Forum in May 2019. Refer to Appendix 1 (first page) for details of the amendments, highlighted in blue text.

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO 1</td>
<td>Ensure an effective, well led, and well governed organisation and its statutory obligations are met.</td>
</tr>
<tr>
<td>CO 2</td>
<td>Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population.</td>
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<td>Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.</td>
</tr>
</tbody>
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3. Measurable Indicators / Outcomes
Members of the Strategy and Organisational Development Forum in May 2019 discussed the addition of measurable indicators / outcomes in the BAF.

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>Corporate Objective Description</th>
<th>Measurable Indicator / Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure an effective, well led, and well governed organisation and its statutory obligations are met</td>
<td>i) Established Governance and management of the local commissioning strategy and wider collaborative commissioning commitments. ii) Improvement Assessment Framework (NHSE) submission. iii) Delivery of People and Organisational Development Strategy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iv) Assured by Internal Audit on Governance and Risk Management.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 2 | Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population | i) Achieve safe effective care and a positive experience.  
ii) Achieve Joint Commissioning Health and Social Care Strategy  
iii) Achieve against the Primary Care Strategy and Annual Workplan  
v) Positive Quality and Performance reports |
| 3 | Ensure that the healthcare system in Doncaster is sustainable | i) Achievement against the joint commissioning health and social care strategy and operational delivery plans  
ii) Delivery of Place Plan with partners  
iii) Achieve control total, efficiencies and system affordability |
| 4 | Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships | i) Improvement in quality as part of the ICS delivery objectives  
ii) Achieve Patient and Public Involvement NHSE requirements  
iii) Achieve actions and outcomes contained in the Joint Commissioning Health and Social Care Strategy  
iv) Ensure the reporting of reducing health inequalities is transparent across the three Life Stages |

4. **Board Assurance Framework**
- A full review of the BAF has been undertaken by Senior Risk Owners.  
- Measurable indicators / outcomes have been added to the BAF.  
- Risk description, cause and consequences updated throughout.  
- Initial, current and target scoring reviewed.  
- Controls, assurances, gaps, actions and progress have been updated.  
- The risk scoring matrix (Appendix 2) was used during the review process.  
- Corporate objective 4 – 4.3 has been recommended by Audit Committee to be removed from the BAF. This is due to the risk being:
Integrated Care System non-delivery. The removal of this risk was discussed at the Strategy and Organisational Development Forum in May 2019.

Key highlights are:

a) Corporate objective 1 – 1.1: Ensure an effective, well led, and well governed organisation and its statutory obligations are met.

- The initial risk likelihood scoring has moved from 3 to 2.
- Key actions to be carried out:
  o Consideration to be given across the Accountable Care Partnership to engage a workforce consultancy.
  o Appointment of a Band 8B fixed term post to support Workforce Development.
  o People and OD Strategy to be approved by Governing Body.

b) Corporate objective 2: Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population.

- CO2 2.1:
  o Key actions to be carried out:
    • Develop joint commissioning relationship with providers with new models of care within 12 months.
    • Influence providers to develop clinical governance structures within 12 months.
  o Target risk score achieved.

- CO2 2.2:
  A full review of this objective will be undertaken in quarter 2.

- CO2 2.3:
  o The initial risk likelihood scoring has moved from 4 to 3.
  o Key actions to be carried out:
    • A workshop on engagement and relationship with General Practice in July 2019.
    • Work is required with individual practice issues with sustainability and business models.

- CO2 2.4:
  o The initial risk impact scoring moved from 4 to 5. The initial likely scoring moved from 5 to 4.
  o Key actions to be carried out:
    • Consideration to be given across the Accountable Care Partnership to engage a workforce consultancy.
    • Appointment of a Band 8B fixed term post to support Workforce Development.
    • Provider organisations to provide a response to NHS E/I on the Interim People Plan
• ICS Strategic Workforce Lead to work across workforce planning.

c) Corporate objective 3: Ensure that the healthcare system in Doncaster is sustainable.

- CO3 3.1:
  o The initial risk impact and likelihood scoring has moved from 5 to 4.
  o Key actions to be undertaken:
    • System Transformation Board continues to evolve and work on system priorities.
    • Waiting list validation and modelling is nearly finalised which will give clear oversight of any emerging risk of non-delivery to enable any mitigating actions to be put in place if necessary.
    • Joint commissioning and pooling of Children's CHC is being progressed.
  o Target risk score is achieved.

- CO3 3.2:
  o Target risk score is achieved.
  o Four business cases have been developed and are currently going through an assurance process.

- CO3 3.3:
  o Key actions to be addressed:
    • Continue to develop aligned incentive contracts with providers which will aim to reduce volatility across the system.
  o Target score has been met.

- CO3 3.4:
  o Key actions to be addressed:
    • Continue to develop aligned incentive contracts with providers which will aim to reduce volatility across the system.
  o Target score has been met.
  o System Transformation Board has been established to look at opportunities for joint savings.

d) Corporate objective 4: Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.

- CO4 4.1:
  o Target score is achieved.
  o Key actions to be carried out:
    • Agreement of SYB Clinical approval for transformation work - June 2019.
• Workshop planned for 1 August to decide on options for joint team structure with the Council.

- CO4 4.2:
  o Key actions to be addressed:
    • Development of new CCG website - March 2020
    • Implementation and recommendations of NHS long term plan.
    • Review of coversheet and report templates - October 2019
    • Annual General Meeting - 17 July 2019
    • Communications and Engagement Strategy review - December 2019

- CO4 4.3:
  o The current risk likelihood scoring has moved from 4 to 3.
  o Target score has been achieved.
  o Strategy and Organisational Development Forum at the meeting in May 2019 considered and discussed if there is a risk to ICS non-delivery. Delivery plans have been refreshed and agreed. QIPP has been embedded into these plans and tracked through provider contracts. The Transformation Board is evolving and making good progress across shared opportunities eg. outpatients. The ICS System Efficiency Board has commissioned Deloittes to develop business cases for four priority areas to target system savings. Doncaster system is working together effectively managing the risk collectively and at an organisation level.

5. Board Assurance Framework – Dashboard
   The dashboard can be viewed in Appendix 1, page 2. The outturn for quarter 1 2019-20 illustrates seven risks have achieved against their target score.

6. Deep Dives – Corporate Objectives
   The deep dive of corporate objective 1 will take place in September 2019.

7. Next Steps
   The Board Assurance Framework will continue to be reviewed by the Head of Corporate Governance and Senior Risk Owners on a quarterly basis.

   The Senior Risk Owner has requested a further review of corporate objective 2 - 2.2 to be undertaken during quarter 2.

8. Recommendations
   The Governing Body is asked:
   a) Approve the amendments to the Corporate Objectives,
   b) Approve the revised format and layout of the BAF,
   c) Approve the revisions to the high level risks,
d) Approve the measurable indicators / outcomes,
e) Note the current position and updates to the BAF,
f) Approve the removal of risk Corporate Objective 4 – 4.3 (ICS Non-Delivery).
# NHS Doncaster CCG Governing Body Assurance Framework

## Last updated: 2 July 2019

### Corporate Objectives (COs)

<table>
<thead>
<tr>
<th>CO</th>
<th>Description</th>
</tr>
</thead>
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<td>CO 4</td>
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</tr>
</tbody>
</table>

### Consequences / Impact

<table>
<thead>
<tr>
<th>Likelihood of occurrence</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Low</td>
<td>The risk appetite under which risks can be tolerated is a score of 12 or below.</td>
</tr>
<tr>
<td>4-6</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>8-12</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>15-20</td>
<td>Very High</td>
<td>Risks scored at or in excess of a score of 13 must be escalated to the Governing Body.</td>
</tr>
<tr>
<td>25</td>
<td>Extreme</td>
<td></td>
</tr>
</tbody>
</table>
**Corporate Objective**  
**High Level Risk Description**  
**Risk Consequent / Impact Assessment**  
**Risk Rating**  

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>High Level Risk Description</th>
<th>Risk Consequent / Impact Assessment</th>
<th>Risk Rating</th>
<th>Owner</th>
<th>Oversight (Committee)</th>
<th>Assurance (Committee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO1 (1.1)</td>
<td>Organisational Change - The CCG needs to have the right capacity and capability to meet current and future commissioning and to meet its statutory duties.</td>
<td>Catastrophic Year-End: Q1, Q2, Q3, Q4</td>
<td>2018-19 Q1 2019-20 Q4</td>
<td>Associate Director of HR and Corporate Services</td>
<td>Executive</td>
<td>Governing Body</td>
</tr>
<tr>
<td>CO2 (2.1)</td>
<td>Quality Impact - There is a risk to maintaining quality, services and outcomes through local transformation, financial constraints and wider determinants, eg workforce</td>
<td>Quality</td>
<td>8</td>
<td>8</td>
<td>Chief Nurse</td>
<td>Quality and Patient Safety</td>
</tr>
<tr>
<td>CO2 (2.2)</td>
<td>Quality Impact - There is a risk to maintaining quality, services and outcomes through provider financial constraints.</td>
<td>Quality</td>
<td>9</td>
<td>9</td>
<td>Director of Strategy and Delivery</td>
<td>Executive</td>
</tr>
<tr>
<td>CO2 (2.3)</td>
<td>Primary Care: Failure to commission effective, resilient and sustainable primary medical care services, the quality of care delivered to patients. The quality of care delivered to patients and the achievement of associated quality and performance targets could be adversely affected by the failure to engage and involve primary care.</td>
<td>Quality</td>
<td>9</td>
<td>9</td>
<td>Director of Strategy and Delivery</td>
<td>Primary Care Commissioning</td>
</tr>
<tr>
<td>CO2 (2.4)</td>
<td>Provider Workforce - Providers in Doncaster may not have access to a sufficiently skilled workforce, which could be detrimental to patient care.</td>
<td>Quality</td>
<td>9</td>
<td>9</td>
<td>Associate Director of HR and Corporate Services</td>
<td>Executive</td>
</tr>
<tr>
<td>CO3 (3.1)</td>
<td>Transformation - Expenditure is in excess of income and QIPP / transformation plans fail to bridge the gap resulting in the CCG not meeting its statutory financial and quality duties.</td>
<td>Quality</td>
<td>8</td>
<td>8</td>
<td>Chief Officer</td>
<td>Executive</td>
</tr>
<tr>
<td>CO3 (3.2)</td>
<td>Efficiencies - The quality and efficiency savings within the Delivery Plans are not achieved, therefore alternative commissioning arrangements including the decommissioning of services may be required.</td>
<td>Quality</td>
<td>6</td>
<td>6</td>
<td>Chief Officer</td>
<td>Executive</td>
</tr>
<tr>
<td>CO3 (3.3)</td>
<td>Control Total and System Affordability - Inability to commission efficiently, effectively and to achieve value for money if the control total is impacted is not achieved.</td>
<td>Quality</td>
<td>9</td>
<td>9</td>
<td>Chief Officer</td>
<td>Audit</td>
</tr>
<tr>
<td>CO3 (3.4)</td>
<td>Control Total - As further delegation of statutory duties and financial decision-making develops (with the DMBCC in ‘Place’ and with other CCGs in the DYMveld ICS) the CCG may agree to decisions which are considered to be in the greater good.</td>
<td>Quality</td>
<td>9</td>
<td>8</td>
<td>Chief Finance Officer</td>
<td>Audit</td>
</tr>
<tr>
<td>CO4 (4.1)</td>
<td>Collaboration - The dual areas of focus may stretch the local system leadership as resource is aligned both locally and across a wider collaborative footprint, this complexity could potentially impact upon our capacity to commission services.</td>
<td>Quality</td>
<td>6</td>
<td>6</td>
<td>Director of Strategy and Delivery</td>
<td>Executive</td>
</tr>
<tr>
<td>CO4 (4.2)</td>
<td>Engagement &amp; Prevention: Doncaster Place does not achieve the move towards tackling inequalities and move towards greater self-care prevention and patient empowerment.</td>
<td>Quality</td>
<td>8</td>
<td>8</td>
<td>Director of Strategy and Delivery</td>
<td>Executive</td>
</tr>
<tr>
<td>CO4 (4.3)</td>
<td>KIS Non-Delivery – Greater savings needed to be identified at Place level should the South Yorkshire and Bassetlaw ICS not deliver their financial targets</td>
<td>Quality</td>
<td>9</td>
<td>9</td>
<td>Chief Officer</td>
<td>Executive</td>
</tr>
</tbody>
</table>

**Governing Body Board Assurance Framework 2019-20 - Quarter 1**

The risk appetite under which risks can be tolerated is a score of 12 or below. Risks scored at or in excess of a score of 13 must be escalated to the Governing Body.
### Strategic Objective 1 - Ensure an effective, well led, and well governed organisation and its statutory obligations are met.

#### Outcomes

<table>
<thead>
<tr>
<th>Reference</th>
<th>Lead Risk</th>
<th>Risks</th>
<th>Key Controls</th>
<th>Current Controls</th>
<th>Internal and External Assurances</th>
<th>Positive Assurance</th>
<th>Gaps in control and timescale for remedial action</th>
<th>Gaps in assurance and timescale for remedial action</th>
<th>Actions to be taken</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO1 - 1.1</td>
<td>Lead</td>
<td>What could Happen and Should the Risk Materialise, What is the Impact</td>
<td>Current Risk Rating</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What controls/systems do we have in place that are operating at this level and assist in the delivery of aims and manage/mitigate risks. Where can we gain evidence that the controls / system are placing reliance on us effective internally? externally? What evidence shows we are reasonably managing our risks and our objectives are being delivered. Areas where we do not have adequate controls/systems in place or existing controls/systems are not effective. Areas where we are not receiving evidence that controls / systems are effective.</td>
<td>Target Risk Rating</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
</tr>
</tbody>
</table>

#### Risk Description:
The CCG needs to have the right capacity and capability to meet current and future commissioning and to meet its statutory obligations.

#### Risk Cause:
Organisational Development Strategy not supporting the current and future direction of the CCG. Corporate Governance structure fails to meet statutory obligations.

#### Risk Consequence:
Potentially not achieving both our local commissioning strategy and our wider collaborative commissioning commitments. Regulatory and structural risk. If we are not seen to be forward thinking and transformational within the ICS. Poor annual review from NHS E / I in relation to the Improvement Assessment Framework.

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<thead>
<tr>
<th>Reference</th>
<th>Lead Risk</th>
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**Strategic Objective 2: Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population.**

### Outcomes

**Director of Clinical Delivery**

**Risk Description:** Quality of care delivered to patients and the achievement of expected quality and performance targets.

**Risk Cause:** Deterioration in the quality of patient care and safety, leading to poor outcomes.

**Risk Consequence:** Increased mortality and morbidity.

- Reduced observance of governance requirements (1)
- Increase in delayed transfers of care.
- Reduced performance in A&E and acute services.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>End Date</th>
<th>Lead Committee / Board for delegation of actions</th>
<th>Action Taken</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-19</td>
<td>- R&amp;D perfect tools to undertake with regards to risk description, cause and consequence; during quarter 2.</td>
<td>Executive</td>
<td></td>
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</tr>
<tr>
<td>04-10-19</td>
<td>- Refresh urgent care delivery plan for 2019/20; signed off by governing Board.</td>
<td>Lay Member Lead - Andy Oakford</td>
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<tr>
<td>15.04.19</td>
<td></td>
<td>Senior Risk Owner meeting.</td>
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<tr>
<td>07-12-19</td>
<td></td>
<td>Senior Risk Owner meeting.</td>
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<tr>
<td>31.01.19</td>
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<td>Senior Risk Owner meeting.</td>
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<tr>
<td>01.07.19</td>
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<td>Senior Risk Owner meeting.</td>
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<tr>
<td>01.07-20</td>
<td></td>
<td>Lay Member Lead - Andy Oakford added.</td>
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<tr>
<td>02-10-18</td>
<td></td>
<td>Lay Member Lead - Andy Oakford added.</td>
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<tr>
<td>02-10-18</td>
<td></td>
<td>No change to risk. monitoring activities.</td>
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<tr>
<td>08-08-18</td>
<td></td>
<td>System Wide planning has commenced, awaiting comments from NHS.</td>
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### Strategic Objective 2: Commission high quality, continually improving, cost effective healthcare which meets the needs of the Doncaster population.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Date</th>
<th>Lead</th>
<th>What could happen</th>
<th>How to mitgate</th>
<th>Impact / Consequence</th>
<th>Risk Description</th>
<th>Risk Cause</th>
<th>Risk Mitigation</th>
<th>Current Controls</th>
<th>Action to be taken</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>C02 - 2.3</td>
<td></td>
<td></td>
<td>What could happen</td>
<td>Should the risk materialise, what is the impact</td>
<td>CO2 - 2.3 Lead</td>
<td>Director and responsible Director</td>
<td>1. There would be delays within primary care.</td>
<td>2. Adverse quality and risk consequence of commissioning primary care services are not met.</td>
<td>3. Risk cause is not delivered.</td>
<td>4. Current controls are unsustainable.</td>
<td>5. Risk description is not delivered.</td>
</tr>
</tbody>
</table>
### Strategic Objective 2: Commission high quality, continually improving, cost-effective healthcare which meets the needs of the Doncaster population.

#### Outcomes

<table>
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<tr>
<th>Reference</th>
<th>Risk</th>
<th>Description</th>
<th>Date Identified</th>
<th>Likely Impact</th>
<th>Initial Risk Rating</th>
<th>Current Risk Rating</th>
<th>Countermeasures</th>
</tr>
</thead>
</table>
| CO2 - 2.4 | Lead | • Doncaster Place Plan - a vision of an Accountable Care System with providers working in partnership together.  
Team Doncaster - working together to improve the economic climate in Doncaster, attract and retain new workforce, and train our own staff from within Doncaster.  
Joint Commissioning Partnership with Doncaster Council - including the Better Care Fund.  
2-year outcome-based contracts providing providers greater flexibility to innovate.  
Local Digital Roadmap (LDR) describing a vision of paper-free at the point of care by 2020 and interoperability to support better provider integration and cross-working.  
Integrated care record to support LDR.  
Partnership engagement with Health Education England and Doncaster College on provider workforce needs.  
Integrated Care Partnership reserves reports on provider workforce.  
Provider organisations have shared workforce risk assessments with the CCG and have plans in place to mitigate these risks.  
HNS Doncaster People Plan | Apr-10 5 4 3 3 9 8 | 3 3 3 3 3 8 | 12-10-18 - No change to risk. | 17-06-2019 - Senior Risk Owner review. Full review of CO2-2.5. Initial risk scoring impact amended from 4 to 5.  
17-04-19 - Place Plan under refresh. Target risk score not achieved | 28-01-2019 - Senior Risk Owner meeting. Plan is on track. Risk net scoring likelihood moved from 4 to 3. Items in red are to be removed. Items in blue are new / updated. The Joint Workforce and Education Committee will be developing the 4 workstreams: workforce strategy, education, leadership and organisational development. A joint recruitment fayre is being set up for February 2019.  
12-10-18 - No change to risk monitoring position. | 03-09-2018: Plan is on track. A joint workforce and education committee is to be implemented in Quarter 3 and a HR & OD network established in Quarter 4.  
Providers across Doncaster have commissioned expertise to bring value to the provider alliance. No current change in risk rating. |
Strategic Objective 3: Ensure that the healthcare system in Doncaster is sustainable.

**Risk Description Transformations:** Expenditure in integrated care systems (pre- QIPP) is transformational in nature. They are often unthought in terms of outcomes and operational delivery plans.

**Chief Officer:**

- Financial sustainability of the delivery of services is more likely to be achieved through the partnering model.
- Local partnerships and collaborations are taking place.

**Risk Consequence Transformations:** The CCG would not meet its statutory financial requirements. The CCG would not meet its statutory financial requirements.

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## Strategic Objective 3: Ensure that the healthcare system in Doncaster is sustainable.

### Outcomes

- **Cost effective care is being delivered:** This is possible only after the publication of the five year allocations 2019-20.
- **Commissioning for Value Decision Making framework:** This framework is going through an update and will be re-launched.
- **Standards of Business Conduct & Conflict of Interest policy:** This policy is in place.
- **CCG financial guidance:** This guidance is being reviewed and will be updated.
- **Mental Health Transformational Board:** This board is ongoing and will be continued.
- **Evaluation of CCG’s clinical commissioning contracts:** This evaluation is being done.
- **Joint Commissioning Strategy for Health and Social Care approved by Governing Body in March 2019 and delivery plans:** This strategy is being implemented.
- **Governing Body reporting of prescribing spend:** This reporting is being done.
- **Prescribing Audit:** This audit is being carried out.
- **Review of Financial Strategy being refreshed:** This review is being done.

### Risk Description: Efficiencies

- **Standards of Business Conduct & Conflict of Interest policy:** This policy is in place.
- **CCG financial guidance:** This guidance is being reviewed and will be updated.
- **Mental Health Transformational Board:** This board is ongoing and will be continued.
- **Evaluation of CCG’s clinical commissioning contracts:** This evaluation is being done.
- **Joint Commissioning Strategy for Health and Social Care approved by Governing Body in March 2019 and delivery plans:** This strategy is being implemented.
- **Governing Body reporting of prescribing spend:** This reporting is being done.
- **Prescribing Audit:** This audit is being carried out.
- **Review of Financial Strategy being refreshed:** This review is being done.

