NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**Proposed Governing Body Decision Making Arrangements During Response to COVID 19**	**Agenda Item No.**	3
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	Steven Cleasby (CCG Chair, GP Member)	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer/Deputy Chief Officer)

Executive Summary							
Please include a brief summary of the purpose of the report	Providers and commissioners have received guidance from NHS England and Improvement setting out actions to enable the release of as much capacity as possible within the system during the response to the pandemic. The guidance includes the direction that CCG Governing Body GPs should be focused on primary care provision. In response to this direction, this paper proposes that GP Members of the Governing Body and other clinically active Governing Body members are stepped down from CCG Governing Body activity to allow them to focus on the frontline response. This is with the exception of the CCG Clinical Chair (see 2.3 below) To enable this to happen, and to allow the Governing Body to continue to make decisions in the interim, the Governing Body is required to suspend standing order 9.7 with regard to Governing Body quoracy. A suspension requires the support of one third of the Governing Body. Temporary quoracy arrangements that the Governing Body would adhere to during the period of the suspension are also set out for agreement and/or amendment.						
Previous consideration	**Name of meeting**		**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body **APPROVES**: 1. the suspension of standing order 9.7, Quoracy; 2. the temporary quoracy arrangements set out in this paper at Table 1 subject to any amendments. 3. the standing down of clinically active Governing Body members from CCG activity in order to prioritise the frontline response to COIVD 19.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications	
Quality & Safety implications	None
Engagement & Equality implications	None

Resources / Finance implications		None					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)		**Yes**		**No**		**N/A**	X
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**			None		
Legal / CCG Constitutional Implications	Decisions made by the CCG should be in accordance with its Constitution and supporting documents, policies and procedures.	**Conflicts of Interest**			Any conflicts of interest will be managed in accordance with the CCG Management of Conflicts of Interest Policy.		

1. Introduction

This paper recommends that the Governing Body suspends standing order 9.7 with regard to Governing Body quoracy in order to enable clinical Governing Body Members to prioritise the frontline response to the COIVD 19 pandemic.

2. Detail

2.1 Providers and commissioners have received guidance from NHS England and Improvement setting out actions to support the release of as much capacity as possible within the system. The full letter is provided at appendix 1. This guidance has implications across different areas of CCG activity. In terms of the CCG Governance the main points are as follows:

- Commissioners should review clinical and non-clinical staffing arrangements in order to focus on supporting the frontline response including in Primary Care. This includes the direction that CCG Governing Body GPs should be focused on primary care provision.

- Governing Body meetings should continue but with streamlined papers, focused agendas and take place virtually as default. Public attendance is encouraged as far as technology allows.

- There will be no punishment for technical quorum breaches (e.g.) because of self-isolation.

- With the exception of quality committee meetings, all others meetings should be streamlined and where possible delayed until later in the year.

- While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.

2.2 The CCG has already acted in response to the above guidance the outcomes of which have already been communicated to the Governing Body by email, for example, all meeting are now taking place virtually with agendas focussed on the COVID 19 response and key decisions. Further conversations have taken place between the Chief Finance Officer/Deputy Chief Officer and CCG Chair concerning further necessary steps.

2.3 In response to the direction that CCG Governing Body GPs should be focused on primary care provision, it is proposed that GP Members of the Governing Body and other clinically active Governing Body members are stepped down from CCG Governing Body activity to allow them to focus on the frontline response. This is with the exception of the CCG Clinical Chair. The Chair feels that it is important that the CCG retains a clinical lead within its decision making structure to help direct the response to COIVD 19 and to represent primary care members in other decisions.

2.5 This arrangement would be kept under regular and ongoing review by the Chair and Chief Finance Officer/Deputy Chief Officer with clinical members being recalled when it is judged appropriate to do so.

2.6 In order to enable the Governing Body to continue to make decisions in accordance with its Constitutional arrangements, this change will require the Governing Body to suspend the section of its standing orders relating to quoracy (9.7) and for new temporary arrangements to be put in place. These are set out below.

2.7 A suspension of the Standing Orders requires the support of one third of the Governing Body.

2.8 The proposed arrangements include provision to maintain clinical input in all decisions made via the involvement of the CCG Chair, Registered Nurse or Chief Quality and Nursing Officer. They also take account of the potential for short notice absence and the need to managing conflicts of interest.