### Risk Cause: The CCG won’t achieve delivery against the identified schemes.

- **Prescribing spend:** This spend is being monitored.
- **Review of Financial Strategy:** This review is being done.
- **Joint Commissioning Strategy for Health and Social Care approved by Governing Body in March 2019 and delivery plans:** This strategy is being implemented.
- **Governing Body reporting of prescribing spend:** This reporting is being done.
- **Prescribing Audit:** This audit is being carried out.
- **Review of Financial Strategy:** This review is being done.

### Risk Consequence: Breach of law means that statutory requirements, increase QIPP to deliver more savings.

### Action Plan

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<th>Action</th>
<th>Lead Committee/Board for delegation of Actions</th>
<th>Progress Against Actions</th>
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<td><strong>Financial Strategy being re-launched:</strong> After the publication of the five year allocations 2019-20.</td>
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<td><strong>Prescribing Framework - a continuous risk-based process, plan to NHSE. ** Implementation framework Guidance review and submission of operating framework to NHSE.</strong></td>
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</table>
### Strategic Objective 3: Ensure that the healthcare system in Doncaster is sustainable.

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<th>Risk Description: Control total and System Affordability: statutory duties not being undertaken.</th>
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<tbody>
<tr>
<td>Risk Cause: The CCG will be unable to ensure the statutory duties in commissioning efficient, effective and value for money health care services.</td>
</tr>
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<td>Risk Consequence: The CCG would be in breach of the statutory duties to commission efficient, effective and value for money health care services. This would lead to increasingly limited financial resources which may require the CCG to undertake greater prioritisation to meet the needs of the population.</td>
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<tr>
<th>Reference</th>
<th>Action End Date</th>
<th>Lead Committee/Board for delegation of Actions</th>
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<td><strong>CO3 - 3.3 Lead</strong></td>
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<td>What could Happen and Should the Risk Materialise, What is the Impact</td>
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<tr>
<td>ii) Delivery of Place Plan with partners in the Commissioning &amp; Contracting function</td>
<td></td>
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<tr>
<td>iii) Achieve a risk of deviating from the Place Plan or the ICS, resulting in 'Place' and with other CCGs developing (with the DMBC in the Sturdiway ICS) the statutory duties to achieve value for money if the controls / systems we are placing in place are not effective.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>What controls/systems do we have in place that are operating at this level and assist in the delivery of aims and manage / mitigate risks.</td>
<td></td>
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<tr>
<td>Where can we gain evidence that the controls / systems are placing reliance on are effective internally / externally?</td>
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<tr>
<td>What evidence shows we are reasonably managing our risks and our objectives are being delivered</td>
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<tr>
<td>Areas where we do not have adequate controls / systems in place or existing controls / systems are not effective</td>
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<td></td>
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<tr>
<td>Areas where we are not receiving evidence that controls / systems are effective</td>
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<tr>
<td>Actions to be taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and Name of Committee or Board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal and External Assurances</td>
<td>Positive Assurance</td>
<td>Gaps in control and timescale for remedial action</td>
<td>Gaps in assurance and timescale for remedial action</td>
</tr>
<tr>
<td>Collaborative Partnership Board minutes.</td>
<td></td>
<td></td>
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<tr>
<td>NHS England operational plan submission.</td>
<td></td>
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<td>Lowering the risk has been agreed in the 12 organisation total has been agreed in the 12 organisation total. In the Bassetlaw footprint to develop a Shared Care System - April 2018.</td>
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<td>• Operational planning templates 2019-20 submitted to NHS England alongside a planning overview setting out plans to deliver agreed activity instructions, standards and targets and financial affordability.</td>
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<td>• Commissioning for Value Decision Making Framework.</td>
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<td>• Working together Partnership Board - collaborative decision making on Hyper Acute Stroke Units services and Children’s Surgery &amp; Anaesthesia and Hospital Services Review Place Plan State of Readiness Report and recommended next steps.</td>
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<td>• South Yorkshire &amp; Bassetlaw ICS Mindset Understanding (MU).</td>
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<td>• Commissioning legal agreement between Local Authority and CCG (1 April 2019) 31 March 2020.</td>
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<tr>
<td>• Assurance of external assurance where finance is a significant element.</td>
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<td>• Joint Commissioning for Strategy for Health and Social Care Local Authority and CCG.</td>
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Risk Description: Control total: If we do not meet our CCG statutory control total due to the impact of external controls on CCG allocations and/or the impact of unplanned in-year pressure costs, then we will be unable to commission effectively, efficiently and to achieve the value for money.
This will lead to increasingly limited financial resource which may require the CCG to make increasingly greater good. This may result in a risk of being in breach of the statutory duties to commission efficient and/or the impact of unpredicted in-year pressure costs, then we will be unable to commission effectively, efficiently and to achieve the value for money.

Risk Consequence: Financial Strategy refreshed after the publication of the five year allocation 2018 - 24
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Finance report to Governing Body on a monthly basis
Meeting of Financial Instructions, Standing Orders, Scheme of Delegation
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Joint Commissioning Strategy for Health and Social Care (Local Authority and CCG)
Detailed action plan to the achievement of the CCG's financial plan.
• Governance and Finance Sustainability Self-Assessment report to those charged with governance. This will lead to increasingly limited financial resource which may require the CCG to undertake greater duties to commission efficient, effective and to achieve the value for money.
### Strategic Objective 4: Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.

#### Outcomes

**E1.** Improvement in health and care outcomes as a result of the ICS delivery of its objectives.

**E2.** Achieve all or improve upon the ICS delivery of its objectives.

**E3.** Achieve and sustain the integrated Commissioning and Social Care Strategy.

#### Risk Description: Joint working focus. We have real areas of potential commissioning focus - our local focus on Doncaster as a place delivering the ambitions described in the Doncaster Place Plan, and our collaborative commissioning commitments within areas such as the South Yorkshire & Bassetlaw Sustainability & Transformation Plan. If these areas of focus draw on our local system leadership as CSSG as resource is aligned both locally and across a wider collaborative footprint, this footprint should potentially impact upon our capacity in commissioning.

**Risk Cause:** Breakdown of Governance agreements and conflicting objectives across joint commissioning.

**Risk Consequence:** Competencies within the commissioning cycle and prioritising with providers. Reduction in quality and financial sustainability.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Risk Description</th>
<th>Risk Cause</th>
<th>Risk Consequence</th>
<th>Director of Strategy &amp; Delivery</th>
<th>Action End Details</th>
<th>Lead Committee/Board for delegation of Actions</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO4 - 4.1</td>
<td>• Gooding Body approval for establishment of Joint Committees, and the level of delegation to joint committees.</td>
<td>• Governing Body minutes.</td>
<td>• Governing Body support of ICS Plan.</td>
<td>April-19</td>
<td>3 3 3 3</td>
<td>Committee for Joint Commissioning and Social Care Strategy</td>
<td>06-08-2019 - the plan is on track.</td>
</tr>
<tr>
<td></td>
<td>• CS approval for the level of delegation to joint committees</td>
<td>• Collaborative Partnership Board minutes.</td>
<td>• Collaboration of Joint Commissioning Strategy and Delivery.</td>
<td></td>
<td></td>
<td></td>
<td>04-03-19 - Audit Committee deep dive - the plan is on track.</td>
</tr>
<tr>
<td></td>
<td>• Doncaster Integrated Care Partnership Board (Doncaster Place Plan) - represented on collaborative partnership by Chair &amp; Chief Officer and Director of Strategy and Delivery.</td>
<td>• Development of Joint Reporting mechanisms for June 2019.</td>
<td>• Joint Commissioning Agreement at Governing Body in March 2019.</td>
<td></td>
<td></td>
<td></td>
<td>13-04-19 - DCCS-Governing Body and Council Executive approval of Joint Health &amp; Social Care Commission Strategy with Delivery.</td>
</tr>
<tr>
<td></td>
<td>• Joint commissioning across Team Doncaster representation.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<td></td>
<td>• Section 75 agreement with Doncaster Council (BCP).</td>
<td>• Joint Communication across media and organisations.</td>
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<td></td>
<td>• Commissioning agreement with Doncaster Council and Joint Commissioning Management Board.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<tr>
<td></td>
<td>• Colleague Engagement Group (CEG) &amp; Staff Briefs - involving staff in readiness for the future.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<tr>
<td></td>
<td>• Admission of Understanding (MOU) for Continuing Health hosting arrangements to NHS Doncaster CCG.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<tr>
<td></td>
<td>• Standards of Business Contact &amp; Conflict of Interest Policy 2018 including business case and procurement requirements.</td>
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<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<td></td>
<td>• Chief Officer representation on JCCCG and CCG Programme Boards.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<td></td>
<td>• Individual representative on ICS workstreams.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
</tr>
<tr>
<td></td>
<td>• Finance Officer, Director of Strategy and Delivery, and Chief Nurse representation on System Efficiency Board.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
</tr>
<tr>
<td></td>
<td>• Chair representation on ICS Governance Group.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<td></td>
<td>• Lay Member input into future ICS workshops.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
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<tr>
<td></td>
<td>• Lay Member for Patient and Public Involvement in a member of ICS.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
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<td>• Joint Communication across media and organisations.</td>
</tr>
<tr>
<td></td>
<td>• Chief officer and Director of Strategy and Delivery representation on JCCCG Sub Group.</td>
<td>• Joint Communication across media and organisations.</td>
<td>• Joint Communication across media and organisations.</td>
<td></td>
<td></td>
<td></td>
<td>• Joint Communication across media and organisations.</td>
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</tbody>
</table>

#### Strategic Actions

1. **CO4 - 4.1 Lead**

   - **Date Identified:** March 2019
   - **Total Risk Rating:** 3
   - **Likely Target Risk Rating:** 1
   - **What could Happen:** Risks Current Controls

<table>
<thead>
<tr>
<th>Date Identified</th>
<th>Total</th>
<th>Likely Target Risk Rating</th>
<th>What could Happen</th>
<th>Risks Current Controls</th>
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</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>3</td>
<td>1</td>
<td></td>
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</tbody>
</table>

#### Actions to be taken

- GB approval for the level of delegation to joint committees.
- Doncaster Integrated Care Partnership Board (Doncaster Place Plan) - represented on collaborative partnership by Chair & Chief Officer and Director of Strategy and Delivery.
- Joint commissioning across Team Doncaster representation.
- Section 75 agreement with Doncaster Council (BCP).
- Commissioning agreement with Doncaster Council and Joint Commissioning Management Board.
- Colleague Engagement Group (CEG) & Staff Briefs - involving staff in readiness for the future.
- Admission of Understanding (MOU) for Continuing Health hosting arrangements to NHS Doncaster CCG.
- Standards of Business Contact & Conflict of Interest Policy 2018 including business case and procurement requirements.
- Chief Officer representation on JCCCG and CCG Programme Boards.
- Individual representative on ICS workstreams.
- Finance Officer, Director of Strategy and Delivery, and Chief Nurse representation on System Efficiency Board.
- Chair representation on ICS Governance Group.
- Lay Member input into future ICS workshops.
- Lay Member for Patient and Public Involvement in a member of ICS.
- Chief officer and Director of Strategy and Delivery representation on JCCCG Sub Group.
Outcomes
- Communication, Engagement & Experience Strategy - Doncaster CCG and Doncaster Council collaboration on the ICS Plan. The qualitative dashboard has been developed.
- Intranet - the CCG has launched a brand new staff intranet to assist in the delivery of aims and objectives.
- CCG staff intranet.
- Joint health and social care commissioning strategy - Doncaster CCG and Doncaster Council effectively engaged with almost 800 people to gain their views on planning services together. Strategy published in April 2019 - CCG IAF Patient and Public Engagement Assessment 2018-19 was scored on 8 April 2020 where the CCG demonstrated that engagement activity had been extended effectively engaged with almost 800 people to gain their views on planning services together. Strategy published in April 2019.
- Communication, Engagement & Experience Strategy - Doncaster CCG and Doncaster Council effectively engaged with almost 800 people to gain their views on planning services together. Strategy published in April 2019.
- CCG staff intranet.
- Revised Experience and Engagement Strategy.
- Engagement & Experience Committee.
- Overview of EEC.
- Revised Experience and Engagement Strategy.
- Fully developed and refreshed for 2018-19.
- Leadership team involvement.
- Engagement with the public on the engagement strategy to EEC - May 2019.
- Gender and Boyd approval of E&D Strategy.
- Annual General Meeting - October 2019.
- Outcome monitoring report on the risk of the changes to experience and engagement strategy - February 2019.
- Outcome monitoring report on the impact of the Engagement Improvement Framework.
- The qualitative dashboard has been developed.
- Intranet - the CCG has launched a brand new staff intranet to assist in the delivery of aims and objectives.
- CCG staff intranet.
- Joint health and social care commissioning strategy - Doncaster CCG and Doncaster Council effectively engaged with almost 800 people to gain their views on planning services together. Strategy published in April 2019.
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- Engagement & Experience Committee.
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- Leadership team involvement.
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- Gender and Boyd approval of E&D Strategy.
- Annual General Meeting - October 2019.
- Outcome monitoring report on the risk of the changes to experience and engagement strategy - February 2019.
- Outcome monitoring report on the impact of the Engagement Improvement Framework.
- The qualitative dashboard has been developed.
### Outcomes

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Actions Taken</th>
<th>Lead Committee/Board for delegation of Actions</th>
<th>Progress Against Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4: Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Risk Description
- ICS non-delivery if the South Yorkshire & Bassetlaw Integrated Care System Plan does not deliver the expected savings. Greater savings will need to be identified at a Place level, and we may not be able to commission all the services which we have identified that our population needs.

#### Risk Cause
- Organisations not achieving individual cost saving plan and therefore not meeting control targets.

#### Risk Consequence
- The South Yorkshire and Bassetlaw system control target will not be achieved. This may impact on the ability to access capital funds and further system investment. There may be an expectation that other STB organisations are asked to provide financial support.

---

#### Current Controls

<table>
<thead>
<tr>
<th>What can we do to have in place that are operating at this level and assist in the delivery of aims and manage/mitigate risks.</th>
<th>Where can we gather evidence that the controls/systems are being placed reliance on are effective internally/externally?</th>
<th>What evidence shows we are reasonably managing our risks and our objectives are being delivered.</th>
</tr>
</thead>
</table>

### Strategic Objective 4: Work collaboratively with partners to improve health, care and reduce inequalities in well governed and accountable partnerships.

#### Action Plan

<table>
<thead>
<tr>
<th>Action</th>
<th>Action End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01.2019 - Senior Risk Owner Meeting.</td>
<td></td>
</tr>
<tr>
<td>2019 - ICSIQ, DBTHFT and CCG.</td>
<td></td>
</tr>
</tbody>
</table>

---

#### Control and Assurance

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Risk Cause</th>
<th>Risk Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS non-delivery if the South Yorkshire &amp; Bassetlaw Integrated Care System Plan does not deliver the expected savings. Greater savings will need to be identified at a Place level, and we may not be able to commission all the services which we have identified that our population needs.</td>
<td>Organisations not achieving individual cost saving plan and therefore not meeting control targets.</td>
<td>The South Yorkshire and Bassetlaw system control target will not be achieved. This may impact on the ability to access capital funds and further system investment. There may be an expectation that other STB organisations are asked to provide financial support.</td>
</tr>
</tbody>
</table>
The purpose of the report is to provide assurance to the Governing Body on all corporate matters. The key points from this report to which the organisation’s attention is particularly drawn are:

- **Board Assurance Framework (BAF):** The Head of Corporate Governance has met with each Senior Risk Owner during Quarter 1. The Audit Committee received the BAF at its meeting on 11 July 2019 for consideration and discussed the new layout, the updated corporate objectives, high level risks, measurable indicators and the updates to all the risks with the exception of CO2 – 2.2.

  A full review of the corporate objectives, high level risks and measurable indicators / outcomes was undertaken at Strategy and Organisational Development Forum in May 2019.

- **Risk Register:** At the end of Quarter 1, there were sixteen risks on the risk register, three risks being rated as very high.

- **Incident Reporting:** There were eight internal IG breaches which originated at Doncaster CCG.

- **External assessments:**
  Internal Audit presented a Progress Report and Charter to the Audit Committee on 11 July 2019. Work is in progress with audits on: Governance and Risk Management, and Policy Monitoring.

  External Audit: The Annual Audit Letter 2018/19 was presented to Audit Committee on 11 July 2019. An unqualified audit opinion on the accounts on 24 May 2019 was issued. There were no unadjusted audit differences and no significant matters which were required to report to those charged with governance.

- **Corporate Governance:** A new model CCG Constitution is to be presented to Governing Body for approval at its meeting on 1 August 2019.
• **Health & Safety, Fire and Security:** The competent person for Health & Safety at the CCG has confirmed that the CCG is in compliance with legislation.

• **Information Governance:** Our Privacy Notice was last updated in November 2018 in line with GDPR requirements and has been published on our website. Our 2018/19 Data Security and Protection Toolkit was published as: Standards Met. The Information Governance workplan is being implemented. Training compliance is 96% (target is 95%).

• **Equality and Diversity:**
The annual report will be presented to Engagement and Experience Committee in the first quarter of 2020. The Corporate Governance Manager will be presenting an update to Engagement and Experience Committee in September 2019.

The full report can be reviewed in Appendix 1.

**Recommendation(s)**

The Governing Body is asked to note the Corporate Assurance Report, quarter 1, 2019/20.

**Report Exempt from Public Disclosure**

Yes ☐ No [x]

If yes, detail grounds for exemption:

**Impact analysis**

<table>
<thead>
<tr>
<th>Impact Analysis</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality impact</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td></td>
</tr>
<tr>
<td>An Equality Impact Analysis/Assessment is not required for this report.</td>
<td>X</td>
</tr>
<tr>
<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
<td></td>
</tr>
<tr>
<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>None Identified</td>
</tr>
<tr>
<td><strong>Consultation /</strong></td>
<td></td>
</tr>
<tr>
<td>Engagement (internal departments, clinical, stakeholder &amp; public/patient)</td>
<td>None</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Report previously presented at</td>
<td>None</td>
</tr>
<tr>
<td>Risk analysis</td>
<td>None</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>CO1 – 1.1</td>
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</table>
CORPORATE ASSURANCE REPORT

Quarter 1
2019/20
(1 April – 30 June 2019)
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Sub-Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Section 1</strong> Risk Management</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>1.1. Assurance Framework</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>1.2. Risk Register</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>1.3. Internal Incident Reporting</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>1.4. Claims &amp; Legal Issues</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>Section 2</strong> External Assessments</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td><strong>Section 3</strong> Committee Activity</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Section 4</strong> Corporate Governance</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>4.1. Constitution &amp; Establishment</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>4.2. Standards of Business Conduct / Conflicts of Interest</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>4.3. Governance Structure</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>4.4. Statutory roles</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>4.5. Procedural Document Management</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>4.6. Health &amp; Safety, Fire Safety &amp; Security</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>4.7. Emergency Resilience &amp; Business Continuity</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>4.8. Sustainability</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>4.9. Complaints Management</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>4.10. Counter Fraud</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>4.11. Whistleblowing</td>
<td></td>
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</tr>
<tr>
<td><strong>Section 5</strong> Information Governance</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>5.1. The protection and use of personal confidential data</td>
<td></td>
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<tr>
<td>5.2. Information Governance Toolkit</td>
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<tr>
<td>5.3. Information Governance Workplan</td>
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</tr>
<tr>
<td>5.4. Freedom of Information Act Requests</td>
<td></td>
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</tr>
<tr>
<td>5.5. Subject Access Requests</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td><strong>Section 6</strong> Organisational Development &amp; Staffing Governance</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>6.1. Organisational Development</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>6.2. Workforce Structure</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>6.3. Workforce Breakdown</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>6.4. Mandatory &amp; Statutory Training</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>6.5. Workforce Capacity</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td><strong>Section 7</strong> Equality and Diversity</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>7.1. Strategy</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>7.2. Equality and Delivery System 3</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>7.3. Annual Report</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>7.4. Training</td>
<td></td>
<td>28</td>
</tr>
</tbody>
</table>
Executive Summary

The key points from this report to which the organisation’s attention is particularly drawn are:

- **Board Assurance Framework (BAF):** The Head of Corporate Governance has met with each Senior Risk Owner during Quarter 1. The Audit Committee received the BAF at its meeting on 11 July 2019 for consideration and discussed the new layout, the updated corporate objectives, high level risks, measurable indicators and the updates to all the risks with the exception of CO2 – 2.2.

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- **Equality and Diversity:**
  
  The annual report will be presented to Engagement and Experience Committee in the first quarter of 2020. The Corporate Governance Manager will be presenting an update to Engagement and Experience Committee in September 2019.
1.1. Assurance Framework

**Board Assurance Framework (BAF):**
The BAF captures risks to the achievement of our strategic corporate objectives. The Audit Committee received the BAF at its meeting on 11 July 2019 for consideration and discussed the new layout, the updated corporate objectives, high level risks, measurable indicators and the updates to all the risks with the exception of CO2 – 2.2.

A full review of the corporate objectives, high level risks and measurable indicators / outcomes was undertaken at Strategy and Organisational Development Forum in May 2019. Meetings with Senior Risk Owners have taken place at the end of June / beginning of July.

The key highlights are:
- A full review of the BAF has been undertaken by Senior Risk Owners.
- Measurable indicators / outcomes have been added to the BAF.
- High level risk description, full risk descriptions, causes and consequences have been updated throughout.
- Initial, current and target scoring reviewed.
- Controls, assurances, gaps, actions and progress have been updated.
- Corporate objective 4 – 4.3 has been recommended by Audit Committee to be removed from the BAF. This is due to the risk being: Integrated Care System non-delivery. The removal of this risk was discussed at the Strategy and Organisational Development Forum in May 2019.

As at 23 July 2019 the BAF shows:

<table>
<thead>
<tr>
<th>Risk treatment</th>
<th>Start of year</th>
<th>End of Q1</th>
<th>End of Q2</th>
<th>End of Q3</th>
<th>End of Q4</th>
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<tbody>
<tr>
<td>Tolerate</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat</td>
<td>6</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk rating</th>
<th>Start of year</th>
<th>End of Q1</th>
<th>End of Q2</th>
<th>End of Q3</th>
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<tr>
<td>4 to 6</td>
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<td>8 to 12</td>
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</tbody>
</table>

| TOTAL     |             | 12            | 12        | 12        | 12        | 12        |

A separate report on the BAF is to be presented to the Governing Body at its meeting on 1 August, to approve the revised corporate objectives, high level risk descriptors and the format.
1.2. Risk Register

At the end of Quarter 1 2019/20 there were sixteen risks on the risk register. Eight risks are deemed as high and have action plans to treat the risk. The three very high risks are:

- Non-achievement of Cancer 62 day target, posing a potential risk to the timely treatment of Doncaster patients.
- More patients are waiting longer for planned treatment (Referral to Treatment 92% / waiting list size increasing).
- The contract for the collection and delivery of sharps bins to patients in their own home expired resulting in a gap of service for the CCG.

Two risks were removed during Q1:

- CO3-SD017 (there is a potential impact on reporting figures for Delayed Transfers of Care under national requirements that may result in a negative CCG position due to the increased effectiveness and accuracy of reporting):
  Risk mitigation - the reporting is now in line with guidance. A Task and Finish Group reviewed the re-published guidance and assessed the gaps in reporting. The recommended changes to reporting to match the guidance were agreed by the System Resilience Group and went live 1 April 2019.

- CO4-SD015 (Joint collaborative commissioning arrangements could potentially impact adversely on our local financial and contracting position in respect of Hyper Acute Stroke Unit (HASU) and Children’s Surgery and Anaesthesia).
  Risk mitigation - contracting financial implications of these cases is now included in the 2019/20 plans. The HASU service change is now at implementation stage and all risks have been dealt with from a finance and contracting perspective.

<table>
<thead>
<tr>
<th>Risk treatment</th>
<th>2018/19</th>
<th>End of Q4 18/19</th>
<th>End of Q1</th>
<th>End of Q2</th>
<th>End of Q3</th>
<th>End of Q4</th>
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<tr>
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<th>End of Q4 18/19</th>
<th>End of Q1</th>
<th>End of Q2</th>
<th>End of Q3</th>
<th>End of Q4</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>4 to 6</td>
<td>Medium</td>
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<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 to 12</td>
<td>High</td>
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<td></td>
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<tr>
<td>15 to 20</td>
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<td>3</td>
<td>3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Extreme</td>
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<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>19</td>
<td>16</td>
<td></td>
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</tr>
</tbody>
</table>
There have been twenty three incidents reported in Q1, eight of which originated from DCCG, all were internal IG breaches. It should be noted that there were nine internal IG breaches reported in Q1 2018/19.

Of the eight internal incidents the two key themes to note are:

- Email information Governance breaches
- Letters sent to incorrect address

Please see below for further details.
The first incident related to an issue with the enquiries form on the internet. The complaints team were not receiving these enquiries. Action – RDaSH IT services checked and amended the link to the complaints inbox.

The second related to an email that was sent to a NHS email address but the wrong recipient. The confusion occurred because both NHS staff members had the same name. Action – The email was immediately recalled and the GP Practice where the information originated was informed of the breach.

The third incident reported involved patient identifiable information details being sent from the CCG to a non-secure email address. The information was sent from DCCG to another CCG and was sent to the appropriate staff member. Action – The Business Support Officer requested that the staff member at the receiving CCG provide a NHS net secure email address to use in the future.

The fourth incident occurred when a letter containing patient identifiable information was opened by a staff member who didn’t require this to carry out their role. Action – the employee was reminded not to open post. All letters must be given to the appropriate addressee and if post is not addressed to specific staff it should be handed to the Information Governance Manager to open.

The fifth incident involved an appointment letter which was posted to a patient’s previous address rather than the care home where they were now residing. The letter did not contain details of care received. Action – investigator given assurance that the letter was addressed to ‘Person in Charge’ therefore should not have been opened by other 3rd parties. Care Home address recorded on Systmone and apologies of the mistake given to the family.

The sixth incident reported involved an email for an investigation around a patients care being sent to an email group which involved a person who was not involved in the case. The email was immediately recalled. It had been received by a trusted NHS staff member and sent via secure nhs.net address. Action – A reminder to all staff to ensure correct email addressed to be included in the next IG bulletin.

The seventh incident involved a letter being posted to the patient’s previous address rather than the new address where they were now resi...
residing. The letter was an invitation to an assessment but did not contain details of care received. Action – new address recorded on Systmone and apologies of the mistake given to the family.

The eight incident involved information being sent to a solicitor when they no longer had the authority to act. The solicitor had acted on behalf of the appellant previously therefore all the information detailed in the letter was already known to them. Action – The solicitor confirmed through email that they were no longer acting and sent the documents to the appellant. They provided clarity that they would destroyed all copies of the documents or return to us.

After investigation by the Corporate Governance Manager, it was not necessary to report the incidents externally to the Information Commissioners Office.

<table>
<thead>
<tr>
<th>Category</th>
<th>End of Q4 18/19</th>
<th>2019/20</th>
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</thead>
<tbody>
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<td>End of Q1</td>
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<tr>
<td>Accident / Injury</td>
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<tr>
<td>Disruptive or Violent behaviour / Assault</td>
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<tr>
<td>Estates / Facilities / Security / Health &amp; Safety</td>
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<td>Patient Safety</td>
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</table>

<table>
<thead>
<tr>
<th>Score</th>
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<td>8 to 12</td>
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<td>15 to 20</td>
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<td>25</td>
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<tr>
<td><strong>TOTAL</strong></td>
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<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
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</tr>
</tbody>
</table>

1.4. Claims & Legal issues

Insurance to the CCG is commissioned from NHS Resolution (Formerly NHS Litigation Authority - April 2017). There have been no claims and legal issues.
Section 2 – External Assessments

The following external assessment / inspection reports have been received in the last Quarter.

| Internal Audit | Completed Audit Reports: None to report. |
| Internal Audit Charter: The internal audit charter was reviewed by the Audit Committee at its meeting on 11 July 2019. |
| Internal Audits: Internal audits for governance and risk management, and policy monitoring are in progress and will be reported to Audit Committee in September 2019. |
| The Terms of Reference for the Head of Internal Audit Opinion have been issued, which will test the effectiveness of strategic risk management, leadership and committee governance. |
| Counter Fraud: The 2018/19 Counter Fraud, Bribery and Corruption Annual Report was presented to the Audit Committee on 11 July 2019. The Annual Self Review Tool was submitted to the NHS Counter Fraud Authority by 30 April 2019. The CFS supported the CCG in the recovery of an overpayment amounting to over £92,000. |
| A conflicts of interest test was undertaken to ensure the CCG were compliant with declarations of interest. |
| Actions for 2019/20 are: |
| • Corporate Risk Register to include counter fraud, |
| • Conflicts of interest to be tested as part of the national procurement proactive exercise during 2019. |

| External Audit | The Annual Audit Letter 2018/19 was presented to Audit Committee on 11 July 2019. The fee for 2018/19 was £36,370 excluding VAT. An unqualified audit opinion on the accounts on 24 May 2019 was issued. There were no unadjusted audit differences and no significant matters which were required to report to those charged with governance. |
| The estimated fee will be £10,000. |
| KPMG presented a report on key changes related to: |
| • Creating a culture of excellence in healthcare |
| • Department of Health and Social Care Group Accounting Manual |
2019 to 2020.
- Commissioning for Quality and Improvement 2019/20 Guidance.

<table>
<thead>
<tr>
<th>Service Auditor Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Business Services (Financial Accounting Services):</strong> Nothing to report this quarter.</td>
</tr>
<tr>
<td><strong>Business Services Authority (Prescribing):</strong> Nothing to report this quarter.</td>
</tr>
<tr>
<td><strong>Electronic Staff Record:</strong> Nothing to report this quarter.</td>
</tr>
</tbody>
</table>
## Section 3 – Committee Activity

| **Audit Committee** | At the meeting held in May 2019, the Committee noted the following reports:  
| | • External Audit Technical report / progress report.  
| | • Annual Governance Report (ISA260) – positive report, no control recommendations.  
| | • Internal audit progress report – All audit assignments for 2018/19 have been completed and reported. Four recommendations have been marked as implemented since the last Audit Committee and one has been marked as superseded. All Key Performance Indicators were met in 2018/19.  
| | • Annual Internal Audit Report and Head of Internal Opinion - significant assurance opinion has been issued overall.  
| | • A brief overview of the Finance exception reports.  
| | • Risk Register Annual Report.  
| | • Annual Probity Register Report.  
| | • Audit Committee Annual Report from the Chair 2018/19. |
| **Remuneration Committee** | • Review of on-call allowance and an annual review to be presented to the Committee.  
| | • Annual review of remuneration, terms and conditions of employment for non-agenda for change staff. |
| **Quality & Patient Safety Committee** | At the meeting held in June 2019 the Committee discussed the following:  
| | • the Continuing Healthcare Team (CHC) continues to meet the national requirements in regards to performance. There has been a significant improvement in outstanding reviews.  
| | • Quality Report - a detailed report was provided around the number of care homes requiring support. There are no care homes that are currently under embargo and on-going work is being undertaken with the support of RDaSH.  
| | • Deprivation of Liberty report.  
| | • Care Quality Commission (CQC) inspection undertaken at DBFTH 'requires improvement'. The Trust developed an immediate action plan to address the concerns raised within the report.  
| | • An overarching improvement plan is in place for Maternity Services. Assurances around the progress of improvement plans within the services will be obtained.  
| | • There is a steady improvement in incidents in 2019 with DBFTH still being below their target. The Trust is working with care groups to improve the reporting of all incidents and to ensure the reduction in the number of serious incidents.  
| | • Work between DBTHFT and Doncaster CCG to review the approach to follow up care which should see a reduction in the number of outpatient follow ups needed. Healthwatch are also working with... |
patients on this.

- **Ophthalmology** – the Serious Incident (SI) report has identified a number of ophthalmology incidents that have come through. The Trust is working to seek additional assurance.
- **Waiting times for children accessing RDaSH services.** The CCG continue to work with the Trust around this issues and possible models to improve performance.
- **Medicines Management Report.**
- **CCG and Primary Care Doncaster (PCD) to support the on-going and specific training needs of General Practice Nurses across the area.**
- **Wound care service is due to commence on 1 October 2019.**
- **Premier Care Direct (Renal Transport Services) regular meetings continue to take place around the improvement plan.**
- **Yorkshire Ambulance Service (YAS) has secured the contract for the new 111 contract.**
- **Integrated Personalised Commissioning report.**
- **Quarter 3 - Safeguarding Children and Adults and Safeguarding Adults Board Performance Report. No concerns raised.**
- **Patient Experience report.**
- **Corporate Risk Register. No new risks to escalate.**

**Engagement & Experience Committee**

Meetings were held in April, May and June 2019 with the following noted:

- **Engagement around the 100 day rapid improvement and Missed Appointments agenda.**
- **Missed Appointments work discussed. Full audit report is available on the Doncaster Healthwatch website.**
- **The 100 day work patient information leaflet to signpost Ophthalmology patients to services.**
- **The spinal 100 day programme has co-developed a patient leaflet, to gain their feedback from patients.**
- **Information has been made available regarding the 100 Day Rapid Improvement. Leaflets produced will reflect back to patients to show how their input has been used.**
- **Received a report on the Primary care covering the period August 18 to end May 19.**
- **The ‘trailblazer’ status given to Doncaster means we can coordinate new MH support teams based near schools. There will also be funding to train senior MH leads in schools and colleges working towards a whole-school approach to well-being.**
- **Complaints report.**
- **The live Social Media Analysis Dashboard was shared with the Committee members.**
- **Received Equality Report Gap Analysis for Ambulatory Care, Geographical Areas of Doncaster, Population Health Management.**
- **The Healthwatch update report was received.**
- **The 360 report was presented to the group highlighting, improved engagement with GP practices and the staff directory.**
### Executive Committee

Two meetings were held in Quarter 1 at which the Committee:
- Considered the outcomes of the Follow-Up Appointment Programme, aimed to reduce follow-up appointments within defined guidelines and protocols. An Outpatient Follow-Up Policy was proposed. The work will be monitored and reported through Finance, Performance and Intelligence Group and Contracting Boards.
- Contract agreed with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for 2019/20, to support the delivery of Referral to Treatment waiting times. The investment will focus on the priority areas of critical care, audiology, pathology, paediatric assessment and other healthcare resource groups.
- Improving Access to Psychological Therapies (IAPT) investment of workforce was approved to achieve the 2020/21 prevalence target.
- Care Home Fees for the cost of care approach and the fee methodology were approved.
- The initiation of the procurement process for the Ophthalmology Community Services and the extension to the current contracting arrangements were approved.
- Funding was approved for NTproBNP testing following a trial for GP access to N-terminal pro-B-type natriuretic peptide which helps patients with suspected heart failure and improves clinical outcomes.
- Draft Annual Report and Governance Statement was reviewed.
- QIPP Performance was reported as over-achieved at 117%.
- Workforce sickness absence rate has decreased. A staff survey action plan has been prepared. The People and Organisational Development Strategy to under review.
- Complex Care Home Provision to be separated into two contracts, one for complex physical needs and the other for learning disability / autism spectrum disorder. A framework to procure and a current contract extension to 31 March 2020 were approved.
- Discharge to Assessment Beds current contract with various care homes for block booked nursing and nursing dementia beds approved to extend the current contract for 12 months to enable procurement models to be explored.
- TARGET Evaluation Report was considered and noted sessions are well attended between 12.00 – 4.00pm.
- Flu Vaccination Programme 2019/20 was considered and the A&E Delivery Board will deliver the programme.
- Risk Register Annual Report was reviewed.
- Organisational Health and Safety Risk Assessment was reviewed.

### Primary Care Commissioning Committee

Two meetings were held during Quarter 1 at which the Committee:
- Reviewed the Primary Care Estates Strategy.
- Noted Safeguarding training had been well attended at TARGET sessions and a training needs analysis for practice nurses to be presented at the next committee.
- Agreed to receive quarterly TARGET reports and the implementation of claw-back of funding for practices who do not attend TARGET sessions.
- Noted five recent inspections of GP practices by the Care Quality Commission were rated as good.
- Noted 14 GP practices require an improvement plan for proactive care, which is being supported by the Quality Team.
- Reviewed the Primary Care Delivery Plan Reporting Mechanism, which provides quality outcomes, financial efficiencies and QIPP.
- Reviewed the GP Contract Reform guidance and agreed to ensure GMS, PMS and AOMS practices are treated equitably, no local supplementary services would be included in the network contract DES, process put in place for identifying and reimbursing additional workforce roles and ensure access requirements are met.
- Reviewed the Extended Access Six Month Evaluation of the following areas: digital, inequalities, effective access to wider whole system services, quality assurance, advertising and ease of access, capacity, timing of appointments and measurement of appointment activity.
- Reviewed the report on prostate cancer and agreed the Local Enhanced Service for patients with a cancer diagnosis, LES remain as a Tier 1 service, the payment should be adjusted for the removal of a face to face assessment.
- Reviewed Quarter 4 2018/19 Finance and Contracting report.
- Agreed to support the practice merger of Dr Sheikh’s practice with the Ransome Practice, which will bring a wider range of services for patients and the ability to offer an increase number of appointment and continuity of care.

<table>
<thead>
<tr>
<th>Joint Commissioning Management Board</th>
<th>Nothing to report.</th>
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</thead>
</table>

| Joint Committee of Clinical Commissioning Groups | Noted the implementation of the new South Yorkshire and Bassetlaw mode for Hyper Acute Stroke Services.  
|                                                       | Noted the Hospital Services Programme, with work now underway with Trusts and Commissioners to agree a structure, membership and work programme.  
|                                                       | Noted the requirement of Integrated Care System partners to develop their local response for producing an ICS five-year strategic plan by Autumn 2019.  
|                                                       | Reviewed the draft JCCCG Manual Agreement and Terms of Reference. |
| **4.1. Constitution and Establishment** | A new model CCG Constitution was published by NHS England due to national changes in policy and the law needed to reflect the model guidance. Key differences are the new model is shorter and several sections have been removed, whilst others have been simplified. The new process will give the option for members to delegate the approval of minor changes to the Governing Body. The Strategy and Organisational Development Forum agreed at its meeting on 20 December 2018 to develop the CCG Constitution over the next 12 months. All committee terms of reference have been reviewed and approved by the Governing Body within the last 12 months. Terms of Reference will be updated following a review by the Governing Body of the revised CCG Constitution. The revised CCG Constitution, based on the new model, has been developed and is to be presented to the Governing Body on 1 August 2019 with a recommendation to the CCG Membership for approval. A Committee Handbook has been developed which includes the governance meeting structure and all meeting terms of reference relevant to the CCG. The handbook will be presented to Audit Committee in September 2019. |
| **4.2. Standards of Business Conduct & Conflicts of Interest** | The Corporate Governance Team maintain the register with regular updates provided to the published register which includes all decision makers that can be found on the CCG website or at the following link: Lists-and-registers Disclosure of Gifts and Hospitality: There were no disclosures of Gifts and Hospitality made within the last quarter. |
| **4.3. Governance Structure** | No changes have been made to the governance structure in quarter 1 2019/20. |
### 4.4. Statutory Roles

The Officers fulfilling the key statutory roles required of a CCG are:

**Strategic:**
- Accountable Officer – Chief Officer
- Accounting Officer – Chief Finance Officer

**Governance:**
- Accountable Emergency Officer – Chief Officer
- Conflict of Interest Guardian – Lay Member for Audit & Governance
- Conflict of Interest Lead – Associate Director of HR and Corporate Services
- Whistleblowing Lead – Associate Director of HR and Corporate Services
- Senior Information Risk Owner – Associate Director of HR and Corporate Services
- Health & Safety Competent Person – Head of Health, Safety & Security
- Fire Safety Responsible Person – Associate Director of HR and Corporate Services
- Fire Safety Competent Person – Head of Health, Safety & Security
- Security Management Director – Associate Director of HR and Corporate Services
- Local Security Management Specialist – Head of Health, Safety & Security
- Claims Officer – Associate Director of HR and Corporate Services Local Counter Fraud Specialist – 360 Assurance
- Registration Authority – HR Team

**Quality / Safeguarding:**
- Caldicott Guardian – Chief Nurse
- Safeguarding – Chief Nurse
- Research Governance – Chief Nurse
- Equality & Diversity Executive Lead – Associate Director of HR and Corporate Services
- Accountable Officer Controlled Drugs – Director of Nursing in the local NHS England Area Team (delegated operationally to the CCG Head of Medicines Management)

### 4.5. Procedural Document Management

Policy and procedural documents are monitored for review. The following procedural documents require review:
- Choice Strategy
- Clinical Supervision Policy
- Commissioning for Outcomes Policy
- Commissioning Safeguarding Vulnerable People Policy
- Divert Policy
- Dress Code Policy
- Individual Funding Requests Policy
- Information Technology Strategy
- Organisational Development Strategy and Action Plan
- Prior Approval Policy
- Public and Patient Involvement Payment Procedure
• Working Time Policy

Chiefs of Service are currently working on the revision of the outstanding policies and procedures.

4.6. Health and Safety, Fire Safety and Security

• The Competent Person for Health & Safety has confirmed that the CCG remains compliant with health & safety legislation.
• On the 11th June 2019 the annual fire, premises and security inspections were undertaken at Sovereign House and White Rose House.
• The inspections have highlighted an increase in the number of hazards compared to the previous year’s reports. A breakdown of the numbers is shown below with a comparison to previous year’s reports:

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<th>Year</th>
<th>Number of Issues</th>
<th>Number of Grading</th>
<th>Actions for</th>
</tr>
</thead>
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<tr>
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<tr>
<td>2019</td>
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<td></td>
<td>Fire Risk Assessment</td>
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<tr>
<td></td>
<td>Premises Security Audit</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

2019 Inspections Results

Fire:
• Fire Wardens are running weekly fire alarm tests at Sovereign House and have reported no problems. NHS PS has ended the contract with their third party contractors and has brought the weekly fire panel testing of White Rose House in house alarm.
• The facilities team continue to conduct daily fire safety checks at Sovereign House and members of admin support conduct fire safety checks at White Rose House.

Security:
• A security breach occurred at Sovereign House during quarter 1. A contractor operated the door release switch behind reception and gained entry into the building unaccompanied. The Security Policy will be reviewed and amended during quarter 2.