Table 1

Current Standard Quoracy Arrangements	**Proposed standard quoracy following suspension of standing orders**	**Commentary**
No business shall be transacted at a meeting of the Governing Body unless at least the following are present: ▪ The Chair or Deputy Chair ▪ 3 other GPs/Nurse Practitioners as elected by the membership (i.e. not including the Clinical Chair) ▪ 1 lay member ▪ Either the Accountable Officer (Chief Officer) or the Chief Finance Officer/Deputy Chief Officer	During the period of the suspension of standing order 9.7, business of the Governing Body will only be transacted when the following are present: ▪ The Chair or Deputy Chair ▪ Chief Finance Officer/Deputy Chief Officer (CFO/DCO) ▪ Two other GB Members (to include either the Registered Nurse (RN) or the Chief Quality and Nursing Officer (CQNO) if the Chair is conflicted or absent)	This proposal reflects the current urgent/emergency decision making powers set out in Standing Orders in terms of the members and numbers (4) required to be involved in urgent decision making. It provides flexibility in terms of achieving quoracy from among the remaining Governing Body Members. The requirement for the RN or CQNO ensures clinical input in the event that the Chair is conflicted or absent.
Proposed Alt Quoracy 1	In the event that the above standard quoracy cannot be convened due to the CFO/DCO being conflicted or absent, the meeting will be quorate when the following are present: ▪ The Chair or Deputy Chair ▪ Three other Governing Body members (to include either the Registered Nurse or the Chief Quality and Nursing Officer if the Chair is not in attendance) The Governing Body would be supported by the Lead SMT members for the proposal in these circumstances in order to receive the required assurances.	Maintains the requirement for the number numbers (4) required to be involved in urgent decision making. The requirement for the RN or CQNO ensures clinical input in the event that the Chair is not in attendance.

2.9 In the event that urgent or emergency decisions are required outside of meetings, these will be carried out in line with the existing provisions for this in the Standing Orders:

> "9.14.3. The powers which the Governing Body has reserved to itself may, in an emergency or for an urgent decision, be exercised by the Accountable Officer (or in his absence by the Chief Finance Officer/Deputy Chief Officer) and the Chair (or in his absence by the Deputy Chair), after having consulted at least two other Governing Body members. The exercise of such powers by the Accountable Officer and Chair shall be reported to the next meeting of the Governing Body in public session for formal ratification. "

3. Next Steps

3.1 Subject to the support of the Governing Body, a communication notifying CCG staff and Members will be circulated.

4. Recommendations

4.1 It is recommended that the Governing Body **APPROVES**:

1. the suspension of standing order 9.7, Quoracy;
2. the temporary quoracy arrangements set out in this paper at Table 1 subject to any amendments.
3. the standing down of clinically active Governing Body members from CCG activity in order to prioritise the frontline response to COIVD 19;

5. Appendices

Appendix 1 - Constitution Extract (9.7) from current constitution approved by NHSE November 2019
Appendix 2 - Letter from NHSE and NHSI

Appendix 1

9.7. Standard Quoracy Arrangements

9.7.1. No business shall be transacted at a meeting of the Governing Body unless at least the following are present:

- The Chair or Deputy Chair
- 3 other GPs/Nurse Practitioners as elected by the membership (i.e. not including the Clinical Chair)
- 1 lay member
- Either the Accountable Officer (Chief Officer) or the Chief Finance Officer/Deputy Chief Officer

9.7.2. Alternative Quoracy Arrangements (1)

. Where a standard quorum cannot be convened from the membership of the Governing Body, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, alternative quoracy arrangements may be applied. In such circumstances, the Governing Body will be quorate with the presence of at least four of the remaining members of the Governing Body, to include:

a) Either the Registered Nurse or the Secondary Care Specialist and;
b) Either the Chief Officer or the Chief Finance Officer/Deputy Chief Officer

9.7.3. Alternative Quoracy Arrangements (2)

Where neither a standard quorum nor alternative quorum (1) can be convened due to an actual or potential conflict of interest for both the Chief Officer and the Chief Finance Officer/Deputy Chief Officer; for example when decisions are required regarding the remuneration and/or terms of service for the Chief Officer and/or Chief Finance Officer/Deputy Chief Officer, the Governing Body may be considered quorate with the presence of at least the following members of the Governing Body:

- Either the Chair or Deputy Chair
- 3 other GPs/Nurse Practitioners as elected by the membership
- 1 lay member
- Either the Registered Nurse or the Secondary Care Specialist

9.7.4. These arrangements must be recorded in the minutes.

Publications approval reference: 001559

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers

Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Chairs of ICSs and STPs
NHS Regional Directors

28 March 2020

Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic

We wrote to you on 17 March 2020 setting out important and urgent next steps on the NHS response to COVID-19. Following this letter and detailed guidance to GPs we are writing today to provide further guidance to support you to free-up management capacity and resources.

During this challenging period NHS England and NHS Improvement is committed to doing all it can to support providers and commissioners, allowing them to free up as much capacity as possible and prioritise their workload to be focused on doing what is necessary to manage the response to the COVID-19 pandemic. Further information is provided on the following pages.

We will continue to review and monitor the situation and will remain agile in making further changes where necessary.

We appreciate the incredible amount of commitment and hard work going on across the NHS in these challenging times.

Yours sincerely

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

The system actions

Changing NHS England and NHS Improvement engagement approaches with systems and organisations

Oversight meetings will now be held by phone or video conference and will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis. For our improvement resource, we have reprioritised their work to focus on areas directly relevant to the COVID-19 response:

- GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge coordination
- The outpatient transformation work is focused on video consultation and patient-initiated follow up
- We have prioritised our special measures support in agreement with CQC to ensure we support the most challenged in the right way to help them manage the COVID-19 pressures.

1) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually not face-to-face. No sanctions for technical quorum breaches (eg because of self-isolation) For board committee meetings, trusts should continue quality committees, but consider streamlining other committees (eg Audit and Risk and Remuneration committees) and where possible delay meetings till later in the year. While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation All system meetings to be virtual by default	Organisation to inform audit firms where necessary
2.	FT Governor meetings	Face-to-face meetings should be stopped at the current time[1] but ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 eg via webinars/emails	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary Annual members' meetings should be deferred Membership engagement should be limited to COVID-19 purposes	FTs to inform lead governor
4.	Annual accounts and audit	Deadlines for preparation and audit of accounts in 2019/20 are being extended. Detail was issued on 23 March 2020.	Organisation to inform external auditors where necessary
5.	Quality accounts - preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. We intend it will be deferred	NHSE/I to inform DHSC
6.	Quality accounts and quality reports – assurance	This work can be stopped	Organisations to inform external auditors where necessary

[1] This may be a technical breach of FTs' constitution but acceptable given Government guidance on social isolation

No.	Areas of activity	Detail	Actions
7.	Annual report	We are working with DHSC and HM Treasury on streamlining the annual report requirements – further guidance forthcoming	NHSE/I and DHSC to prepare guidance in due course
8	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

2) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, Cancer, Ambulance waits, MH LD measures)	See Annex B
2.	Friends and Family test	Stop reporting requirement to NHS England and NHS Improvement
3.	Long-Term Plan: operational planning	Paused
4.	Long-term Plan: system by default	Put on hold all national System by Default development work (including work on CCG mergers and 20/21 guidance). However, NHSE/I actively encourages system working where it helps manage the response to COVID-19, providing support where possible.
5.	Long-Term Plan: Mental Health	NHSE/I will maintain Mental Health Investment guarantee.
6.	Long-Term Plan: Learning Disability and Autism	As for Mental Health, NHSE/I will maintain the investment guarantee.
7.	Long-Term Plan: Cancer	NHSE/I will maintain its commitment and investment through the Cancer Alliances to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response.
8.	NHSE/I Oversight meetings	Be held online. Streamlined agendas and focus on COVID-19 issues and support needs
9.	Corporate Data Collections (eg licence self-certs, Annual Governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements Delay the Forward Plan documents FTs are required to submit We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.
10.	Use of Resources assessments	With the CQC suspending routine assessments, NHSE/I will suspend the Use of Resources assessments
11.	Continuing Healthcare Assessments	Stop CHC assessments. Capacity tracker, currently mandated for care homes, is now also mandated for hospices and intermediate care facilities
12.	Provider transaction appraisals	Complete April 2020 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors

No.	Areas of activity	Detail
	CCG mergers Service reconfigurations	Complete April 2020 CCG Mergers but delay work post April 2020. Expect no new public consultations except in cases to support COVID-19 or build agreed new facilities. We will also streamline or waive, as appropriate, the process to review any reconfiguration proposals designed in response to COVID-19
13.	7-day Services assurance	Suspend the 7-day hospital services board assurance framework self-cert statement
14.	Clinical audit	All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. Data collection for the child death database and MBRRACE-UK-perinatal surveillance data will continue as this is important in understanding the impact of COVID-19.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID -19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables.

3) Other areas including HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate
2.	Appraisals and revalidation	Recommendation that appraisals are suspended from the date of this letter, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice. The GMC has now deferred revalidation for all doctors who are due to be revalidated by September 2020. We request that all non-urgent or non-essential professional standards activity be suspended until further notice including medical appraisal and continuous professional development (CPD) The Nursing and Midwifery Council (NMC) is to initially extend the revalidation period for current registered nurses and midwives by an additional three months and is seeking further flexibility from the UK Government for the future.
3.	CCG clinical staff deployment	Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline CCG Governing Body GP to focus on primary care provision
4.	Repurposing of non clinical staff	Non-clinical staff to focus on supporting primary care and providers
5.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc

Annex A

Whilst existing performance standards remain in place, we acknowledge that the way these are managed will need to change for the duration of the COVID-19 response. Our approach to those standards most directly impacted by the COVID-19 situation is set out below:

A&E and Ambulance performance - monitoring and management against the 4-hour standard and ambulance performance (Ambulance Quality Indicators: System Indicators) will continue nationally and locally, to support system resilience. Simultaneously, local teams should maintain flexibility to manage demand for urgent care during the emergency period.

RTT – Monitoring and management of our RTT ambitions will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. The wider announcements on suspension of the usual PBR national tariff payment architecture and associated administrative / transactional processes mean that, financial sanctions for breaches of 52+ week waiting patients occurring from 1st April 2020 onwards will also be suspended.

Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital. The existing RTT recording and reporting guidance is recognised across the country as the key reference point for counting RTT activity and specific clarification of how this should be applied, in the scenarios described above, will be provided in due course.