Training:
• Fire awareness, H&S, practical moving and handling training was conducted for Doncaster CCG staff at White Rose House in April to ensure compliance, further sessions have been arranged for July 2019.

Legislative Requirements:
During quarter 1, the following documents were submitted for approval
• First Aid Risk Assessment
• Organisational Risk Assessment
**Sustainability:**
The CCG continues at Sovereign House and White Rose House respectively, to have recycling facilities in place for paper, cans, batteries and plastics.

The Sustainable Development Management Plan has been reviewed and departments have been tasked for each action point. A meeting is planned for July 2019 and the minutes from the meeting will be included in the Quarter 2 report.

<table>
<thead>
<tr>
<th>4.7. Emergency Resilience and Business Continuity</th>
</tr>
</thead>
</table>

**Emergency Preparedness, Resilience & Response (EPRR):**
An impact assessment is to be conducted on a yearly basis on events that have happened during that year.

To test the South Yorkshire and Bassetlaw CCG’s out of hours/on call communication system In line with NHS England Emergency Preparedness, Resilience and Response Framework; The CCG has a requirement to “exercise” its EPRR arrangements. Under section 10.4.1 it states: Communications exercise minimum frequency – every six months.

These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They should include testing telephone, email, paging and other communications methods in use. The communications exercise should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

The Assistant Chief Officer at Rotherham CCG, is responsible lead for EPPR for South Yorkshire and Bassetlaw CCGs. The Head of Corporate Governance attended two emergency planning exercises in quarter 1.

**Business Continuity:**
- CCG team business continuity plans have been updated in May 2019.
- There have been no business continuity incidents during quarter 1.
4.8. Sustainability

The CCG continues at Sovereign House and White Rose House respectively, to have recycling facilities in place for paper, cans, batteries and plastics.

Batteries:
- During 2018/2019: 15.8kg of batteries was collected by Doncaster CCG for recycling instead of going to landfill
- During quarter 1 the CCG has currently collected 3kg of batteries for recycling.

Waste paper and Cardboard:
- The Environmental Certificate for Quarter 1 from Russell Richardson has not been received by the CCG.

The Sustainable Development Management Plan has been reviewed and departments have been tasked for each action point. A meeting is planned for 22 July 2019 and the minutes from the meeting will be included in the Quarter 2 report.

<table>
<thead>
<tr>
<th>2019/20</th>
<th>Total</th>
<th>Upheld</th>
<th>Partially upheld</th>
<th>Not upheld</th>
<th>Carried Forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>11</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

100% of Complaints were acknowledged within 3 working days as good practice. Of the 11 complaints received and investigated during the quarter:

5 were CHC Complaints:
1 related to the CHC assessment process and outcomes
1 related to the new Retrospective/PUPoC Process
1 related to PHB Financial Query
1 related to the Case Management of a CHC Individual
1 related to the withdrawal of a Respite Provision

6 were CCG Complaints:
5 related to Premier Care Direct - renal transport provider
1 related to the procurement of equipment into a nursing home, when the individual is not fully funded
4.10. Counter Fraud

The CCG’s Counter Fraud Specialist (CFS) is commissioned via 360 Assurance. The Audit Committee receives assurance via Counter Fraud reports which cover the areas of contract performance, strategic governance, inform and involve, and prevent and deter.

4.11. Whistleblowing

Whistleblowing may relate to financial, employment or clinical care concerns. There were no whistleblowing disclosures in the last Quarter.

<table>
<thead>
<tr>
<th>Category</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whistleblowing disclosures</td>
<td>Q1</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
</tr>
<tr>
<td></td>
<td>Q4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whistleblowing disclosures</td>
<td>0</td>
</tr>
</tbody>
</table>
### Section 5 – Information Governance

#### 5.1. The protection and use of Personal Confidential Data
Following the implementation of the General Data Protection Regulation (GDPR) on 25th May 2018 the CCG has progressed with the GDPR action plan with all actions completed.

#### 5.2. Data Security and Protection Toolkit (DSPT)
The Data Security and Protection Toolkit is a national toolkit administered by NHS Digital which enables us to measure our information governance compliance.

Our 2018/19 toolkit was published as: Standards Met (The previous IG Toolkit scores were: 2017/18 – 72%, 2016/17 – 77%).

Internal Audit undertook a review of the toolkit submission and presented their findings to the Audit Committee at its meeting on 14 March 2019, reporting significant assurance.

#### 5.3 Information Governance Workplan
An Information Governance Workplan for 2019/20 continues to be implemented. Work undertaken in the last quarter include:

- Information Governance Bulletin published March 2019 providing staff details on:
  - The Corporate Governance Team
  - Conflicts of Interest
  - Gifts and Hospitality
  - Training
  - IT Assets Audit
  - Incidents.
- A review of Information Sharing Agreements has been undertaken and reviewed at the IG Group on 12 February 2019.
- Processing of Freedom of Information Requests and Subject Access Requests during this period.
5.4. Freedom of Information Act Requests


There were:

- 22 FOIs in April
- 24 FOIs in May
- 18 FOIs in June
- Total 64

There remained a steady level of queries for the Continuing Healthcare team with 6 received this quarter. Requests around Planned and Unplanned care areas also remained steady, as did the number of queries for information on staff roles and responsibilities. The number of queries for Primary Care increased in this quarter - this was mostly down to queries about the introduction of the new Primary Care Networks. Mental Health maintained a steady amount of queries.

The average response rate in this quarter has increased slightly (but still lower than previous years) but this has been due to a select few that pushed the 20 day turnaround time. The amount of FOI requests received in Quarter 1 remains consistent year on year.
61 of the FOIs did not have any exemptions applied, with an additional 1 exempted under section 21 - Information already available. The others were:

- 1 Section 22 - provides an exemption for information that is intended to be published in the future. Information is exempt if, at the time when the public authority receives a request for it: the public authority holds the requested information; the public authority intends the information to be published at some future date, whether that date is determined or not; and in all the circumstances it is reasonable to withhold the information until its planned publication.

- 1 Section 41 - an exemption from the right to know where the information was provided to the public authority in confidence. This was in relation to a data breach by one of the GP practices within Doncaster and information had been provided by one of the subjects of the breach to the Head of Corporate Governance.
<table>
<thead>
<tr>
<th>5.5. Subject Access Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG is required to meet statutory timeframes for responding to Subject Access Requests under the Data Protection Act. The statutory timeframe enforceable by the implementation of GDPR from 25 May 2018 is one calendar month.</td>
</tr>
<tr>
<td>There were no Subject Access Requests received in quarter 1. One request remains open, clarity for consent has been requested.</td>
</tr>
</tbody>
</table>
Organisational Development (OD) is our systematic approach to improving organisational effectiveness – one that aligns our strategy, our people and our processes to drive forward our vision and effectively enact our Strategic Plan.

The results of both the annual NHS staff survey and the 360 Stakeholder Survey have been received. Results have been shared at a number of forums including DCCG Managers, Staff Briefing and Strategy and Organisational Development forum for discussion and for recommendations to target specific issues highlighted.

Work will be undertaken in relation to the Staff Survey with individual teams as well as across the whole organisation.

**Governing Body:** Our Governing Body membership comprises 12 roles – the Chair, four elected Locality Leads, three Lay Members, a Registered Nurse (also the Chief Nurse), a Secondary Care Specialist Doctor, the Accountable Officer (the Chief Officer) and the Chief Finance Officer.

**Chair:** Dr David Crichton.

**Chief Officer:** Mrs Jackie Pederson.

**Locality Leads:** Post holders and portfolios are detailed below:

<table>
<thead>
<tr>
<th>Locality Lead</th>
<th>Lead clinical areas</th>
<th>Lead corporate areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jeremy Bradley</td>
<td>Quality</td>
<td>Remuneration Committee</td>
</tr>
<tr>
<td>East Locality</td>
<td>Prescribing</td>
<td>Quality &amp; Patient Safety Committee</td>
</tr>
<tr>
<td>Dr Marco Pieri</td>
<td>Planned Care</td>
<td>Remuneration Committee</td>
</tr>
<tr>
<td>North Locality</td>
<td>Cancer and Tobacco Control Alliance</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Dr Nick Tupper</td>
<td>Planning and Strategy</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Central Locality</td>
<td>Learning Disability</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Dr Khaimraj Singh</td>
<td>Care Homes</td>
<td>Engagement &amp; Experience Committee</td>
</tr>
<tr>
<td>South Locality</td>
<td>Planned Care</td>
<td>Primary Care Commissioning Committee</td>
</tr>
<tr>
<td></td>
<td>Neurology / Urology / ENT</td>
<td></td>
</tr>
</tbody>
</table>

**Lay Members:** Post holders and portfolios are detailed below:

<table>
<thead>
<tr>
<th>Lay Member</th>
<th>Lead areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member - Audit &amp; Governance Ms Anthea Morris</td>
<td>Chair of Audit Committee</td>
</tr>
<tr>
<td>Lay Member - Patient &amp; Public Involvement Mrs Sarah Whittle</td>
<td>Chair of Engagement &amp; Experience Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lay Member</th>
<th>Lead areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Anthea Morris</td>
<td>Chair of Remuneration Committee</td>
</tr>
<tr>
<td>Ms Anthea Morris</td>
<td>Lay lead for Audit and Governance</td>
</tr>
<tr>
<td>Ms Anthea Morris</td>
<td>Conflict of Interest Guardian</td>
</tr>
<tr>
<td>Mrs Sarah Whittle</td>
<td>Chair of Engagement &amp; Experience Committee</td>
</tr>
<tr>
<td>Mrs Sarah Whittle</td>
<td>Public and Patient Involvement Champion</td>
</tr>
</tbody>
</table>
Lay Member - Primary Care Commissioning
Mrs Linda Tully
- Chair of Primary Care Commissioning Committee
- Lay lead for Primary Care Commissioning

Secondary Care Doctor Member
Dr Emyr Wyn Jones
- Chair of Quality & Safety Committee
- Chair of Clinical Reference Group
- Lead for Secondary Care, bringing an understanding of patient care in the secondary care setting

Senior Management Team: Post holders and portfolios are detailed below:

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Lead areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Finance Officer</strong>&lt;br&gt;Mrs Hayley Tingle</td>
<td>Chief Finance Officer’s Team:&lt;br&gt;• Financial Strategy, management, control, reporting &amp; governance&lt;br&gt;• Contracting&lt;br&gt;• Procurement&lt;br&gt;• External Audit&lt;br&gt;• Internal Audit&lt;br&gt;• Counter Fraud</td>
</tr>
<tr>
<td><strong>Chief Nurse</strong>&lt;br&gt;Mr Andrew Russell</td>
<td>Chief Nurse’s Team:&lt;br&gt;• Quality &amp; Safety&lt;br&gt;• Safeguarding&lt;br&gt;• Medicines Management&lt;br&gt;• Serious Incident management&lt;br&gt;• Contractual quality&lt;br&gt;• Clinical governance and assurance&lt;br&gt;• Continuing Healthcare (including Previously Unassessed Periods of Care)&lt;br&gt;• Personal Health Budgets</td>
</tr>
<tr>
<td><strong>Director of Strategy &amp; Delivery</strong>&lt;br&gt;Mr Anthony Fitzgerald</td>
<td>Director of Strategy &amp; Delivery’s Team:&lt;br&gt;• Strategic Plan&lt;br&gt;• Delivery Plans&lt;br&gt;• System transformation&lt;br&gt;• Commissioning in partnership&lt;br&gt;• Performance management, Business Intelligence &amp; Information Technology&lt;br&gt;• Primary Care Commissioning&lt;br&gt;• Communications, Engagement and Experience</td>
</tr>
<tr>
<td><strong>Associate Director of HR &amp; Corporate Services</strong>&lt;br&gt;Mrs Lisa Devanney</td>
<td>Associate Director of HR &amp; Corporate Services’ Team:&lt;br&gt;• Corporate Governance – including Risk Management, Information Governance, Health, Safety &amp; Security, Emergency Planning, and Headquarters management&lt;br&gt;• Human Resources &amp; Organisational Development&lt;br&gt;• Equality &amp; Diversity&lt;br&gt;• Secretariat and corporate support function</td>
</tr>
</tbody>
</table>

6.3. Workforce Breakdown

**Workforce:** A breakdown of the workforce will be presented in Quarter 2.

6.4. Mandatory and Statutory Training: Compliance is monitored on a quarterly basis to ensure that employees who are non-compliant, or who will become non-compliant in the next three months, are encouraged to complete their training. The quarter end position is detailed below alongside a comparison with the previous Quarter. Those areas that are requiring attention are being addressed through Executive leads and line managers to address the compliance rate.
## Mandatory and Statutory Training

<table>
<thead>
<tr>
<th>Name of Training</th>
<th>Compliance rate</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>97%</td>
<td>78%</td>
</tr>
<tr>
<td>Fraud</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>Health &amp; Safety incorporating Risk Management</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>Information Governance – Data Security</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>97%</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Young People</td>
<td>93%</td>
<td>87%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflicts of Interest</td>
<td>92%</td>
<td>96%</td>
</tr>
</tbody>
</table>

## 6.5 Workforce Capacity

A plan to address the reduction in running costs has been developed and is monitored by the Senior Management Team and includes stringent vacancy control procedures.

Work continues to progress in relation to partnership working through the Joint Commissioning Group, Organisational Development network and the Workforce and Education Committee.

The Personal Development Review and Personal Development Plan process supports succession planning and talent management.

A new Employee Assistance Support Programme is in place which proactively supports health and wellbeing to help employees deal with a range of issues and maintain healthy attendance at work.
### Section 7 – Equality and Diversity

**7.1 Equality and Diversity Strategy**

**Strategy:**
Reducing health inequalities is a priority for NHS Doncaster CCG, as highlighted in our partnership working on the Doncaster Health & Wellbeing Board. In the very challenging financial climate in which we find ourselves in Doncaster, taking action to reduce health inequalities should result in substantial population health gains, reduced healthcare spend and improved health outcomes.

Based on our self-assessment against the national Equality Delivery System, our main areas of focus must be where we have identified there is greatest potential for improvement i.e. outcomes one and two where we have assessed ourselves as “developing”. These outcomes focus on better health outcomes and improved patient access and experience respectively.

Our Equality Objectives are useful success indicators to measure ourselves against our journey to our overall equalities vision:

- **Objective 1:** Utilise information and feedback gleaned from our patients, public and third sector partners to inform and influence the commissioning of healthcare services which are appropriate and responsive to our local population and their needs, ensuring better health outcomes for the Doncaster population by ongoing monitoring and assessment.

- **Objective 2:** Ensure appropriate and accessible targeted communication with local communities to raise awareness and understanding of healthcare options.

- **Objective 3:** Improved patient access and experience ensuring patient and public engagement at the start of each commissioning cycle as determined by the equality impact analysis, and embedding equality and diversity considerations into the decisions and culture of the CCG.

**7.2 Equality and Diversity System 3 (EDS3)**

**EDS3:**
We are awaiting the publication of the new EDS3 from NHS England.

**7.3 Annual Report**

**Annual Report:**
The annual report will be presented to Engagement and Experience Committee in the first quarter of 2020.

The Corporate Governance Manager will be presenting an update to Engagement and Experience Committee in September 2019.
<table>
<thead>
<tr>
<th><strong>7.4 Training</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training:</strong></td>
</tr>
<tr>
<td>Staff continue to refresh their training using the electronic staff record,</td>
</tr>
<tr>
<td>Regular staffing lists from Human Resources are informing the Corporate Governance team of compliance and non-compliance. This information is being used to inform Managers and Leads regarding which staff require to complete their training.</td>
</tr>
</tbody>
</table>
### Purpose of Paper - Executive Summary

The purpose of this report is to update the Governing Body on issues relating to the activity of the Doncaster Clinical Commissioning Group (DCCG) 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:

**CCG:**
- Improvement Assessment Framework – Quality of Leadership
- Improvement Assessment Framework – Patient and Public Engagement
- Annual General Meeting – 17 July 2019
- Outcome report following Mental Health System Perfect week

**National Update:**
- National Data Opt-Out
- Improving the process for joiners, movers and leavers in the NHS
- GP Patient Survey 2019 results published

### Recommendation(s)

The Governing Body is asked to note the report.

### Report Exempt from Public Disclosure

If yes, detail grounds for exemption:

Yes [ ] No [X]
<table>
<thead>
<tr>
<th>Impact analysis</th>
<th></th>
<th></th>
<th>Tick relevant box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality impact</td>
<td>Neutral</td>
<td>Neutral</td>
<td></td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>An Equality Impact Analysis/Assessment is not required for this report. X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>Paper is for information. No relevant interests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong></td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(internal departments, clinical, stakeholder &amp; public/patient)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Report previously presented at</strong></td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk analysis</strong></td>
<td>Nil</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assurance Framework</strong></td>
<td>CO1 - 1.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chair and Chief Officer Report
1 August 2019

1. CCG News

1.1 Improvement Assessment Framework – Quality of Leadership
The CCG has received its official rating from NHS England – we have been rated ‘outstanding’ for the third year running. The assessment takes place every year and is based on four broad areas:
- Better Health
- Better Care
- Sustainability
- Leadership

A full breakdown of the results is available on https://www.nhs.uk/service-search/performance/search and further analysis will be undertaken to determine our position regionally and nationally.

1.2 Improvement Assessment Framework – Patient and Public Engagement
The CCG also received its rating for the approach to patient and public engagement which ensures that we communicate and engage with patients and members of the public at the right time, right place using effective methods.

Since last year’s assessment, we have moved from Amber ‘requires improvement’ to ‘Green Star’. We know there are only 36 CCGs in the country (out of 195) that have achieved a Green Star rating for patient and public engagement.

1.3 Annual General Meeting – 17 July 2019
On Wednesday 17 July, staff, partner organisations, community and voluntary groups, along with patients and members of the public attended the 2018-19 Annual General Meeting (AGM). Held at the National High Speed Rail College in Doncaster, almost 140 delegates attended, marking this, the most attended AGM to date.

A presentation: AGM-presentation-2018-19 was delivered which included key highlights from 2018-19, along with a summary of how public money is used, as well as an overview of key challenges. A patient and public version of the full annual report was also launched.

For the first time, a summary video was also shown at the AGM and is available to watch: 2018-19-annual-report. The event included:
- an overview of 2018-19 including
- a review of performance;
- our Annual Accounts and
- priorities and programmes for the next 12 months.

In addition, a senior officer panel took a number of questions from the audience. The panel was made up of senior health and care representative across Doncaster:
- Jackie Pederson, Chief Officer, NHS Doncaster CCG
Richard Parker OBE, Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Laura Sherburn, Chief Executive, Primary Care Doncaster and Phil Holmes, Director of Adult Social Services, Doncaster Council.

The event was supported by Doncaster’s Chamber of Commerce and included attendance from a number of businesses in Doncaster who engaged with stall holders as part of the networking event to find out more about how to sustain a healthy workforce.

1.4 Outcome report following Mental Health System Perfect week
Earlier this year, Doncaster CCG took part in a Doncaster wide week of action to shine a light on mental health services and how organisations work together to provide the right support, information and advice for patients and members of the public.

An evaluation report of this engagement activity is now available and provides a summary of what people told us and how that information will be used to improve mental health services moving forward.

The outcomes and recommendations from this report will be used to influence current and future mental health services in Doncaster.

2. National News

2.1 National Data Op-Out
All health and adult care organisations in England that provide publicly funded or co-ordinated care must comply with the national data opt-out policy by March 2020. To comply with national data opt-out policy, procedures will need to be put in place to review uses or disclosures of confidential patient information against the operational policy guidance.

National data opt-outs are held on the NHS Spine against an individual’s NHS number. If your use or disclosure of data needs to have national data opt-outs applied, you must remove records for patients with an opt-out registered from the data being used.

Further information can be found: Compliance-with-the-national-data-opt-out.

2.2 Improving the process for joiners, movers and leavers in the NHS
Information is being synchronised to automate staff identities and effectively manage their access to data as they join, leave or move roles in the NHS. This service will align workforce data between the NHSmail Portal, the Electronic Staff Record (ESR) and local Active Directories, providing the following benefits:

- Quicker access to business systems enabling a smoother employee on-boarding experience
• Reduced administrative effort
• Increased accuracy of employee details
• Stronger data and cyber security capabilities through improved access management and audit processes
• We have been communicating with Local Administrators in your organisation to invite them to register their interest for this solution and provide details of the most appropriate person for us to engage with.

2.3 GP Patient Survey 2019 results published
Europe’s largest survey of patients has been published and shows that more than eight out of ten still have a good experience of their GP practice and more than nine in ten have confidence and trust in the professionals they saw or spoke to. Feedback showed areas for improvement, including people contacting practices by telephone and making appointments. More than 770,500 people took part in the GP Patient Survey of practices across England. Data is published at national level, by CCG and by practice. There is an analysis tool to help explore the survey and produce reports. Read our full statement on the survey. Further information can be viewed: nine-out-of-10-patients-have-confidence-and-trust-in-their-gp.
### Purpose of Paper - Executive Summary

The purpose of this paper is to note the final letter received from the CQC and Ofsted Joint local area SEND inspection in Doncaster.

Between 20 May 2019 and 24 May 2019, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Doncaster Metropolitan Borough Council to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014.

The letter represents the formal feedback from the inspection and identifies many areas of strength within the current offer alongside areas for development. Much of what the inspectors experienced was in line with the self-assessment undertaken across the partnership.

The opinion overall is positive and the areas for development will provide a clear focus for improvements across the system including the CCG.

The partnership will now develop a clear plan to address the areas identified as requiring development and consider this through partnership governance arrangements.

The paper also includes a letter from Nadhim Zahawi (MP Parliamentary Under-Secretary of State for Children and Families)
**Recommendation(s)**
The CCG Board is asked to note the letter from Ofsted

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### Report Exempt from Public Disclosure

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, detail grounds for exemption:

### Impact analysis

<table>
<thead>
<tr>
<th>Impact Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality impact</strong></td>
<td>The new arrangements are designed to promote effective safeguarding arrangements across all agencies in Doncaster and provide appropriate Governance in order to meet the required responsibilities and duties. An assurance framework sits across the partnership in relation to this.</td>
</tr>
<tr>
<td><strong>Equality impact</strong></td>
<td>An Equality Impact Analysis/Assessment is not required for this report.</td>
</tr>
<tr>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
</tr>
<tr>
<td></td>
<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
</tr>
<tr>
<td><strong>Sustainability impact</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial implications</strong></td>
<td>No new financial considerations have been identified through this work at this stage.</td>
</tr>
<tr>
<td><strong>Legal implications</strong></td>
<td>This work fall under the requirements detailed within the Children and Families Act 2014</td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
<td>None declared or noted.</td>
</tr>
<tr>
<td><strong>Consultation / Engagement</strong></td>
<td>The Inspection methodology included consultation and engagement with a wide range of people including children, families and professionals across the partnership. Future developments will require engagement at all levels.</td>
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<tr>
<td><strong>Report previously presented at</strong></td>
<td>This paper has not been presented at any previous meetings</td>
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<tr>
<td><strong>Risk analysis</strong></td>
<td>No new risks identified</td>
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<tr>
<td><strong>Corporate Objective / Assurance Framework</strong></td>
<td>Relates to Corporate Objective 1,2 and 4</td>
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12 July 2019

Mr Damian Allen  
Director of Children’s Services, Doncaster LA 
Civic Office  
Waterdale  
Doncaster  
DN1 3BU

Jackie Pederson, Chief Officer, NHS Doncaster Clinical Commissioning Group  
Riana Nelson, local area nominated officer

Dear Mr Allen and Ms Pederson

**Joint local area SEND inspection in Doncaster**

Between 20 May 2019 and 24 May 2019, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Doncaster Metropolitan Borough Council to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors, including an Ofsted Inspector and a children's services inspector from the CQC.

Inspectors spoke with children and young people with SEND, parents and carers, along with local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they are implementing the SEND reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

This letter outlines our findings from the inspection, including some areas of strength and areas for further improvement.
Main Findings

- Local area leaders are committed to improving the life chances of children and young people with SEND. The strategies that they have used have secured improvements to the quality of health, education and social care provision. This is having a positive impact on the quality of services for most children and young people. The ‘big picture’ in Doncaster is one of steady improvement.

- The voice of children and young people with SEND is given high priority in Doncaster. Local arrangements ensure that the ideas of children and young people influence leaders’ strategic planning and the development of services. For example, the local offer has been shaped by the voice of children and young people.

- The local area’s self-evaluation is detailed, accurate and comprehensive. Leaders know what is working well and where improvements are needed. They are acting quickly to bring these about. Development plans are sharply focused on what needs to improve.

- Relatively soon after the reforms in 2014, decisions to align services geographically into ‘neighbourhoods’ brought easier access to support for children and young people with SEND and their families. This structure has enabled more effective communication between health, care and education professionals from that point.

- Local area leaders have a history of working together to improve services and outcomes for children and young people with SEND. Child and adolescent mental health services (CAMHS) work effectively with education professionals to support the needs of children and young people with SEND. Systems to identify emerging need operate in a well-established and timely fashion, especially for children and young people with hearing impairments, and young people who are involved with the youth offending service (YOS).

- Leaders have an accurate picture of the local area’s effectiveness in identifying, assessing and meeting the needs of children and young people with SEND. As a result, the development plans that are in place are strong. Leaders know what needs to be done and are moving at a pace to further improve provision and outcomes for children and young people.

- Support for children in the local area aged 0 to 5 years is cohesive and coherent. Frontline practitioners in early years services show a clear commitment to improving health, education and care provision for young children with SEND. Partnership working is contributing to better outcomes for this group of young children.

- Inspectors have identified some areas for development. For example, some children and young people with SEND do not always receive effective support
at points of transition. Education, health and care (EHC) plans are not of a consistently high quality. Rates of absence and the number of fixed-term exclusions are too high for children and young people with SEND. In addition, the progress that children and young people make by the time they leave Year 11 is slower than that of their peers nationally.

- Although there are examples of effective joint commissioning and co-production (a way of working where children and young people, families and those that provide services work together to decide or create a service which works for them all), local leaders have been slower to implement these aspects of the 2014 reforms than others.

- There is variation in the quality of schools’ work in the local area. Despite the support offered by the SEND education support team, this variation is having an impact on how well the needs of children and young people are met.

- Only a few parents to whom inspectors spoke were aware of the local offer or the special educational needs and disability information, advice and support service (SENDIASS). Many of the parents in individual schools and settings were unaware of the support that is available from Doncaster Parents’ Voice. Consequently, even though the quality of the support offered in the local area is relatively strong, parents that were unaware of this support described feeling isolated.

**The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities**

**Strengths**

- The needs of children aged 0 to 5 years are identified early and swiftly. This is because early childhood health programmes and working relationships between health, care and education colleagues are well established. Professionals have a good understanding of each other’s roles, they share information, and coordinate support effectively. A prime example of this is the way in which the health visiting service delivers the Healthy Child Programme in which families access a range of universal services from the antenatal period onwards. This helps to identify any additional needs that children have.

- Access to services is a relative strength in the local area. For example, children and young people do not need a formal diagnosis to access specialist health interventions. This ensures that children and young people’s needs are identified in a timely fashion. Access to mental health services is an example of this.

- Children and young people with complex needs benefit from specialist health visiting and school nursing services to ensure that their individual and unique
needs are met. Because of this additional provision, health visitors and school nurses have more time to support other children and young people with SEND.

- Children and young people with a hearing impairment have their needs identified at an early stage; the hearing impairment service works closely with health colleagues to identify any additional needs from birth. The support that children and their families receive is swift and effective. It is appreciated by parents. These strengths are mirrored for children and young people with visual or physical impairment, who also benefit from early identification of any additional needs.

- Within the YOS, young people have access to a range of specialist services such as speech and language therapy and forensic psychology. As such, they benefit from a range of specialist assessments and interventions. This ensures that any previously unmet or additional needs they have are identified accurately and in a timely fashion.

**Areas for development**

- Some children and young people do not receive high-quality support at key transition points. Families report a wide variation in how much support they receive and how effective it is. Sometimes, preparation for transition between schools does not begin early enough or in a fully joined-up way. Within health services, the transition process between paediatric and adult services is of variable quality. Although improvements are under way, this is not having a consistently positive impact at this point.

- The emerging needs of children and young people with SEND are not consistently identified well by schools. As a result, any additional support is not always timely or appropriate.

- The health needs of some children and young people are not always identified at the earliest opportunity. For example, too few young people after the age of 14 access their annual health assessment. Health assessments for some children who are looked after are not completed within statutory timescales.

**The effectiveness of the local area in meeting the needs of children and young people with special educational needs and/or disabilities**

**Strengths**

- Arrangements for identifying any emerging SEND needs among young children aged 0 to 5 years are effective. Education, health and care colleagues work together in integrated teams to ensure that children’s needs are met. As a result, children with SEND are accurately matched to
appropriate nursery placements in specialist or enhanced provision.

- Professionals in the portage service work effectively with children with SEND from pre-birth to school age. Professionals from the service support families in the home environment, as well as attending other settings to help to assess any additional needs. They then shape any support given more effectively. This service is highly valued by parents.

- Children from Doncaster benefit from an integrated two-year health review to assess any potential additional needs and support is provided accordingly.

- The General Development Assessment (GDA) pathway is the route for children and young people to be formally assessed for autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and non-global developmental delay. This pathway is increasingly effective. It helps to ensure that children and young people can access the most appropriate service to meet their individual needs.

- The local offer is informative and well considered. Children and young people are actively involved in its formulation and development. Indeed, local area leaders actively seek the views of children and young people with SEND. The Learning About Disability, Discrimination, Equality and Rights youth forum, and the youth council provide opportunities for the voices of children and young people to be heard. These are two examples among many.

- Children and young people appreciate the range of participation and involvement activities that take place across the local area. For example, within CAMHS, children and young people with SEND help to shape the development of services. Representatives are part of the scrutiny panel that holds senior local area leaders to account.

- SENDIASS in Doncaster is viewed positively by parents who have accessed the service. Many families value the support and guidance that they have received. Similarly, the networks and support provided by Doncaster Parents’ Voice are appreciated by a range of parents.

- Within health services, families benefit from a ‘tell it once approach’. Therapy services work effectively and collaboratively in assessing children and young people with additional needs. Joint assessments are in place where this is applicable. Support is particularly effective for children and young people with hearing impairment, and for those with ASD.

- Children at risk of hospital admission benefit from an ‘Intensive Homebased Treatment Service’. As a result, hospital admissions have significantly reduced. More children can stay at home with their families.

- Children and young people with SEND who are educated at home have access to the school nursing service. There is a robust process for sharing information across agencies to ensure that the health needs of these children
and young people are met.

- Children and young people have open access to mental health services. Children and young people are placed on the most appropriate pathway to meet their individual needs and are seen in a timely manner. CAMHS works closely with local schools, with a link practitioner to all settings within ‘neighbourhoods’ to this end.

- Children and young people who are additionally vulnerable are, overall, well supported to make progress to meet their goals. Children and young people who are fostered talked animatedly to inspectors about the emotional support they receive. In addition, young people with SEND who are supported by the YOS make gains in their development due to the additional support that they receive.

- Children and young people who are looked after with SEND are well supported by the virtual school. Teachers and other professionals are attuned to any additional emotional needs these children and young people may have. Intensive support and tracking ensure that children looked after and young people make gains in their wider development and learning.

- The support that school leaders receive from the SEND education team is appreciated. Professional networks for special educational needs coordinators in schools are valued by school leaders.

- Children and young people with complex SEND are increasingly well supported at school. Members of the SEND education team support schools with a tailored and creative approach to help teachers to support individual pupils. In addition, special schools in the local area share their expertise with mainstream schools and offer packages of support for teachers. By doing so, some mainstream settings are developing specific expertise in supporting children and young people with more complex needs.

**Areas for development**

- Children and young people have not always benefited from a cohesive approach to the organisation of support across the local area to meet their needs. Joint commissioning arrangements across the local area have been slow to develop. Leaders have recognised this issue and sharply focused plans to further strengthen and build upon current joint commissioning arrangements are in place.

- Some children and young people with ASD and ADHD wait for too long for a formal diagnostic assessment of their needs, despite improvements because of the GDA pathway.

- There is too much variation in the quality of EHC plans. Health and care professionals do not contribute consistently well to the plans. The perspective
of the child or young person and their parents is sometimes missing. Desired outcomes in the plans sometimes lack precision. Aspirations for individuals are sometimes too low. As a result of this, some children and young people are not having their needs met precisely enough.

- There is variation in the quality of support provided by some schools for children and young people with SEND. The SEN education team is working to tackle inconsistencies in the effectiveness of ‘SEN support’ for children and young people in schools where this is an issue. Variation remains at this point, however.

- Although several parents that contacted inspectors were happy with much of the support that their children were receiving, others talked of the need to ‘fight’ to have the needs of their children identified and met. Despite the quality of the support on offer, many parents are unaware of the range of services available. Many have not heard of the local offer or SENDIASS.

- Opportunities for leisure activities in the community for young people with the most complex needs are limited.

- There is no paediatric splint service available for children and young people in Doncaster. As a result, children are not benefiting from specialist intervention that would improve their long-term outcomes.

**The effectiveness of the local area in improving outcomes for children and young people with special educational needs and/or disabilities**

**Strengths**

- There have been some improvements in the standards that children and young people reach and the progress that they make. For example, the proportion of children and young people with SEND reaching the expected standard in the phonics screening check has improved steadily. The standards reached by children and young people has been on an improving trend, both at key stage 2 and key stage 4.

- Children and young people who are looked after and who have SEND make gains in their learning due to the bespoke support they receive through the virtual school and local settings.

- The number of young people accessing supported internships has increased. In addition, Doncaster Project Search, which started in 2014, has been increasingly successful in supporting young people with SEND to secure employment.

- A greater number of young people are living independently due to more accessible accommodation being commissioned. For example, the housing department and the supported living service worked together to develop
Harmony House. This renovated accommodation also enables young people with SEND to develop the necessary life skills to live independently.

- On an operational level, health services use a range of systems to check that the work of professionals is having a positive impact for children and young people. ‘Star outcomes’ and feedback from children and young people from social media platforms have helped to shape services and to improve outcomes.

**Areas for improvement**

- Rates of attendance in school are too low for children and young people with SEND. Too many are persistently absent. Local area leaders have made sure that systems are in place to pinpoint individual settings where absence is a particular issue. They challenge these headteachers and governors to this end. Improvements at this point are too slow.

- The proportion of children and young people with SEND who receive fixed-term exclusions is too high. Similarly, the number of permanent exclusions of children and young people with SEND is too high. Local area leaders have forged positive links with multi-academy trusts and local school leaders with the intention of addressing this issue. This is beginning to have a positive impact. Several schools are now seeing a rapid decline in the use of fixed-term exclusions. All secondary schools have signed an ‘inclusion charter’ to limit the number of exclusions and to work creatively to support the behaviour of some children and young people with SEND. The number of fixed-term exclusions among these children and young people in Doncaster remains high.

- By the end of key stage 4, children and young people with SEND make less progress from their individual starting points than all pupils nationally, and other pupils in Doncaster. Although some gains in progress are evident, the rate of improvement is currently too slow.

- The CCG is not routinely collecting information about the holistic impact of their services in relation to children and young people with SEND. As a result, there are a few gaps in the understanding of senior leaders as to how to have a greater impact on the health outcomes of children and young people with SEND.

- Therapy and community nursing services have been under review for a prolonged period, which has led to drift and delay. Leaders are aware and have a clear plan to drive forward and implement the change.
Yours sincerely

<table>
<thead>
<tr>
<th>Ofsted</th>
<th>Care Quality Commission</th>
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<tbody>
<tr>
<td>Katrina Gueli, HMI Acting Regional Director</td>
<td>Ursula Gallagher Deputy Chief Inspector, Primary Medical Services, Children Health and Justice</td>
</tr>
<tr>
<td>Michael Wardle, HMI Lead Inspector</td>
<td>Rebecca Hogan CQC Inspector</td>
</tr>
<tr>
<td>Mark Emly</td>
<td></td>
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<td>Ofsted Inspector</td>
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Cc: DfE Department for Education
Clinical commissioning group(s)
Director Public Health for the local area
Department of Health
NHS England
Dear Damian, Jackie and Riana,

**Joint local area SEND inspection – Doncaster**

I am taking a close interest in the Ofsted and CQC inspections of SEN and disability services and I read with great interest the findings in your report, published on 22 July.

I was pleased to read about the many positive findings for Doncaster, including improvements to the quality of provision across health, education and social care; participation of children and young people in influencing strategic planning and in the development of services; and open access to mental health services.

I previously congratulated you in March this year for the Ofsted outstanding judgements you received for two children’s homes and your adoption and fostering services. The SEND inspection report is another example of Doncaster’s journey of continuous improvement of services for children and young people.

I have been encouraged by the response from leaders in local areas to their SEND inspections, and pleased to see their commitment to improving outcomes for children and young people. Please continue to share your effective practice with others and build on your strengths, as well as focusing on your areas for development, including ensuring that all children and young people receive effective support at points of transition; achieving consistently high quality EHC plans; and reducing the high rate of absence and fixed-term exclusions.

I have asked our professional SEND Adviser, Elaine Baulcombe, to continue to be your link to the Department. If you have any questions or need any support, please contact Elaine in the first instance. Wendy Barker will remain your link to NHS England. I am copying this letter to Mayor Ros Jones, and to the MPs for Doncaster.

Yours sincerely,

Nadhim Zahawi MP
Parliamentary Under-Secretary of State for Children and Families
Purpose of Paper - Executive Summary

The purpose of this paper is to present the Doncaster Clinical Commissioning Group Safeguarding Annual Report.

This Safeguarding Annual Report sets out Doncaster Clinical Commissioning Group (DCCG) safeguarding arrangements and activity within commissioning and provider services across the Doncaster health economy for 2018/19.

The report details the performance and main achievements in relation to the CCG duties and responsibilities and the work within the Safeguarding Children Partnership and the Safeguarding Adults Partnership.

In addition to the Safeguarding report, the Designated Nurses will explore the wider impact upon safeguarding and partnership working through the roles of the Designated Nurses and wider safeguarding and Quality Team.

Recommendation(s)

The CCG Board is asked to note the Safeguarding Annual Report and discuss the wider impact and future direction of Safeguarding across the partnership within Doncaster.
The new arrangements are designed to promote effective safeguarding arrangements across all agencies in Doncaster and provide appropriate Governance in order to meet the required responsibilities and duties. An assurance framework sits across the partnership in relation to this.

<table>
<thead>
<tr>
<th>Equality impact</th>
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<td>An Equality Impact Analysis/Assessment is not required for this report.</td>
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<td>An Equality Impact Analysis/Assessment has been completed and approved by the lead Head of Corporate Governance / Corporate Governance Manager. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.</td>
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<td>An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.</td>
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<th>Sustainability impact</th>
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| Corporative Objective / Assurance Framework | Relates to Corporate Objective 1, 2 and 4 |
Safeguarding Children & Adults at Risk

Promoting the safety and welfare of the most vulnerable

Annual Report

1 April 2018 – 31 March 2019

Authors: Safeguarding Team
Doncaster Clinical Commissioning Group
1. Introduction

The purpose of this report is to provide the Quality and Safety Committee with the assurance that Doncaster Clinical Commissioning Group (DCCG) is fulfilling its statutory requirements in respect to safeguarding the health and wellbeing of children, young people and adults residing and receiving care across Doncaster. This report confirms the safeguarding arrangements and activity from 1 April 2018 to the 31 March 2019.

The joint report demonstrates the commitment of Doncaster CCG to support the continual improvement of safeguarding practice across the Doncaster health economy and multi-agency partners. Striving for quality services, that are able to meet the often complex needs of those within our care, ensuring children, young people and adults remain the centre of all we do.

2. National Context - Accountability

The statutory safeguarding arrangements and activities in this reporting period have been articulated through seven key national documents.

- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DfE 2018).
- Children and Social Work Act 2017
- Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Royal College of Paediatrics and Child Health 2014).
- The Care Act 2014
- The Mental Capacity Act 2005

Provider compliance is assured through the contract monitoring process, Clinical Quality Review Group and is reported through the CCG’s internal governance processes. Compliance is also monitored via feedback from the Doncaster Partnership assurance processes, Section 11 audits, Care Quality Committee (CQC) activity and site based assurance visits made by DCCG.

The Designated Nursing / Doctor team is responsible for the assurance monitoring and review of safeguarding practice by all trusts, services and independent contractors.
3. **Local Safeguarding Board (Children & Adults)**

Doncaster’s Local Strategic Partnership is called ‘Team Doncaster’. It is a non-statutory, non-executive organisation which brings together organisation’s and individuals from the public, private, voluntary and community sectors to take shared ownership and responsibility for Doncaster’s vision, leadership and direction.

It’s strategy, Doncaster Growing Together, has as one of its themes Doncaster caring, supporting out most vulnerable residents, whether children, adults, disabled people, families and / or older people. The emphasis is on joining up social and health care and support and support on shifting our focus to prevention and support that enables people to enjoy lift with their families and communities.

3.1 **Working Together**

One of the key actions that has taken place during 2018/2019 has been a review of the functionality of the two Doncaster Safeguarding Boards; this led to a decision being made during 2018/2019 to align both Children and Adults Boards together. This now means that the ever increasing numbers of safeguarding areas that cover both children and adults are now addressed together within one forum (the Chief Officers Safeguarding Overview Partnership).

Doncaster has recognised the strong linkages between issues from children and adults and has the intention through a number of its strategic partnership to work in a more integrated ‘whole family’ all-age approach. To further this ambition, the Safeguarding Partnership has developed close structural relationships with the Safeguarding Adults Board, as illustrated in the structure below.

The Children’s Partnership Board and Adults Board now meet on the same day in one meeting that has separate children and adult’s agenda with a joint agenda in between. This model has been very effective to date. As Team Doncaster continues to develop its wider vision for whole family working, the Safeguarding Children’s Partnership Board and Adults Board will continue to explore opportunities to work even closer together to promote safeguarding practice cross the life stages in Doncaster.