Cancer – Cancer treatment should continue, and that close attention should continue to be paid to referral and treatment volumes to make sure that cancer cases continue to be identified, diagnosed and treated in a timely manner. Clarification has already been released to the system through the COVID-19 incident SPOC to confirm that appropriate clinical priority should continue to be given to the diagnosis and treatment of cancer with appropriate flexibility of provision to account for infection control. We have also confirmed modifications to v10 Cancer Waiting Times guidance to allow for this to be appropriately recorded. In addition, it has been agreed that the 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1 April) will still have data collected, but will not be subject to formal performance management. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Annex B

Data collections/reporting

NHS Digital maintains a significant volume of data which is mandated for return from commissioners and providers[2]. Much of this data is routinely submitted and imposes minimal burden on local systems.

It will be important to maintain a flow of core operational intelligence to provide continued understanding of system pressure and how this translates into changes in coronavirus and other demand, activity, capacity and performance – and in some areas it may be necessary to go further to add to and extend existing collections. For this reason, and to ensure effective performance recovery efforts can begin immediately after the intense period of COVID-19 response activity has subsided, the majority of data collections remain in place.

Notwithstanding the above, a subset of the existing central collections will be suspended, and these returns will not need to be submitted between 1 April 2020 to 30 June 2020:

- Urgent Operations Cancelled (monthly sitrep)
- Delayed Transfers of Care (monthly return)
- Diagnostics PTL
- RTT PTL
- Cancelled elective operations
- Audiology
- Mixed-Sex Accommodation
- Venous Thromboembolism (VTE)
- 26-Week Choice
- Pensions impact data collection
- Ambulance Quality Indicators (Clinical Outcomes)
- Dementia Assessment and Referral (DAR)

[2] https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections

Annex C

Data Security and Protection Toolkit Submission 2019/20

It is critically important that the NHS and Social Care remains resilient to cyber-attacks during this period of COVID-19 response. The Data Security & Protection Toolkit helps organisations check that they are in a good position to do that. Most organisations will already have completed, or be near completion of, their DSPT return for 2019/20.

The submission date for 2019/20 DSPT has been extended to 30 September 2020. However, in light of events NHSX recognises that it is likely to be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSX has therefore taken the decision that:

- Organisations that have completed and fully meet the standard will be given 'Standards Met' status, as in previous years.
- Where NHS trusts, CCGs, CSUs, Local Authorities (including Social Care providers), Primary care providers (GP, Optometry, dentist and pharmacies) and DHSC ALBS **do not fully complete or meet the standard because doing so would impact their COVID-19 response this will be considered sufficient and they will be awarded 'Approaching Standards' status** and will face no compliance action. It will be possible to upgrade from 'Approaching Standards' status to 'Standards Met' status through the year. The cyber risk remains high. All organisations must continue to maintain their patching regimes and Trusts, CSUs and CCGs must continue to comply with the strict 48hr and 14 day requirements in relation to acknowledgment of, and mitigation for, any High Severity Alerts issued by NHS Digital (allowing for frontline service continuity).
- Organisations that have not taken reasonable steps to complete their toolkit submission for 2019/20 will be given 'Standards Not Met' and may face compliance activity, as per previous years.

For any queries please contact or for further information please go to https://www.dsptoolkit.nhs.uk/News

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**COVID-19 Update**	**Agenda Item No.**	4
Report Author	Neil Smurthwaite, Deputy Chief Officer	**Public / Private Item**	Public
GB / Clinical Lead	Steven Cleasby (Chair, GP Member)	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer/Deputy Chief Officer)

Executive Summary							
Please include a brief summary of the purpose of the report	This report updates the Governing Body on the CCG's response to COVID-19 Pandemic. It also proposes change to the Scheme of Delegation to temporarily increase the Head of Finance limit to £250,000.						
Previous consideration	**Name of meeting**	N/A	**Meeting Date**				
	Name of meeting	N/A	**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: ▪ **RECEIVES** and **NOTES** the content of the report ▪ **APPROVES** the proposed change to the Scheme of Delegation to temporarily increase the Head of Finance limit to £250,000.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications	None identified.		
Public / Patient / Other Engagement	The CCG is committed to working with public, staff, patients, partners and other stakeholders to improve health care services.		
Resources / Finance implications (including Staffing/Workforce considerations)	None identified.		
Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risks**	None identified.
Legal / Constitutional Implications	None identified.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest will be managed in line with the CCG's Conflict of Interest Policy

1.0 INTRODUCTION

1.1 As the Governing Body will be aware the international pandemic is affecting all. The purpose of this report is to brief the Governing Body and provide some assurance and information on the work the CCG is undertaking during this difficult time. The detail of the report will cover the vast range of initiatives the CCG is supporting in Calderdale and across West Yorkshire but is purely a snap shot of the level of work that has been undertaken over the last month or so. Believe me the commitment shown by all our staff and partners has been incredible and this is a high level flavour only.

1.2 Everyone will hear, participate and recognise the Thursday evening appreciation for the NHS, I can't emphasis enough that whilst the media rightly covers the work in hospitals there is so much more that goes on behind scenes. The Governing Body needs to recognise the CCGs role and that of all health and social care partners, the effort shown by all truly reflects integration in Calderdale. Whilst the hospitals have clearly mobilised this hasn't been without the help of social care, Primary Care Networks and the huge amount that went into discharging and getting to where we are now in managing the pandemic.