As a statutory partner of both the Doncaster Safeguarding Board, Doncaster CCG is represented on all appropriate sub groups and on the main board. Doncaster CCG contributes funding towards the both the Doncaster Safeguarding Adults Board and Doncaster Safeguarding Children Board on behalf of the health community.
Safeguarding Partnership Structure

Chief Officers Safeguarding Overview Group (Children & Adults)

Doncaster Safeguarding Adults Board

Doncaster Safeguarding Children & Adults Partnership

Doncaster Safeguarding Children’s Board

Keeping Safe Group (with adults)

Case Review Group

Quality & Performance Group

Child Death Overview Panel
Keeping Children and Adults Safe in Doncaster

Principles:
- Always put the wellbeing of the child, young person or adult first.
- Ensure services address the impact of adverse childhood experiences across the lift stages
- Promote a culture of creativity and curiosity
- Promote whole family working

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<tr>
<th>Strategic Priority 1</th>
<th>Strategic Priority 2</th>
<th>Strategic Priority 3</th>
<th>Strategic Priority 4</th>
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<td><strong>ASSURE EFFECTIVENESS AND IMPACT OF SAFEGUARDING ARRANGEMENTS</strong></td>
<td><strong>LEAD AND SHAPE SAFEGUARDING PRACTICE</strong></td>
<td><strong>ABILITY TO RESPONSE TO CURRENT AND EMERGING ISSUES</strong></td>
<td><strong>COLLABORATE, TRUST AND BUILD PARTNERSHIPS</strong></td>
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We will seek to:
1. Ensure the voice of the child / adult informs all that we do ‘nothing about me without me’
2. Listen to the voice of the front line practitioner
3. Ensure learning from critical incidents and serious cases is embedded in practice
4. Received assurance through multi-agency practice audits across the partnership
5. Ensure that everyone working with children and adults is adequately trained and competent in safeguarding
6. Ensure there is an effective multi-agency assurance process in place
7. Have performance frameworks that enable the Adults Board and Children’s Partnership to see what is happening
8. Promote the use of person centred models based on asset / strengths based practice
9. Promote and be assured of whole family approaches to:
   - Prevention and early intervention
   - Exploitation
   - Mental Health and wellbeing
   - Domestic Abuse
   - Neglect / Self-Neglect
   - Contextual / Organisational issues
10. Explore the benefits of an all-age multi-agency safeguarding hub
11. Develop a clear escalation process for resolving professional differences across the partnership
12. Engage the voluntary, community and faith sector ensuring that ‘safeguarding is everyone’s responsibility’
13. Ensure safeguarding is core to all strategic and partnership work in Doncaster.
14. Work across children and adult partnerships identifying further opportunities to work more closely together
15. Have an effective communication and engagement strategy in place
4. **Safeguarding Children**

Doncaster CCG’s Children’s safeguarding team have the capacity and capability to support the CCG in its statutory function to safeguard and promote the health and welfare of children cared for by the services we commission. All leads have acted as clinical advisors to the CCG on safeguarding matters and have worked alongside the Chief Nurse to ensure that the local health system is meeting their safeguarding responsibilities effectively.

The strong designated function of the Safeguarding Children & LAC Nursing team within the DCCG has permitted an increased presence and participation at the Doncaster Safeguarding Children’s Board (DSCB). This has awarded the surrounding health services (Commissioners and Providers), a greater voice and influence within high level decision making and service design, development and delivery across the Doncaster Safeguarding partnership.

Working closely with the Children and Maternity Strategy & Delivery team, the Designated Safeguarding Nurse and Deputy have continued to advocate the local needs of children, young people and families. Ensuring the voice of the child and their carers remains central to commissioning consideration and strategic planning.

The Doncaster CCG model is for the designated function to be incorporated into wider quality and patient safety roles, the principle being that safeguarding is considered a priority and at the outset in the context of assuring high quality of care. To support capacity Doncaster CCG also has Deputy Designated roles to support this function.

4.1 **Local Context**

Approximately 307,374 people live in Doncaster, in terms of indices of Multiple Deprivation (IMD) 2015 Doncaster is:

- 48th most deprived out of 326 local authority areas in England.
- 4th most deprived out of 21 local authority areas in the Yorkshire and Humber region.
- The 2nd most deprived areas in South Yorkshire.
- The 4th most deprived area in its comparator group.
- 1 in 5 lower super output areas in Doncaster is in within the deprived 10% of the UK.

A rise in the number of cohabiting partners, step families, lone parents and the recording of same sex relationships in the past 10 years has changed family composition in Doncaster. The latest ‘information for Doncaster’ (provided by DMBC) shows that nearly 71.9% of families with dependent children are a couple; which means nearly 1 in 3 families (28.1%) are lone parent families. The main difference between Doncaster and the national picture is the higher proportion of families that are cohabiting, particularly where this involves step-families.

The population of young people aged 0-24 is 89,500 which is 29.1% of the total population. This is the same as our comparator group and but slightly lower than national proportions at 30.2%.

The number of children in poverty in Doncaster is 21.0% which is higher than the nation average of 16.6%. This equates to around 13,930 children and young
people aged 19 and under. Poverty is not distributed equally across the borough with some lower super output areas (LASO) having over 50% of children in poverty compared to other area only having 5%.

The NSPCC have estimated that one in five children in the UK is impacted by domestic abuse. However; Growing Futures estimate that in Doncaster this is one in three children. This suggests that more children compared to the national average are entitled to services to achieve their best outcomes.

4.1.1 Health

The health and wellbeing of children in Doncaster is generally worse than the England average. The infant mortality rate of 4.8 per 1000 is higher than both the regional and national rate of 4.1 and 3.9 respectively (2014-16).

The smoking status of mothers at time of delivery in Doncaster is higher, at 13.0%, compared to the national average of 10.7% (2016-17).

Children in Doncaster have average levels of obesity: 23.0% of children aged 4-5 years and 35.8% of children aged 10-11 years (2016-17).

Life expectancy at birth for males, in Doncaster is 77.8, lower than the regional and national averages in 2014-16. There is a higher life expectancy for females at 81.5 however; this still compared unfavourably with regional and national averages.

4.2 Child Protection Conferences and Plans

The year 18-19 began with 374 children subject to Child Protection Plans and closed with 300 children subject to child protection plans. The trend is a steady decline over recent years and there are no Child Protection Plan that have been in place for two years or more.

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Child Protection Conferences</strong> (Child Protection Plans transferred from another area)</td>
<td>310</td>
<td>315</td>
<td>232</td>
</tr>
<tr>
<td><strong>Review Child Protection Conferences</strong></td>
<td>632</td>
<td>585</td>
<td>482</td>
</tr>
<tr>
<td><strong>Total Number of Conferences</strong></td>
<td>942</td>
<td>900</td>
<td>734</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>30.50%</td>
<td>14.9%</td>
<td>48%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Neglect</td>
<td>69.24%</td>
<td>74.9%</td>
<td>39.1%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Physical</td>
<td>5.86%</td>
<td>4.9%</td>
<td>9.7%</td>
<td>6%</td>
</tr>
<tr>
<td>Sexual</td>
<td>4.31%</td>
<td>5.3%</td>
<td>3.1%</td>
<td>3%</td>
</tr>
</tbody>
</table>
In some instances, the risk to the child remains significant despite intervention through the Child Protection Plan. In such instances, Doncaster Children’s Trust may seek legal advice about applying to the Family Court for the child to be accommodated elsewhere, at the same time making further efforts to work with the family to try to avoid this – this is referred to as ‘pre-proceeding’.

In 2019-19, 82 cases were progressed to pre-proceedings'.
- 19 (23%) were still in pre-proceedings on the 31st March 2019.
- 27 (33%) progressed into legal proceedings, an application being made for a care order
- 36 (44%) no further actions – this may have been because the family responded positively to the prospect of the child being accommodated.

### 4.3 Child Death Reviews

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Child Deaths</strong></td>
<td>12</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Unexpected Child Deaths</strong></td>
<td>5</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

### 4.4 Serious Case Reviews

There have been no new Serious Case Reviews commissioned by Doncaster Safeguarding Children’s Board during 2018-19.

### 4.5 Joint Target Area Inspection

The Designated Nurse and Deputy Designated Nurse for Safeguarding Children & LAC has engaged with and continues to engage with the strategically driven Joint Strategic Improvement Group (JSIG). Meeting monthly, the JSIG reports directly into the Safeguarding Overview Partnership.

Doncaster CCG will continue to remain sighted on the Joint Inspection Frameworks during 2019-20.
5. **Looked After Children**

As Commissioners of high quality, safe healthcare, Doncaster Clinical Commissioning Group (DCCG) has the local responsibility to ensure the timely and effective delivery of health services for Looked After Children and Young People. As outlined in legislation and national guidance, the NHS is committed to meeting the health needs of Looked After Children. Under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from the Local Authority to help them provide support and services for children in care.

Doncaster has the necessary Designated Professional roles in place, with the capability and capacity to deliver their required function as outlined in the national intercollegiate framework (2019). In addition to the designated roles, Doncaster CCG has a children’s commissioner who works closely with the designated professionals and NHS England in order to commission and monitor quality services in this area of care.

Doncaster CCG, NHS England and NHS provider services have a duty to comply with requests from the local authority to undertake health assessments and to ensure support and services for Looked After Children are delivered without undue delay (DoH, 2015).

**Children in Care**

At the end of 2018-19, 534 children were in the care of Doncaster Children’s Services, at a rate of 81.0 per 10,000 children. This is a further reduction of 26 children and young people since the end of the previous quarter, where the rate was 85.0 per 10,000 children. The current rate of children in care is higher than the national rate of 64 per 10,000 but lower than out Statistical Neighbour rate of 90.1, based on 2017-18 out turns.
5.1 Initial Health Assessments (IHA)

In January 2017, a local Primary Care GP service was awarded a 3 year contract to deliver the Initial Health Assessment service in Doncaster. In addition to the medical led element of the IHA, Doncaster CCG commissioned RDaSH to provide an enhanced nurse led service that would complement and enrich the holistic IHA.

Of the IHA completed a dip sample is quality assured by the Designated Doctor for LAC. The Designated Doctor assesses based on the national standards, periodically providing the CCG with a written report that highlights any requirement for improvement, development and training. The Designated Doctor works alongside the Designated Nurse and Named Nurse to develop and deliver bespoke training to GPs in order to ensure the quality of assessments undertaking is of the highest and expected quality.

Doncaster CCG and the partnership acknowledge the importance of meeting the 20 days statutory target as a means of fully assessing the health needs of a child in a timely fashion. The Designated Nurse for Looked After Children has worked alongside, RDaSH Named Nurse for LAC, GP service and Doncaster’s Children Service Trust (DCST) in order to fully understand the reasons for any delay in IHA completion. The completion of IHAs in timescale relies on an efficient and effective pathway across health and social care.

5.2 Review Health Assessment (RHA)

The review of any initial health assessment / plan sit’s with the RDaSH LAC Nursing team. The review of the child’s health plan must happen at least once every 6 months for children under 5 years, and annually for children over 5 years. The purpose of the RHA is to ensure that the health needs of each Looked After Child is reviewed and a health plan is put in place to address any new or emerging health needs. Doncaster CCG continues to work with RDaSH to ensure that performance data is captured accurately. Latest published data for health assessments, development assessments, immunisations, and dental checks shows that looked after children in Doncaster have higher rates than reported national.

5.3 Care Leavers

It is the responsibility of both the Local Authority and CCG to ensure that there are effective plans in place to enable looked after children aged 16 or 17 to make a smooth transition into adulthood (DOH, 2015). Providers Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) LAC Nursing Team and DCST have well established links in order to support children and promote independence as they become adults. RDaSH provide all children leaving care with a ‘Leaving Care Health Summary’ as a means of enabling an effective transition of service deliver and future care planning.
6. **Safeguarding Adults**

6.1 **Safeguarding Hub**

The Board have supported the significant developments that have taken place with the Adults Safeguarding Hub. The hub have had a series of reviews to provide some rigour to the processing safeguarding alerts. This process has passed through several stages of work and continues to do so. The key impact has been the management of a high level of cases that the team inherited at the beginning of the year.

The number of outstanding cases started the year at around 1000 and to around 440 in Quarter 2 as a result of changes to pathways. This number rose to 624 in Quarter 3, at the time of writing this is being explored further to understand greater.

Supporting this work has been the development of significantly improved performance data. This alters on a daily basis as a result of the nature of the tool, thus enabling the Board to have clear sight of the operational challenges faced by the whole system.

The CCG continue to support this aspect of work specifically by the funding of a healthcare professional that ‘sits’ within the Safeguarding Hub and provides operational health advice. The post continues to be provided and supported by RDaSH and is currently an Occupational Therapist. This role continues to provide excellent support to the whole Health and Social Care Economy.

6.2 **Safeguarding Adult Reviews (SARs)**

During 2018/2019 there have been 18 SAR's, this is a significant increase and continues to increase. Analysis has shown no theme or trend to these reviews. A recent evaluation has identified there is further work to be done around the application of a consistent, robust criteria in this process.

6.3 **Domestic Homicide Reviews**

During 2018-19 there have been no new Domestic Homicide Reviews commissioned.

6.4 **Community Multi Agency Risk Assessment Conference (CMARAC)**

During 2018-19 is a new initiative was developed that now sits above and supports the Vulnerable Peoples Panel (VPP). The new CMARAC will provide governance, accountability and support to high risk / complex cases which often causes front line and supporting managers concern and anxiety as to how they are being managed.

The CMARAC will provide health, social care and the police with a final supportive sign off process in these high risk / complex cases.

6.5 **Historical Sexual Abuse Case**

A piece of work was undertaken during 2019-19 around the area of reporting Historical Sexual Abuse. A team was established, led by the Designated Nurse for Safeguarding Adults, to follow the experiences of a service use following the
realisation her alleged abuser was still practicing which was contrary to the information she had been led to believe following her raising concerns many years ago.

The work took on two approaches, the first involved hearing at first hand the service user’s experiences of trying to navigate the health systems. The second reviewed the processes and pathways against a framework that has been developed following the service users experiences.

The recommendations from the review were:
- Review training to ensure historic allegations of abuse are incorporated.
- Review both internal and external websites to enable ‘entry’ into the different organisations.
- Adopt the developed Practice Guidance.

Discussions have also taken place around how this work can be extended and shared across the wider health community, it was agreed that this would be actioned via NHS England. NHS England are to share the communication initially regionally and then possibly wider.
6.6 Safeguarding Adults Performance
7. **Safeguarding Assurance (adults and children)**

Safeguarding remains one of the core areas of Quality within the CCG and is communicated through the Quality and Patient Safety Committee and in turn up to the CCG Governing Body. Any areas of concern or developments are reported at this Bi Monthly Meeting.

In order to seek assurance from the two key care providers during 2018-19 the CCG was host to the Safeguarding Assurance Group; this was taking place bi-monthly and was attended by Senior Members of the CCG Safeguarding Team and by Senior Members of RDaSH and DBHFT, along with representatives from the Safeguarding Boards. Following a review of safeguarding governance it was agreed that the Safeguarding Assurance Group would be disbanded and form part of the Clinical Quality Review Groups (CQRGs) for each main provider.

The new CQRG terms of reference have been developed and approved by both groups and the refreshed agendas will be taking place during June 2019.

The CCG continues to monitoring safeguarding assurance via the contractual safeguarding annual declaration. At the time of producing this report neither RDaSH nor DBTH had submitted their declaration. These are currently being chased by the contracting team. The other provider annual declaration, such as primary care, care homes, etc, continue to be received during quarter one.

8. **Recommendations**

The Committee is asked to:

- Receive, note and endorse the progress made by the NHS Doncaster CCG Safeguarding Team.
- Consider the format of the Quarterly report and any additional assurances that may be required.
**South Yorkshire and Bassetlaw Integrated Care System CEO Report**

**SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM**

**July 2019**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Andrew Cash, Chief Executive, South Yorkshire and Bassetlaw Integrated Care System</th>
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</thead>
<tbody>
<tr>
<td>Sponsor</td>
<td></td>
</tr>
<tr>
<td>Is your report for Approval / Consideration / Noting</td>
<td>For noting and discussion</td>
</tr>
<tr>
<td>Links to the STP (please tick)</td>
<td></td>
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<tr>
<td>Reduce inequalities</td>
<td>Join up health and care</td>
</tr>
<tr>
<td>Standardise acute hospital care</td>
<td>Simplify urgent and emergency care</td>
</tr>
<tr>
<td>Create financial sustainability</td>
<td>Work with patients and the public to do this</td>
</tr>
</tbody>
</table>

**Are there any resource implications (including Financial, Staffing etc)?**

N/A

**Summary of key issues**

This monthly paper from the South Yorkshire and Bassetlaw Chief Executive provides a summary update on the work of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) for the month of June 2019.

**Recommendations**

The SYB Collaborative Partnership Board (CPB) and SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.
1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System Chief Executive provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of June 2019.

2. Summary update for activity during June 2019

2.1 Launch of the South Yorkshire and Bassetlaw Regional Stroke Service

We have now launched the first phase of the South Yorkshire and Bassetlaw (SYB) Regional Stroke Service, in line with the NHS Long Term Plan ambition to roll out expert stroke teams across the country to ensure thousands more people ‘survive and thrive’.

The SYB Regional Stroke Service concentrates the expertise and equipment under one roof in three locations to provide world-class care and treatment around the clock, reducing death rates and long-term disability. Patients with suspected strokes will be taken to the Royal Hallamshire Hospital and Doncaster Royal Infirmary, and for those who live in north Barnsley, to Pinderfields Hospital.

Rotherham Hospital stopped providing the hyper acute stroke service (up to the first 72 hours) on 1 July and Barnsley Hospital will stop on 1 October. Both hospitals will continue to provide care and treatment after the first 72 hours as part of a network of local hospitals.

Recently Professor Stephen Powis, NHS national medical director, cited a major new study which found 170 extra lives are saved a year in London and Manchester alone thanks to the establishment of Hyper Acute Stroke Units (HASUs). They give patients faster access to specialist diagnosis and treatment, such as brain scans, clot-busting drugs and mechanical thrombectomy. Patients treated at the specialist centres also spend less time in hospital, which is better for them and frees up staff and beds to care for more patients.

I would like to record my thanks to the team behind making this happen and particularly to Richard Jenkins and Marianna Hargreaves. With their leadership and the support of clinicians and managers, they have ensured a smooth transition to the new service.
2.2 SYB Allied Healthcare Professionals Conference and Awards

I was delighted to attend the SYB Allied Healthcare Professionals (AHP) Annual Conference and present their Awards at the Doncaster Keepmoat Stadium on 3 July. I was joined by Joanne Fillingham, Clinical Director Allied Health Professions for NHS Improvement and SYB Integrated Care System (ICS) Medical Director Des Breen.

The Conference highlighted some of the excellent work taking place locally, regionally and nationally and generated good discussions. The AHP Awards, the first ever in South Yorkshire and Bassetlaw, recognised a broad range of schemes being led by AHPs, from a project in Doncaster linking primary school children with people with dementia to organisations in Barnsley helping people make faster recoveries by getting them the right support after a hospital stay.

Our workforce, of which we have over 72,000, are our biggest champions in helping to make our ambition a reality and our AHP colleagues are really leading the way in making this happen. I heard about some fantastic initiatives taking place in local neighbourhoods, organisations, towns and across the region and commend not just the winners but all those who took part.

Suzanne Bolam, Chartered Physiotherapist and Lead for the South Yorkshire and Bassetlaw AHP Council has demonstrated strong leadership in getting the AHP Council and Awards off the ground and is to be commended for making the Conference and Awards such a success.

2.3 National Award for the South Yorkshire and Bassetlaw Nursing Bank Management team

The South Yorkshire and Bassetlaw Nursing Bank Management team has won the Award for Workforce Contribution in Health and Social Care Systems (sponsored by NHS England) in the Healthcare People Management Association (HMPA) 2019 Awards.

This is an innovative partnership with a single nurse bank provider (NHS Professionals) across all of the trusts. For the first time local bank nurses can now work at any of the hospitals and this is enabling a more flexible workforce with the same high quality standard of patient care wherever they work. There is now a reduced reliance on staff from nursing agencies and a saving of £1.2m year to date (at January 2019) has been made which has been reinvested back into healthcare through the trusts’ banks. This has allowed an extra 87,000 hours of support from bank nurses to be provided via frontline care.

This is a good example of how the ICS workforce team is increasingly identifying areas for joined up approaches that benefit all and I would like to extend my thanks to Linda Crofts, Ben Chico and the HR teams in our Partner organisations for co-ordinating the initiative.

2.4 National Recognition for Medicines Optimisation in Care Homes Team

The South Yorkshire and Bassetlaw ICS Medicines Optimisation in Care Homes Team was highlighted as good practice in the national Future Health and Care Bulletin last month. The team, which is made up of pharmacists and pharmacy technicians, works in care homes to make sure residents get the most from their medication, reduce the risk of harm, and improve residents’ quality of life.

2.5 Performance Scorecard

The attached scorecards show our collective position at June 2019 (using predominantly April/May 2019 data) as compared with other areas in the North of England and also with the other nine advanced ICSs in the country.

The data shows that across the system, our overall performance has declined since last month. This trend is in keeping with other systems. We were the only ICS in the North and advanced ICS to meet the two week wait time and although our A&E performance is below the NHS
Constitutional Standard, we have seen an improvement in the month (from 88.2 to 90.9). However, our performance has worsened on Referral To Treatment (RTT) and Diagnostic Waits. We are only just below the NHS Constitutional Standards in many of the areas and are working hard collectively to improve these.