1.3 Not one for words this leads me on to the formal part, on 17th March, NHS England and NHS Improvement issued a letter containing initial guidance in relation to the response to the impact of COVID-19, which has continued to be refined and updated.

1.4 The letter set out important actions that all parts of the NHS were asked to put into place to redirect staff and resources to:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.
- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

1.5 The CCG has acted with the both the local health and care system and also at an Integrated Care System level to develop plans to respond to the crisis as detailed in this report.

2.0 FINANCE

2.1 The guidance issued set out specific financial arrangements for the NHS for the period between 1st April and 31st July 2020. These arrangements included:

- Agreeing block contracts between commissioners and providers based on 2019/20 payments plus inflation but excluding tariff efficiency factor.
- Making an additional month's payment on account to all acute and ambulance providers to ensure cash flows.
- Trusts suspending non-contract activity invoicing for the period with funds instead flowing through the providers coordinating commissioner.
- A national top up process to fund the difference between the actual costs incurred during the period and income received.

2.2 For CCGs there are no proposals to change published allocations for 2020/21; however in assessing commissioner financial positions and affordability the following will be taken into account:

- The impact of the block contracting approach
- The temporary arrangements for non-contracted activity funding
- The cost of additional service commitments to assist the response to COVID-19 for example additional step down beds and provision of rapid discharge and additional social care capacity.
- Review of planned transformation initiatives

2.3 In relation to the purchase of enhanced discharge support services, the CCG has been asked to work in conjunction with the local authority to commission additional capacity. It is anticipated that additional funds will flow initially to CCGs, which will then be pooled with local authority budgets as part of a section 75 arrangement.

2.4 Financial Governance

Whilst financial constraints must not stand in the way of taking immediate and necessary action, the maintenance of financial control and stewardship of public funds remains critical during the NHS response to COVID-19. Therefore, the following principles will be applied in the management of CCG resources:

- the current systems of financial governance as set out in the CCG's Standing Orders and Standing Financial Instructions will continue to apply;

- the CCG's Scheme of Delegation will be amended as required to enable timely decisions to be made which allow services and resources to be mobilised quickly to respond to the COVID-19 pandemic;

- proportionate systems will be put in place to ensure that public resources committed to support the response to COVID-19 are reasonable and represent value for money for the taxpayer; and

- the financial arrangements put in place will follow national guidance as issued by NHS England/Improvement.

Currently under the CCG's Scheme of Delegation the Chief Officer and the Chief Finance Officer/Deputy Chief Officer can approve investments up to a combined value of £500,000, with commitments above £500,000 requiring Governing Body approval.

In recognition that the CCG does not currently have a Chief Officer it is recommended that in order to maintain the combined limit of £500,000, that the Head of Finance limit is temporarily increased to £250,000. This will ensure that decisions can be made at the appropriate level without requiring Governing Body approval.

The CCG has set in place a financial template to capture decisions in relation to COVID-19 expenditure. Heads of Service are expected to approve expenditure within their delegated limits of £50,000 and report this expenditure through to the Head of Finance for inclusion in the CCG log of COVID-19 expenditure. Expenditure above £50,000 to £250,000 will require either the Chief Finance Officer or Head of Finance approval. Expenditure between £250,000 and £500,000 will require combined approval and any expenditure in excess of £500,000 will require Governing Body approval.

The NHS England (NHSE) guidance outlines that as normal financial arrangements have been suspended, no new business investments should be entered into unless related to COVID-19 or unless approved by NHSE and NHS Improvement (NHSI) as consistent with a previously agreed plan.

2.5 2019/20 Financial Position

In terms of the 2019/20 financial forecast, the CCG is forecasting to achieve its control total of delivering a £1m surplus.

The CCG has reported through some additional expenditure in relation to COVID-19 and is expecting these to be covered by additional resources in 2019/20 accounts.

The CCG is due to submit its draft annual accounts and annual report to NHS England on 27th April.

2.6 2020/21 Financial Planning

Following the suspension of operational planning for 2020/21, the introduction of revised contracting arrangements for the period 1 April 2020 to 31 July 2020, and in the absence of further guidance regarding the CCG financial framework for 2020/21, the following approach to setting budgets and managing CCG resources will be adopted:

- Budgets for 2020/21– budgets will initially reflect the financial plan as submitted to NHS England in January 2020. This plan was considered in the CCG Quality. Finance and Performance Committee on 26th March 2020.
- The CCG will reforecast the financial plan based on the national priorities for responding to COVID-19 and the guidance that has been issued.
- The CCG will need to ensure that impact of the guidance can be captured and measured and the impact to the CCG clearly understood.
- The CCG will complete the monthly COVID-19 Cost reimbursement forms for any relevant reclaimable expenditure.
- As per the national guidance the CCG, no new investments will be agreed unless they are COVID-19 related or related to a national delivery expectation.

There is an expectation that the CCG will deliver its control total for 2020/21 of an in year breakeven position.

The CCG will continue to monitor the impact of the existing and new guidance and keep the Governing Body and Committees updated.

3.0 QUALITY

3.1 Quality Governance

As part of business continuity arrangements it has been necessary to adapt our quality governance arrangements, whilst ensuring the CCG continues to meet its statutory duties during the COVID-19 Pandemic.

It has been necessary to adapt our processes in response to the need for the NHS to respond to the rapidly changing commissioning and delivery of service, changes to mandated quality

requirements, and how we are maintaining an overview of any new or emerging quality issues and risks in relation to our provider organisations.

3.2 Essentially there are three elements to this work;

a. **Rapid Change Process** – a combined Equality Impact Assessment/Quality Impact Assessment (EQIA/QIA) has been developed which has been discussed and approved by the Senior Management Team (SMT). This process will be followed when any new service is developed or there is a variation to an existing service. The Quality Team will support the Project Leads to complete this Rapid Change EQIA/QIA. At the end of the pandemic we will revert back to full impact assessments.

b. **Nationally mandated quality requirements** – a catalogue of all nationally mandated quality requirements has been collated, based on guidance from NHS England, listing any quality requirements where notification has been received that timescales will be slowed down/revised or stopped e.g. / Serious incidents, Safeguarding reviews, Friends and Family tests

c. **Quality reporting and monitoring** – the Quality Team is maintaining regular dialogue with our quality colleagues across all our main providers. Virtual Quality Board/quality review meetings will take place as required throughout this process. Should decisions need to be taken regarding any quality issues, e.g. Commissioning for Quality and Innovation (CQUINs) scheme, a mechanism will be established in order to do this and a log will be maintained in order that any decisions taken can be reported through committee at a later stage.

3.3 The Quality Team will continue to review the quality information published by our main providers on a monthly basis and any new or emerging issues will be discussed during our regular dialogue with providers.

3.4 As and when any quality risks are identified associated with COVID-19, these will be included on the Risk Register.

4.0 GENERAL PRACTICE

4.1 As part of the response to COVID-19 General Practices in Calderdale have worked together, as part of their Primary care Networks, with the CCG and the Local Medical Committee to change the way people use GP services during the coronavirus pandemic to help protect people and slow the spread of the virus, in doing this there has been a focus on six urgent priorities:

1) **Moving to a total triage system** (whether by phone or online). This ensures that patients are appropriately triaged to the right health professional setting. The upsurge in telephone calls to general practice has meant that providing a reliable and timely response for patients has become a vital operational priority.

2) **Moving to a model that provides essential face-to-face services, one in each Primary Care Network area.** Access to this is following triage (as above).

3) **Undertaking all care that can be done remotely via appropriate channels**, guided by clinical judgement.

4) **Preparing for a significant increase in home visiting** as a result of social distancing, home isolation and the need to discharge all patients who do not need to be in hospital. A

Home Visiting Team for each PCN has been established along with additional resource from a Calderdale wide acute visiting service. This is additional capacity that has been secured in preparation for an increase in demand. Individual practices will continue to visit patient's with palliative care needs at present in order to provide continuity of care.

5) **Prioritising support for particular groups of patients at high risk.** Focussed work is ongoing to ensure collaboration between GP practices within primary care networks (PCNs) and the wider healthcare system to continue to deliver the best care for patients.

6) **Helping staff to stay safe and at work, building cross-practice resilience** across primary care networks. Work is on-going to establish a baseline number of clinical staff, administrative staff and others including part-time and full-time members. A daily reporting system by practices through to the LMC has been established for workforce issues (sickness absence, home isolation) further work is planned to refine this to make it more useful.

4.2 Arrangements to Free up Capacity and Protect Income

Work has been undertaken both nationally and in Calderdale to free up practice capacity to prioritise workload to both prepare for and manage the COVID-19 outbreak. All routine CQC inspections have been cancelled and advice is being issued on suspension of appraisal and revalidation activities.

All practices have been asked to consider stopping any private work they are doing to help free up capacity.

To ensure that funding does not influence clinical decision making all GP practices in 2020/21 will continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of the Quality and Outcomes Framework (QOF) Directed Enhanced Services (DES) and Locala Enhances Services (LES) payments.

4.3 Medicines Management

The Medicines Management Team (MMT) has been supporting the CCG COVID-19 response by providing answers to medicines supply and administration queries to help GP practices continue to provide safe and effective care. Work is ongoing to support robust access to end of life medicines in primary care.

The CCG has re-deployed the commissioned practice pharmacy team away from planned cost effective prescribing work to support practices with increasing the uptake of electronic repeat dispensing and 28 day prescription supply in line with NHSE guidance. The team will be able to support practices with other tasks such as medicines reconciliation and prescription queries on the completion of this task. The MMT will also be re-deployed depending on capacity to support this work.

5.0 WORKFORCE SUPPORT

5.1 Staff across health and the care sector are currently working in a very difficult and unprecedented situation. We've never experienced anything like this before and it has already had a huge impact on our personal lives and how we work e.g. Reducing face-to-face contact,

caring for others wearing Personal Protection equipment, working at home more, sometimes in isolation.