In our financial position, there are small variances at month 2 in year to date positions compared to plan. As is to be expected at this stage in the year, all organisations are forecasting achievement of plans. There is a potential risk to system Provider Sustainabilitiy Funding (PSF) of £5.7 million depending on the outcome of further discussions.

2.6 Place Reviews

A further two formal Place reviews were undertaken this month with Rotherham Accountable Care Partnership on 17 June and Doncaster Accountable Care Partnership on 26 June. Following the reviews carried out in April (Sheffield) and May (Bassetlaw and Barnsley) this now completes the first round across our Places.

We are now reviewing the approach we took during the first round to refine it and maximise the focus on delivery and transformation at Place while exploring both good practice and issues or areas where additional support would be helpful.

2.7 Simon Stevens visit to South Yorkshire and Bassetlaw

I was delighted to welcome Simon Stevens to South Yorkshire and Bassetlaw on 18 June when he visited Doncaster and Rotherham as part of his tour to the new regions to meet staff and wider NHS colleagues. In the morning he visited Doncaster Royal Infirmary to hear about the local NHS’s Long Term Plan for children’s mental health and in the afternoon Simon he met with NHS England and Improvement staff in Rotherham to share his vision for the NHS.

2.8 Sheffield City Region

I met with Sheffield City Region Mayor, Dan Jarvis and his team to explore how we could strengthen the work of the Mayor and the ICS. It was an informative and productive discussion and we agreed that there are areas of crossover where the population of SYB would benefit greatly from a more joined up approach. This included exercise and active travel, homelessness and a continuation of the support to help people into work or back to work. We agreed to meet regularly to take this agenda forward and to also arrange an information sharing session with all our MPs in the Autumn.

2.9 Health and Well Being Board Leads

On June 10, I met with the South Yorkshire and Bassetlaw Health and Wellbeing Board Leads. The session is one of my regular meetings with leaders across the system to provide an update on the work of the ICS and to hear from them on issues and topics that are of significance.

2.10 Commissioning Development

Across South Yorkshire and Bassetlaw commissioning; deciding what services should be provided to local populations, who should provide them and how they should be paid for has already started to evolve and adapt to better meet the need of people and patients as set out in the ambition of the Long Term Plan which is more integrated.

In each of our local places NHS commissioners continue to develop closer working with Local Authorities enabling joint working and joint teams and supporting and enabling the development of neighborhood working and the development of Primary Care Networks. Across South Yorkshire and Bassetlaw, commissioners are working jointly with providers and others to agree population health ambitions and outcomes together, decide priorities together and plan together where this make sense to do so especially where this reduces variation in standards, quality and accesses to
A number of workshops have been established bringing together each of the 5 CCG Clinical Chairs and Accountable Officers, NHS England and senior leadership from the ICS to identify proposals for how commissioning could develop further to strengthen delivery of ambitions set out in the NHS Long Term Plan with a view to having this in place for 2020/21.

2.11 Long Term Plan Implementation Framework

Following the publication of the NHS Long Term Plan, NHS England and NHS Improvement committed to publishing an implementation framework, setting out further detail on how it would be delivered.

The Implementation Framework summarises these commitments alongside further information to help local system leaders refine their planning and prioritisation. This includes detail about where additional funding will be made available to support specific commitments and where activity will be paid for or commissioned nationally. It is available on the NHS England website https://www.longtermplan.nhs.uk/implementation-framework/

2.12 South Yorkshire and Bassetlaw Integrated Care System Focus Meeting with NHS England and Improvement

I reported last month that the first ‘focus’ meeting with NHS England and Improvement and South Yorkshire and Bassetlaw ICS took place on 16th May 2019. The discussion was the first since the ICS took on greater responsibilities on April 1st 2019 and was between senior managers in the ICS Chief Executive Lead’s team and the Joint Regional Director’s team.

I have now received the formal feedback from NHE England and Improvement Regional Director, Richard Barker and attach it to this report for your information.

2.13 ICS Guiding Coalition event

This Autumn we will set out our refreshed vision and ambition for the South Yorkshire and Bassetlaw Integrated Care System Five Year Plan. The aim is for our collective strategic intentions to build on the work we set in motion three years ago when we came together to develop our Sustainability and Transformation Plan.

Partners’ contributions are crucial in shaping the refreshed plan and I have invited representatives from our wide partnership to a workshop to take part in its development on Tuesday 9th July at the New York Stadium in Rotherham from 9.30am to 12.30pm. We will consider the key themes within the NHS Long Term Plan, published earlier this year, alongside the discussions that have already been taking place across the system, in each of our Places and also with the public.

2.14 Health Oversight Board

The ICS Health Oversight Board (HOB) met for the first time on 27 June. The Board provides a joint forum between health providers, health commissioner, NHS England, NHS Improvement and other national arms’ length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan. It also builds on the SYB partnership working on strategic health priorities requiring closer working across systems.

Discussions at the meeting included a focus on purpose and turning our attention to delivery, with an emphasis on the ICS adding value and having robust governance.

2.15 ICS Review

As we prepare for discussions on refreshing our vision and ambition, it is timely to look back on our work as a Partnership and we are preparing an ICS Review to do this.
We have much to celebrate and the Review will capture the work that has been taking place across the system over the last three years. With support from staff, the public and stakeholders we are making real inroads into transforming the way we do things at a system level so that people continue to receive high quality services but in ways that are more convenient and with better outcomes. You will be able to read about some of the initiatives making a difference to people’s lives across the region when it is published, both in print and online, in July.

Andrew Cash  
Chief Executive, South Yorkshire and Bassetlaw Integrated Care System  

Date 4 July 2019
Dear Andrew

ICS Focus meeting with South Yorkshire and Bassetlaw

Thank you for coming to Quarry House on 16th May 2019 for the South Yorkshire and Bassetlaw ICS Focus meeting and for a constructive discussion on the key strategic and delivery issues in your area, including a review of progress made in 2018-19.

Strategic progress

SY&B continues to make good progress in addressing the health and wellbeing, care and quality and efficiency gaps. There are notable areas of strong delivery and innovation, such as; the reduction in DTOC from a very challenged position, recovery and maintenance of improved diagnostic performance, delivery of all mental health standards, the introduction of new care models for children and young people and support for homelessness and isolation and people with complex lives.

All organisations met or exceeded their control total, apart from SCH where offsets were used to secure Q4 PSF, recognising the lessons to be learned from the changes to the incentive scheme in 2018/19. I encourage you to share areas of best practice with other STPs and ICSs.

Leadership and Governance

Governance and enabling workstreams are well developed - the ICS continues to refine its governance to support partnership working and delivery. The System Health Oversight Board and the System Health Executive Group are key parts of the overall governance structure as is the Partnership Board. The ICS is considering the potential establishment of an ICS Assembly, reflecting national arrangements.

The ICS has a clear ambition to be the best delivery system and this will be key to creating the headroom needed for a major focus on improving health inequalities and outcomes, where there is an urgent need to accelerate progress across the ICS, in common with the rest of the north. These health challenges are significantly higher than those being experienced in other areas of the country and deteriorating. This will be a key theme as the ICS continues to develop its five-year strategy over the spring and summer and critical to your ambition to become the most transformed system. The strategy will need to clearly address the choices and trade-offs to be made across the ICS.

Key challenges

SY&B is generally a well performing system with a clear approach to improvement which aims to use partnership and peer approaches to identify risks and drive delivery. Benchmarking against the best performing systems should continue to be used as a tool to improve.

The strategic and delivery challenges facing the ICS, and the issues requiring particular focus and effort to effect change over the coming year are summarised below.

- **Ensuring strategic sustainability** - RDASH and SHSCFT– the ICS is in discussions with these organisations considering an alliance, you will keep me briefed as this progresses. The ICS will also continue to make progress on the HSR having already engaged positively with
• patients and the public. The development of a compelling narrative for change will be a key part of the ICS’s development of its 5 year plan. A strategic approach to the challenges of **workforce and talent management** will be essential.

• **Quality** - TRFT and DBHFT CQC action plans are a key focus for improvement.

• **Elective performance** – total waiting list size is an area for focus although elective performance is otherwise good.

• **Cancer waiting times** – long term sickness and growing demand in urology have impacted on delivery – particularly in relation to 62 day performance. Changes to cancer alliance boundaries will need to be managed carefully to ensure that improved delivery is supported.

• **A&E** – NGH and TRFT are the highest risks to delivery and the ICS will support organisations to have a forensic focus on what is needed to remedy performance, and to ensure that this is driven by organisational leadership. The ICS should ensure that improvements at Rotherham mean that the system is in a much improved position by this time next year. The ICS will start to plan for an up to 20% increase in inpatient NEL capacity needed over the winter, by improved seasonal profiling, reduced LoS, increased same day services etc.

• **2019/20 planning** – £2m real plan alignment differences of which £1.8m is DBTH and Bassetlaw CCG. Non-elective activity is off plan and the ICS will work to identify and address the drivers behind this position. Assurance was provided that sufficient financial coverage had been set aside locally to fund the alignment concern once the local reviews had concluded.

• **Finance** - There is also a need to recognise the level of non-recurrent support being provided for the ICS in year, and to plan for the withdrawal of this support by the next financial year. Further work will take place to ensure the deliverability of CIPs and high risk QIPP, particularly at SCH, D&BNFT and Bassetlaw CCG, and also to prioritise capital requirements in the context of the recent letter from Julian Kelly. We will ensure that Jeremy is aware of the advice we have given to STHNFT on tariff.

• In response to the significant national overcommitment of capital aspirations compared with the available ceiling on **capital spend**, it is likely that STPs will need to undertake a prioritisation exercise to manage scheme proposals within a set amount available to each STP/ICS Community. Details are likely to be announced shortly and NHS England and Improvement colleagues will work with local communities on this exercise.

• **Learning Disabilities** – this remains a challenged area and a major focus for improvement to ensure that numbers of in patients reduce, and people receive the care that they need in a community setting.

• **MOU** – in common with other ICSs the year end assessment against SYB’s MOU will be formally submitted to the national team.

**Regional and ICS operating model**

The NE&Y and SY&B operating model will continue to evolve as the new regions become established. Alison Knowles as the newly appointed Locality Director for SY&B is already aligned to the ICS and will continue to support this work.
SY&B would like to become a test bed for the new regional and ICS operating model, which I am happy to support, recognising that we will be developing similar working relationships with all of the STP/ICSs across the North east and Yorkshire. The NHSE/I phase 3 design work will take a few more months, given the need for a period of staff consultation and recruitment to the new structures which have just been designed. Alison Knowles will work with you to help take this forward, e.g. in terms of testing scenarios such as the approach to escalation and I will continue to work with you directly in addition.
The System Health Oversight Board will become a focus for assurance and we will work together to develop how regulatory oversight could be discharged through this body. We agreed to take stock of the focus meeting approach and discuss arrangements for next year which may include alternate v/c and face to face meetings – including meetings at your local sites.

I will continue to work with you as we refine our operational arrangements together, recognising the need for the ICS to develop sustainable capacity.

**Long Term Plan** - The development of commissioning – at neighbourhood, place and system level is a key focus for the coming year and one on which we will continue to work with you. A focus on the development of primary care networks, as well as place-based and strategic commissioning will continue, in line with the aspirations set out in the Long Term Plan. Mental Health, cancer, digital and workforce are also high priorities. The ICS is already working on its approach to addressing these as part of its development of its 5 year plan. We acknowledge the current challenges around Sheffield CCG and the need to deliver an action plan to restore positive local relationships.

**Summary**

The ICS is to be congratulated on its progress and innovative approaches in many areas and is committed to addressing its delivery challenges and to becoming an international exemplar in health and care. Addressing A&E, Transforming Care and sustainability challenges are key areas for action in the coming year as is a focus on improving outcomes and reducing inequalities as you develop your 5 year plan.

I look forward to continuing to work with you on these issues, and to the development of our mutually beneficial operating model.

Yours etc

RB
Engagement & Experience Committee Meeting
Held on Tuesday 6th June 2019 at 10am – 12pm
In the Boardroom, Sovereign House

Present:

Sarah Whittle - Chair Lay Member for Patient & Public Involvement
Anthony Fitzgerald Director of Strategy & Delivery
Paul Hemingway Head of Communications & Engagement Information Technology & Systems Programme Manager
Chris Empson Rachael Mather Communications & Engagement Manager
Alison Edwards Corporate Governance Manager
Denis Aitken Doncaster Health Ambassador Group Chair
Andrew Goodall Chief Operating Officer – Healthwatch Doncaster
Victor Joseph Public Health Representative

In attendance:

Terri-Marie Scoots Informatics Project Manager
Kerry McGuire Patient Experience Administrator
Karen Connolly Senior Corporate Support Officer (taking minutes)

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<thead>
<tr>
<th>Agenda Ref</th>
<th>Subject</th>
<th>Action Required By</th>
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<tbody>
<tr>
<td>1.</td>
<td>Welcome, Introductions and Housekeeping</td>
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<tr>
<td></td>
<td>The Chair welcomed everyone to the meeting and introductions were made.</td>
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<td>2.</td>
<td>Apologies for Absence</td>
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<td>The Chair noted apologies of absence from the following:</td>
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<td>• Khaimraj Singh – South Locality Lead</td>
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<td>3.</td>
<td>Declarations of Interest</td>
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<td>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).</td>
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<td></td>
<td>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: <a href="http://www.doncasterccg.nhs.uk">www.doncasterccg.nhs.uk</a></td>
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<td>The meeting was noted as quorate.</td>
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<td></td>
<td>Declarations of interest from sub committees / working groups:</td>
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None declared.

Declarations of interest from today’s meeting:
None declared.

4. **Minutes From Previous Meetings**
   The minutes from the previous Committee meeting held on 4\textsuperscript{th} April 2019 were approved as a correct record.

   The minutes from the previous Management Group meeting held on 2\textsuperscript{nd} May 2019 were approved as a correct record.

   The Chair noted her thanks to Miss Lindsay Moore for her previous administration support with Experience & Engagement Committee meetings.

5. **Action Log Update**
   Both the open & closed action logs have been updated:
   - 7 actions closed
   - 1 action remains open
   - 5 new actions

   The updated open and closed action logs will be circulated with the minutes of this meeting.

6. **Matters Arising not on the Agenda**
   The Chair commented that priority areas discussed at this meeting need to coincide with their presentations at Governing Body. To check forward planner.

   Ms. Mather advised ‘10 Steps to Even Better Engagement’, delivered by NHS England, is planned for 10\textsuperscript{th} July. A welcome invite is extended to all.

   Ms. Mather also informed the group of the Cancer Roadshow starting on Monday 10\textsuperscript{th} June on the Health Bus. Morning sessions run from 10am - 12.30pm or an afternoon session from 12.30pm-3pm. Again, a welcome invite is extended to all.

7. **Notification of Any Other Business**
   - Experience & Engagement Management Group

8. **Strategy - Priority Areas**
   The Chair welcomed Mrs. Leivers to the Committee meeting to provide an update on Planned Care

   - **Planned Care**
     Progress has been made over the last 6 months. Engagement around the 100 day rapid improvement and Missed Appointments agenda is ongoing, this will enable further ongoing engagement and
feedback to patients and the public.

With regards to the Missed Appointments work understanding the impact will be an ongoing process as the public audit will be repeated this year to understand whether there have been changes in public perception.

The more recent 100 day work for Ophthalmology has seen the production of a patient information leaflet to signpost patients to services that can assist with common eye complaints, this remains in draft but is expected to be finalised soon.

The spinal 100 day programme has also co-developed a patient leaflet, gaining thoughts from a range of patients within orthopaedic clinics to gain their feedback on the draft developed. A finalised version is now in circulation and printed copies will be shared with practices.

Information has been made available regarding the 100 Day Rapid Improvement Programme on the public facing website http://www.doncasterccg.nhs.uk/your-care/planned-care/latest-100-day-challenge/

The leaflets produced will also reflect back to patients to show how their input has been used.

The Missed Appointments work has a strong presence on the CCG, Doncaster Healthwatch and Hospitals websites and other social media platforms. This includes a copy of the full audit report being available on the Doncaster Healthwatch website https://www.healthwatchdoncaster.org.uk/missedappointments/

Further updates regarding the 100 Day Rapid Improvement Programme will be added to the website. Once approved the patient information leaflets will be made available.

Missed Appointments work will continue to have a strong Patient Engagement focus at its heart with the upcoming repeat of the public questionnaire.

Mr. Hemingway commented on the patient stories coming through, the recent spinal patient was useful and powerful.

The Chair queried Choosing Wisely, is it happening consistently across the board? Is it consistent and embedded? Mr. Fitzgerald informed the Committee members a lot of time has been spent on the access policy, work is ongoing about what should happen, what is happening and why have there been delays. Mr. Empson advised we don’t analyse
perceptions it is very much quantitative style analysis.

Mrs. Leivers advised constant engagement work is undertaken; i.e. survey monkey.

The Chair thanked Mrs. Leivers for her update and commented on the fantastic ongoing work with engagement.

The Chair welcomed Mrs. Ogle to the Committee meeting to provide an update on Primary Care

- **Primary Care**
  The report covers the period August 18 to end May 19. During this period significant work has been undertaken to develop a primary care strategy, workforce strategy and primary care estates strategy. Engagement is ongoing around these strategies which have also been developed in the context of the overarching health and social care commissioning strategy. More recently this has been the formal emergence of primary care networks with the registration approved of five networks during May 2019.

  In the main the primary care team engages with practices as key stakeholders in the delivery of primary care. Where practices agree to make service changes then the responsibility for patient engagement and consultation lies with them.

  Mrs. Ogle advised the key pieces of engagement work by the primary care team is:
  - Health and Social Care Commissioning Strategy
  - Primary Care Strategy Development
  - Provider Engagement
  - Patient Engagement

  Mrs. Ogle advised the Committee that a number of practice visits have taken place and there are a number of ongoing visits planned. This has resulted in strengthened relationships between practices and the CCG.

  A survey and series of engagement sessions are currently being undertaken that will feed into service transformation over the coming years: [https://www.healthwatchdoncaster.org.uk/accessstogpservices/](https://www.healthwatchdoncaster.org.uk/accessstogpservices/)

  The Chair thanked Mrs. Ogle for her thorough and informative report and suggested the report should go to Governing Body to coincide with it coming to EEC this month.

9. **Children & Young Peoples Mental Health Trailblazer**
Mr. Hemingway explained Doncaster, amongst other areas, has been named a ‘trailblazer area’ with funding provided to form new mental health (MH) support teams for children & young people (CYP). NHS England (NHSE) has asked local organisations to engage with young
people to design MH support teams in schools that CYP are comfortable with and can access and use. Nationally, there is a concern around students MH, the funding provided will mean CYP have the right support at the right time and the right place.

Recent reports highlight the complexity of MH problems faced by staff and pupils on a daily basis and it is clear there is a lot of work to be done across schools to deal with problems but also to try and avoid MH issues becoming an issue. A 2017 study found that one in nine CYP had a MH condition; this is just one of the reasons why we need to put support in place across schools. Teenagers with a MH disorder are more than two and a half times more likely to struggle in adulthood.

The ‘trailblazer’ status given to Doncaster means we can coordinate new MH support teams based near schools. There will also be funding to train senior MH leads in schools and colleges working towards a whole-school approach to well-being. Early help is crucial when it comes to MH; the new service will ensure CYP can immediately access life-changing support when signs of MH issues first appear, helping to prevent problems escalating further into adulthood. Encouraging CYP to think about their mental wellbeing in the same way they do their physical aches and pains is a vital part of our goal to put mental and physical health on equal footing and will help to ensure no CYP is left to suffer in silence.

There is an enormous amount of work underway to support CYP if they experience MH difficulties. Training for staff started in January 2019; we are also working in partnership with colleagues in education such as school nurses and educational psychologists, this will improve MH support and provision on offer as we look forward to seeing results over the next few years.

Mr. Hemingway went on to explain that pupils are involved in deciding how the service should be run as it needs to be right with a good solid start. We need to know what they think and what will work for them, from how they access MH support through to how they can find information about the service and how it can help.

There a 6 focus groups in Doncaster and 6 in Rotherham involved in the project; 2 primary groups, 2 secondary groups, 1 college group and 1 special needs school. All ideas have been pulled together to develop a feel and style for the service. These will be taken back for the students to see and ‘sign off’ before the end of the school year; if they like it hopefully other students will like it too. The service will hopefully be up and running by December.

The Chair asked if Lee Golze is involved? Mr. Hemingway advised Mr. Golze is steering the work and Miss Reseigh. DCCG, is the operational lead and Holly Bevan from Doncaster Council is writing the report. The Chair commented on the good partnership working and asked if we are sharing what has been done so far on the website. Mr Hemingway explained there is some basic information on the website at the moment. Mr. Fitzgerald requested further updates to be brought back to the Committee.
10. **Complaints Update Report**

Mrs. McGuire attended the meeting on behalf of Mrs. Joerning and shared the Complaints, Concerns & Enquiries report to the Committee members. The main points for Quarter 4 (Q4) are as follows:

- 10 complaints received, 3 upheld, 3 partially upheld, 8 not upheld
  - 6 CHC Complaints
  - 4 CCG Complaints
  - 4 included an MPs letter
  - 3 complaints from Q4 are carried forward to Q1
- 6 Concerns
  - 4 CHC Concerns
  - 2 CCG Concerns
- 37 Enquiries
  - 6 CHC Enquiries
  - 31 CCG Enquiries
- 8 MP Enquiries
  - 4 relate to complaints are included in complaint figures

Mrs. McGuire advised changes are being made to the report to see data more clearly. The Chair asked how many complaints overall have been upheld? Mrs. McGuire advised questionnaires are sent out requesting feedback and a link to the ombudsman is included if required. Dr. Joseph queried what further options to complainants have and he also queried the large number of ‘not upheld’ complaints. Mrs McGuire will request the information from Mrs. Joerning and feedback to the committee members.