5.2 It is important that as organisations we recognise this and support our staff. Working with colleagues across the system we have developed an easily accessible support service. This service will provide 24hr access by phone to expert advice and support and a direct link to local support services including Improving Access to Psychological Therapies (IAPT). It is for all staff who are involved in caring for people and builds upon the national support line developed for NHS staff.

5.3 This is in addition to our employee assistance programme and the work we are doing to ensure regularly communication with our CCG staff, As a senior management team we talk daily and then ensure through the daily business continuity call key messages are passed on but recognise this is a two way process ensuring messages come back up to SMT. All teams are encouraged to ensure support and communication is in place and regular with all team members. It's been great to see the level of support and aide offered amongst our staff from grocery shopping to partners volunteering at our drive through. Our staff forum is also working hard on alternatives to our usual office activities to ensure that communication and support is maintained.

6.0 ADDITIONAL BED OFFERS

6.1 Calderdale and Huddersfield NHS Foundation Trust (CHFT) have confirmed with the system an approach to ensuring there is a sufficient hospital beds to support the needs of patients in Calderdale and Greater Huddersfield during the peak of the COVID period. Their plan has 5 phases of escalation based on demand modelling, and is focused on; flow through the Emergency Department, Critical Care beds and Respiratory beds. Phase 5 is modelled on needing between 48-100 ventilated beds, and has therefore required us to establish additional post-acute beds outside the current hospital bed base.

6.2 These plans include a request for the system to establish additional beds which can flex in accordance with need and demand; ranging from support for people who need nursing care, those who residential care, to those who need bed based social care. The principle has been to maximise our currently commissioned beds as a system before opening additional beds. Our plans support the bringing on of additional beds from the current sources as needed:

- Post-acute beds with oxygen; Spire and BMI (60 beds in total) – maximum 10 beds open currently. A Standard Operating Procedure has been agreed with a workforce that made up of staff from; general practice, CHFT, Spire and BMI.
- Additional nursing beds providing care and support post hospital discharge before patients are able to go home (positive and non-positive patients). 18 bedded unit at Calderdale Retreat. Phased opening, currently 8 beds open. Staffed by clinical team of; existing care home staff, and nursing staff from the CCG, GPs support.
- Additional residential beds providing care and support post hospital discharge before patients are able to go home (positive and non-positive patients). 25 bedded unit at Calderdale Retreat and 6 bedded Valley View Annex. Not currently opened, and developing a workforce model
- Calderdale Metropolitan Borough Council (CMBC) have agreed to contract a number of beds from Cedar Court to support patients who require social, rather than residential or nursing care. This is for low level step support, housing issues, and to provide support for carer breakdown. The initial offer is for 70 beds, but the opening would be phased in line with demand. The unit will be staffed by social care staff, with a complete staffing model being developed.

7.0 STAFF TESTING

7.1 A staff-testing drive-through service has been established at King Cross Fire Station providing a self-swabbing service for key workers across health and care. Organisations across Calderdale; including healthcare workers, fire, police, social care providers, community pharmacy and third sector staff are beginning to book themselves into the service through a central booking point. The service is one of 3 across the Calderdale, Kirklees and Wakefield footprint.

7.2 Whilst the service has been slow to get off the ground, recent changes to the criteria – making it possible for staff to be tested from the first day of illness/absence - is resulting in the numbers increasing.

7.3 However, until such time as the demand increases sustainably, we are running the Calderdale offer on alternate days with the Kirklees offer in Huddersfield. The Calderdale site is seen as a pilot site, with an initial expectation of reaching 100 tests per day, 7 days per week. At the time of writing the numbers being seen are less than 15. We have recognised through our system calls that the need exists, but that organisations have been working through the criteria and process. We expect to see demand increase in the next week.

8.0 CARE HOME SUPPORT PROGRAMME

8.1 There is increasing focus and concern about the resilience of care home provision during the COVID period. We have therefore agreed with CMBC to develop a new care home support programme which aims to integrate a number of system offers into one system support offer. Iain Baines will lead the programme.

8.2 The support themes include;

- Infection Control, PPE and testing of patients and staff
- End of Life Care and Advanced Care Planning
- Respiratory Care
- Falls Prevention and Nutritional Advice
- Conveyancing and Discharge
- Resident and Staff Mental Health and Wellbeing
- Workforce
- Business intelligence, SITREP development

8.3 The programme will work on the basis of;

- Universal support to all care homes
- Intermediate and targeted support for homes that need support for existing and emerging issues. There have been recent examples where homes are caring for a number of COVID positive patients and therefore require a good deal of support related to infection control, additional staffing, and advice and support.

9.0 SOCIAL CARE AND VOLUNTEERING HUBS

9.1 CMBC have develop two offers to support patients identified as ‘shielded’ patients, as well as other residents who are identified as vulnerable and in need of support.