On a positive note Mrs. McGuire informed Committee members that 4 compliments were received in May.

11. **Social Media Analysis**

Miss Scoots shared the live Social Media Analysis Dashboard with the Committee members. Miss Scoots explained the demographics show who is ‘liking’ posts and how many ‘likes’ are received per month. The analysis also shows what reactions posts get. Miss Scoots to ask Mrs. Harris if the link for the page can be shared. Miss Scoots explained within Facebook we can use organic (free) or paid reach. Mr. Hemingway asked if we can look at using hashtags (#) within Facebook and Twitter.

The Chair commented this is excellent work and we are moving in the right direction. Mr. Empson explained we will be able to show who we are reaching and this will influence our communication and engagement with the public.

12. **Equality Report – Gap Analysis**

Mr. Empson updated the Committee members on the Equality Report.
The following points were highlighted:

- Ambulatory Care
- Geographical Areas of Doncaster
- Population Health Management

It is a targeted piece of work and real outcomes will come out of it. Dr. Joseph commented on the Health & Equality Group, The Chair asked if we can see something on this? Mr Empson advised it will take a couple of months to bring something to the Committee.

### 13. Healthwatch Update Report

Mr Goodall presented the main points of the Healthwatch Doncaster Report to the Committee members:

- Recruiting new Health Ambassadors
- Access to GP Services in Doncaster
- Doncaster Council Outreach Teams
- Outpatients Review at DBTH
- Review of PIN for Patient Navigation Services in hospital settings
- Potential Review of Minor Eye Condition Services (MECS) – Tender – Ophthalmology
- NHS Long Term Plan
- Healthwatch Doncaster Micro-Grants 2019

Mr Goodall informed the Committee members of future planned activities and:

- Accessing Primary Care in Doncaster
- Cancer – quality of local services
- Mental Health
- Missed Hospital Appointments

There is ongoing work around:

- Social Capital 1000 Voices
- Doncaster Pride
- Recovery Games
- Governing Body Stories

The Chair noted the extensive, comprehensive report and thanked Mr. Goodall for sharing it with the Committee members.

### 14. 360 Report

Mr. Fitzgerald presented the 360 report to the group highlighting the following points:

- Improve engagement with GP practices
- Staff Directory

Mr. Fitzgerald will circulate the full presentation to the Committee.
The Chair thanked Mr. Fitzgerald and commented that things are moving in the right direction.

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| 15. | **AGM Update**  
Mr Hemingway informed the Committee the next Annual General Meeting (AGM) is taking place on 17th July from 2.30pm – 6pm at the High Speed Rail College in Doncaster. All teams and key partners will have the opportunity to have a stall that sets out their achievements and highlights over the past year. There will be an overview, performance (including new video), financial accounts and the launch of our public annual report for 2018-19. We will also share key programmes, projects and how we will work with partners to implement joint health and social care commissioning strategy.  
Ms. Mather is liaising on the event and will send out information about the AGM and a booking form so colleagues and organisations can book a stall at this year’s networking and exhibition area. | **RM** |
| 16. | **ICS Update**  
This item was deferred to the next committee meeting. |
| 17. | **EEC Meeting Cycle**  
Mr. Hemingway advised the committee members that future meetings will take place monthly rather than bi-monthly. The main reason being to maintain flow with Governing Body. The need for the Experience & Engagement Management Group has is no longer required but a task and finish style group will have a short monthly meeting, the members being Mr Hemingway, Miss Mather, Miss Edwards, Mr Empson and Miss Smith. |
| 18. | **Forward Plan**  
To be discussed at the next committee meeting. |
| 19. | **Any Other Business**  
New committee meeting dates to be sent out to the committee members. | **KC** |
| 20. | **Date & Time of Next Meeting:**  
Thursday 4th July 2019 at 10am in Meeting Room 3, Sovereign House |
### Action Summary

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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>C119/19</td>
<td>Welcome and Introductions&lt;br&gt;The procedure for submitting questions to the JCCCG meetings held in public is documented on the JCCCG section of the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) website and would also be included within the Terms of Reference.</td>
<td>LK</td>
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<tr>
<td>C122/19</td>
<td>Questions from the Public&lt;br&gt;Question 4 - Perinatal Services in SYBICS&lt;br&gt;It was agreed that Barnsley CCG to respond on behalf of the JCCCG.&lt;br&gt;A copy of the questions and answers to be available on the SYB ICS website.</td>
<td>NB HS</td>
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<td>C126/19</td>
<td>2019/20 Joint Committee Governance arrangements:&lt;br&gt;Update the agreed changes to the JCCCG Manual Agreement and JCCCG Terms of Reference.&lt;br&gt;Review the JCCCG ToR in December 2019 to incorporate any further changes agreed.&lt;br&gt;It was agreed to bring to the next JCSG meeting how the JCCCG could showcase the progress of workstreams to the wider ICS.&lt;br&gt;The Group agreed to the recommendation brought before them and agreed the JCCCGs priorities and the Manual Agreement Terms of Reference and recommended to the CCG Governing Bodies for sign off in July with the changes agreed at today’s meeting. LK agreed to circulate the revised ToR and Manual Agreement to the Group this week in advance of sharing with the CCG Governing Bodies.</td>
<td>LK LK LK LK AOs</td>
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Minutes of the Meeting of
The Joint Committee of Clinical Commissioning Groups
Public Session

Meeting held 26 June 2019, 3.30pm - 5.00pm
at Boardroom, Sovereign House, NHS Doncaster CCG

Present:
Dr David Crichton, Clinical Chair, NHS Doncaster Clinical Commissioning Group (Chair)
Dr Nick Balac, Clinical Chair, NHS Barnsley Clinical Commissioning Group
Dr Eric Kelly, Clinical Chair, NHS Bassetlaw Clinical Commissioning Group
Andrew Goodall, Healthwatch Representative
Philip Moss, Lay Member
Priscilla McGuire, Lay Member
Helen Stevens, Associate Director of Communications and Engagement, South Yorkshire and Bassetlaw Integrated Care System
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Dr Richard Cullen, Clinical Chair, NHS Rotherham Clinical Commissioning Group
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Idris Griffiths, Accountable Officer, NHS Bassetlaw Clinical Commissioning Group
Will Cleary-Gray, Chief Operating Officer, South Yorkshire and Bassetlaw Integrated Care System
Sir Andrew Cash, Chief Executive, South Yorkshire Bassetlaw Integrated Care System
Dr Chris Clayton, Chief Executive Officer, NHS Derby and Derbyshire Clinical Commissioning Group
Brian Hughes, Director of Commissioning and Performance, NHS Sheffield Clinical Commissioning Group
Dr Tim Moorhead, Clinical Chair, NHS Sheffield Clinical Commissioning Group
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group and Interim Accountable Officer, NHS Barnsley Clinical Commissioning Group

Apologies:
Dr Avi Bhatia, Clinical Chair, NHS Derby and Derbyshire Clinical Commissioning Group
Matthew Groom, Assistant Director, Specialised Commissioning, NHS England
Jackie Mills, Director of Finance, NHS Sheffield Clinical Commissioning Group

In attendance
Mags McDadd, Corporate Committee Clerk, Exec PA Business Manager, South Yorkshire and Bassetlaw Integrated Care System
Lisa Kell, Director of Commissioning, South Yorkshire and Bassetlaw Integrated Care System

Public in attendance
Julia Ingram, SYBNAG Mike Smith, SYBNAG Ken Dolan, BSONHS
Nora Everitt, SYBNAG Steve Merriamn, SYBNAG Steve Sullivan, Bayer
Doug Wright, KONHSP Elaine Borthwick, Pfizer
<table>
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<tr>
<th>Minute reference</th>
<th>Item</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>C119/19</td>
<td>Welcome and introductions</td>
<td>LK</td>
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<tr>
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<td>The Chair welcomed members and attendees to the meeting, thanking public members present for the questions submitted in advance of the meeting.</td>
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<td>The Chair reiterated that the agenda allows 10 minutes before the start of the meeting to make a statement or ask a question about items on the day’s agenda in relation to pre-submitted questions.</td>
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<td>DW asked whether anything additional could be heard at this time. The Chair clarified that only pre-submitted questions could be heard, noting the JCCCG meeting is a business meeting held in public. It was noted the procedure for submitting questions to the JCCCG meetings held in public is documented on the JCCCG section of the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) website and would also be included within the Terms of Reference.</td>
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<tr>
<td>C120/19</td>
<td>Apologies</td>
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<td></td>
<td>Apologies were received and noted.</td>
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<tr>
<td>C121/19</td>
<td>Declarations of Interest</td>
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<td>The Group was reminded to submit any outstanding register of interest 2019/20 forms to the Committee Clerk.</td>
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<td></td>
<td>There were no declarations of interest.</td>
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<tr>
<td>C122/19</td>
<td>Questions from the public</td>
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<td>Questions were submitted prior to the meeting. The JCCCG provided a response:</td>
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<td><strong>Question received from Doug Wright, Keep our NHS Public</strong></td>
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| | **Question 1.**  
Manual Agreement for JCCCG  
Appendix 2 - JCCGs Terms of Reference  
10.2 This paragraph does not give the right to members of the public to ask questions or participate in a JCCCG meeting, unless invited to do so by the Chair. This discriminatory paragraph is a late addition to the TOR.  
Will the JCCCG delete paragraph 10.2 in the interests of democracy and open and accountable JCCCGs? |
| | **Response:**  
No. JCCCG meetings are business meetings which we hold in public, they are not public meetings. |
| | **Appendix 5**  
Why can't an elected member of South Yorkshire and Bassetlaw NHS Action Group join up with the Citizens Panel and SYB wide Lay Members, to review and offer advice and support? |
| | **Response:**  
The opportunity to apply for both the Citizens’ Panel roles and JCCCG Lay Member roles were well advertised when we recruited. Recruitment to the Citizens’ Panel is |
ongoing and we are currently looking for more members from Barnsley and Rotherham. The JCCCG Lay Member roles will be advertised next year.

The Travel and Transport Group does have a member from the SYB NHS Action Group.

Questions from South Yorkshire and Bassetlaw NHS Action Group via Nora Everitt

Question 1
Warrington and Halton Hospital NHS Trust
i) Can the JCCCG reassure the public that they will not allow a local NHS Trust to follow the example recently shown by Warrington and Halton Hospital Trust and market treatments listed in the SYBICS Commissioning for Outcomes Policy as chargeable treatments that patients can self fund?

Response:
It is not for the JCCCG to comment on decisions that will be made by individual Trust boards and CCG governing bodies.

ii) Do you recognise the Long Term Plan funding average of 3.1% which, as 4.2% is widely agreed necessary to just stand still, is totally inadequate to;
   a) maintain an efficient and comprehensive free at the point of delivery health service without unrealistic expectations of patient self care or self-financing by moving the goal posts and claiming Limited Clinical Values where none existed before?

Response:
The question of funding is irrelevant. The JCCCG considers clinical evidence, quality and effectiveness and best practice using Royal College and NICE guidance to inform policy development.

   b) ensure a safe, stress free working environment for staff?

Response
This question is not relevant to the JCCCG or the agenda.

   c) ensure a safe treatment environment for patients?

Response:
This question is not relevant to the JCCCG or the agenda.

iii) What steps are the JCCCG taking to ensure central funding not only addresses ii) a), b) and c) (above) but is set at a level which urgently addresses the workforce shortfall of 106,000?

Response:
This question is not relevant to the JCCCG or the agenda.

Question 2.
Minutes of May JC CCG Meeting
Can the JCCCG confirm that the SYBICS Collaboration Partnership board intends to revise its Terms of Reference shared in the Rotherham CCG public papers and will meet in public in 2019/20?
Response:
The JCCCG cannot comment on the Terms of Reference for the Collaborative Partnership. However, as part of redesigning the Collaborative Partnership Board it has been agreed in principle that it will meet in public in the future.

Question 3
Final Draft of the Manual Agreement & JCCCG TOR
i) Purpose of the JC CCG (P6) and JC CCG Guiding Principles (P17)

Rather than summarising minimal public feedback will the JC CCG ensure that all patients, carers and the public have ample opportunity to directly monitor and influence the effectiveness of the JC CCG’s chosen strategic approach for developing patient centred services; improved population health outcomes; more seamless services and equity in access to services across the Integrated Care System?

Response
The JCCCG is established as a decision making committee of the CCGs. The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JCCCG.

(ii) System/local Commissioning Intentions (P8)
(a) Given that plans are also intentions why is the Section 26 14Z13 (2) and (8) (a) & (b) not referred to in this section as this is a CCG statutory duty that must be met in writing or changing commissioning plans?

(We note that the document repeatedly refers to ‘stakeholder’ ‘engagement’ when describing Section 26 14Z2 although the law refers to the “involvement” of “individuals”).

Response
The JCCCG is established as a decision making committee of the CCGs. The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JCCCG.

b) Following the Warrington fiasco of posting price lists and charging patients for low clinical value treatments that had NHS funding removed the ICS plan to remove NHS funding from more such treatments in SYB is now very contentious.

When are the JC CCG going to publish the full details the Commissioning for Outcomes – new stage 2 and share with the public their intended additions to the list of treatments they consider as of low clinical value?

Response:
They will be published during 2019/20 when the work is complete.

iii) Complying with Statutory Duties of CCGs (P9), Appendix 3 and Appendix 5
All points under this paragraph make it clear that the JC CCG must meet the statutory duties of CCGs and summarise these in Appendix 3. However this final draft repeats all the major statutory duty omissions that SYBNAG made sure you were aware of.
Appendix 3:

• Includes 13Q which is the Section 23 statutory duty of NHS England and NOT of CCGs
• Omits reference to Section 26 which lists all new CCG duties that begin with 14, e.g. 14Z2
• Omits new sections 14Z11, 14Z13, and 14Z15, all statutory duties relating to commissioning
  ➢ Omits reference to the clear advice of the Statutory Guidance about when 14Z2 applies:
    o when to involve such as changes in;
    o commissioning arrangements,
    o in procurement and contracts
    o and how to decide if 14Z2 applies

Response
The Appendix refers to commissioners having regard to the other statutory obligations set out in the new sections 13 and 14 of the Act. It refers to ‘the following, amongst others’ and is not intended as a verbatim list.

Appendix 5:

➢ This document outlines a process for deciding whether a 14Z2 duty to involve applies but it bears no relation to the clear advice or the template provided in the Statutory Guidance
➢ CCGs have to justify not having regard to the Guidance and their reasons must be clearly documented
  a) Is the JC CCG going to rectify these errors and if not is it going to justify and clearly
  b) If not is it going to justify and clearly document why it did not have regard for the Statutory Guidance?

Response:
The document outlines the internal process for ensuring how 14Z2 forms are considered, it is not a 14Z2 form.

iv) Governance (P10)
The SYBNAG’s detailed comments on the SYBIC’s JCCCG’s previous draft of the Manual Agreement & Terms of Reference summarises our view that the document reinforces our experience over the past three years that many areas of governance have been unclear and remain unclear.

We are aware that the governance arrangements and accountabilities of an individual Clinical Commissioning Group (CCG) are covered in its Annual Governance Statements (AGS).

We are also aware that from 2019/20, Joint Clinical Commissioning Group Committee decisions are binding on individual CCG’s regarding the operation of the South Yorkshire and Bassetlaw Integrated Care System (ICS).

How will this impact the governance arrangements?, for example, from 2019/20:

Will the JCCGC and / or the ICS be producing their own Annual Governance Statements?

Response:
The JCCCG is established as a decision making committee of the CCGs. The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JCCCG.

Member CCGs produce annual governance statements, outlining how they have fulfilled their statutory duties. The JCCCG will produce an annual report of its business.

**Will bad JCCGC / ICS decisions / actions that lead to patient death or injury, be attributable to it, or to an individual CCG?**

**Response:**
The JCCCG is established as a decision making committee of the CCGs. The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JCCCG.

v) Delegation (P11)
The purpose of delegation describes the JC CCG role as a ‘critical element’ of the interim governance arrangements by the SYB ICS executive and the mechanism by which future collective commissioning decisions can be made.

As ‘critical element’ implies a degree of independence from the ICS, are the JC CCG voting members fully confident that the ICS public involvement tools and mechanisms are as robust as their own, given that the CCGs to take full legal liability for any ICS actions relating to their delegated duties that fail to meet the legal requirements?

**Response:**
Yes

vi) Terms of Reference – Guiding Principles (P14)
What principles are actually involved in ‘managing your stakeholders effectively’?

**Response:**
‘Managing stakeholders effectively’ is one of the guiding principles in the Terms of Reference.

vii) Procurement (P17)
a) Will the JC CCG be having regard to the clear advice in the Statutory Guidance about involving individuals (who use, or may use, services provided) in the procurement of those services, as most of the voting members of your committee do themselves?
b) If not will you justify and clearly document your reasons?

The JCCCG is established as a decision making committee of the CCGs. The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JCCCG.

**Question 4**
Perinatal Services in SYBICS
<table>
<thead>
<tr>
<th>C123/19</th>
<th>Ratification of previous meetings:</th>
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<tbody>
<tr>
<td></td>
<td>The minutes of the public meeting held on 22 May 2019 were accepted as a true and accurate record.</td>
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<table>
<thead>
<tr>
<th>C124/19</th>
<th>Minutes of the Joint Commissioning Sub Group</th>
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<tr>
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<td>The Group noted the minutes of the Joint Commissioning Sub Group meeting held on 7 May 2019.</td>
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<thead>
<tr>
<th>C125/19</th>
<th>Matters arising</th>
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<tbody>
<tr>
<td></td>
<td>There were no matters arising.</td>
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<tr>
<th>C126/19</th>
<th>2019/20 Joint Committee Governance arrangements:</th>
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<tbody>
<tr>
<td></td>
<td>Final Draft JCCCG Manual Agreement and JCCCG Terms of Reference (ToR)</td>
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<td></td>
<td>LK presented the revised final draft JCCCG ToR reflecting feedback from the JCCCG, JCSG, Accountable Officers, members of Governing Bodies and Directors of Commissioning. LK discussed the amendments and in particular the inclusion of a JCCCG clinical engagement assurance process.</td>
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<td>Following discussion, the Group agreed to the following changes:</td>
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<td>- Page 34: remove one of the references to lay members (noted twice)</td>
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Barnsley CCG HS
- Consider voting rights for members representing more than one CCG
- Section 10: Meetings of JCCCG held in public – consistent with SYB ICS website in relation to submitting questions in advance of meetings and questioning during meetings
- Expand on clinical engagement involvement in addition to Primary Care
- Role of the JCCCG – add section (3.1. noted in the circulated cover sheets and reword ‘significant risk’, noting the no worse off agreed principle

It was noted the JCCCG ToR had been given a six month review period and will be revised again in December 2019 to incorporate any further changes agreed.

**Final draft JCCCG priorities 2019/20**
The Group noted the circulated JCCCG priorities presented by LK. The priorities will continue to develop with the ICS workstreams and grow with the new areas added during 2019/20 as SYB future commissioning arrangement are discussed with CCGs. It was noted the priorities sit within the wider ICS, not just in the JCCCG and was shared with JCCCG Governing Bodies earlier in the year.

BH advised that NHS Sheffield CCG Governing Body had not agreed the JCCCG MA/TOR and priorities and would be considered at their GB meeting next week.

It was agreed to bring to the next JCSG meeting how the JCCCG could showcase the JCCCG progress of priorities to the wider ICS.

The Group agreed to the recommendation brought before them and agreed the JCCCGs priorities and the Manual Agreement Terms of Reference and recommended to the CCG Governing Bodies for sign off in July with the changes agreed at today’s meeting. LK agreed to circulate the revised final version ToR and Manual Agreement to the Group this week in advance of sharing with the CCG Governing Bodies.

**NHS Wakefield CCG notice letters**
The Group noted the circulated notice letter received from NHS Wakefield CCG and the response from the ICS.

The Group noted that NHS Wakefield had conveyed their wish to be removed as a formal associate of the JCCCG some time ago and it was therefore appropriate to terminate their membership with immediate effect upon receipt of their letter dated 12th May 2019. It was noted the NHS Wakefield CCG involvement with Stroke HASU transformation would continue as usual until completion of the new HASU going live over the summer 2019 and SYB ICS would continue the positive relationship with NHS Wakefield CCG.

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<tr>
<th>C127/1</th>
<th>Any other business</th>
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<td></td>
<td>There was not business noted.</td>
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<tr>
<th>C128/19</th>
<th>Date and Time of Next Meeting</th>
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<td>The Chair informed the meeting that the next meeting will take place Wednesday 24 July 2019, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield S9 4EU.</td>
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