9.2 The Social Care Hub is the first point of contact/triage for residents needing social support;

- Accessible via web page 24/7
- Telephone referrals by exception 01422 392890 (web referrals preferred)
- https://www.calderdale.gov.uk/v2/coronavirus/community-support/request-support
- 7 days (8-9 M-F, shorter days S,S)
- Focal point for 'vulnerable' residents
- Triaged by social workers/co-ordinators
- Works with families and providers to deliver support
- Refers to Volunteering Hub for support as needed
- Interface with PCNs where new clinical need identified

9.3 The Volunteering Hub is for people with lower level needs (food, medication, pets, support etc)

- Referrals primarily through Social Care Hub**,** but others via Primary Care Networks, Staying Well etc via same webpage
- https://www.calderdale.gov.uk/v2/coronavirus/community-support/request-support
- Accessible 7 days (9-7 M-F,10-3 S,S)
- Central point for those who want to apply to be volunteers via web page above
- Holds growing directory of third sector and neighbourhood groups
- Referral up to Social Care Hub if required

9.4 There is now an opportunity for others, including social care to refer people into the NHS Goodsam volunteering model, and this will provide additional volunteering capacity to support people in Calderdale.

10.0 RECOMMENDATIONS

10.1 It is recommended that the Governing Body

1. **RECEIVES** and **NOTES** the content of the report.
2. **APPROVES** the proposed change to the Scheme of Delegation to temporarily increase the Head of Finance limit to £250,000.

Item 5

NHS
Calderdale
Clinical Commissioning Group

Minutes of the Public Section of the Governing Body Meeting held on Thursday 23 January 2020 at 2pm in the Function Room 2, The Shay Stadium, Halifax

DRAFT MINUTES

Present	Dr Steven Cleasby	SC	Chair
	Neil Smurthwaite	NS	Chief Finance Officer/Deputy Chief Officer
	Penny Woodhead	PW	Chief Quality and Nursing Officer
	Dr Majid Azeb	MA	GP Member and Clinical Vice Chair
	Dr James Gray	JG	GP Member
	Dr Farrukh Javid	FJ	GP Member
	Dr Caroline Taylor	CT	GP Member
	Alison MacDonald	AM	Lay Member, Patient and Public Engagement
	John Mallalieu	JM	Lay Member, Finance and Performance
	Prof Peter Roberts	PR	Lay Member, Audit
	Dr Rob Atkinson	RA	Secondary Care Specialist
In attendance	David Longstaff	DL	Lay Member
	Denise Cheng-Carter	DCC	Lay Advisor
	Paul Butcher	PB	Advisor to the Governing Body, Director of Public Health, Calderdale Metropolitan Borough Council
	Iain Baines	IB	Advisor to the Governing Body, Director of Adults and Wellbeing, Calderdale Metropolitan Borough Council
	Andrew O'Connor	AOC	Corporate Governance Officer (Minutes)
	Kym Brearley	KB	CCG Staff Forum Chair (for item 7, minute no. 07/20)
	Rhona Radley	RR	Deputy Head of Service Improvement (for item 8, minute no. 08/20)
	Debbie Robinson	DR	Head of Primary Care Quality and Improvement (for item 9, minute no. 09/20)
	Rob Gibson	RG	Risk, Health and Safety Manager (for item 13, minute no. 13/20 and for item 14, minute no. 14/20)
	Martin Pursey	MP	Head of Contracting and Procurement (for item 16, minute no. 16/19)
			There was one member of the public in attendance

01/20 WELCOME

SC welcomed PR, AM and DCC to their first Governing Body meeting.

DL was noted to be in attendance for the meeting.

02/20 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST **Action**

Apologies

There were apologies received from Prof Rob McSherry (Registered Nurse), Dr Helen Davies (GP Member) and Matt Walsh (Chief Officer)

Declarations of Interest

1. GP Governing Body members, including the Chair, were declared to have a direct financial interest in item 9 (Extended Access Contracts 2020/21). All Calderdale GP Practices were noted to be members of the Pennine GP Alliance which was the current provider of the service. The Governing Body was advised that DL, as the outgoing CCG Deputy Chair, would Chair this item.

2. JM (Lay Member, Finance and Performance) and AM (Lay Member, Patient and Public Involvement) were declared to have a direct professional interest in item 11 (CCG Constitution). One of proposed variations to the Constitution would specify that the CCG Deputy Chair be either of the two Lay Members.

3. JM (Lay Member, Finance and Performance) was declared to have a direct professional interest in item 12 (Appointment of the CCG Deputy Chair). JM was the proposed appointee.

SC explained that the proposed approaches for managing these conflicts would be set out for agreement when the meeting arrived at the relevant agenda items.

The Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters.

03/20 MINUTES

DECISION:

The minutes of the public section of the Governing Body meeting held on 24 October 2019 were **RECEIVED** and **ADOPTED** as a correct record.

Matters arising

Action (77/19) - Contact had been made with Andy's Man Club regarding their attending a future Governing Body Meeting. The action was ongoing.

04/20 QUESTIONS FROM THE PUBLIC

The CCG had received seven questions from a single member of the public. These concerned:

- The Yorkshire and Harrogate Integrated Care System (ICS) financial targets
- The planned choice process for all patients who reach a 26 week wait
- Non-contract activity spending at Calderdale and Huddersfield NHS Foundation Trust (CHFT) and other questions relating to contract activity and spending with other providers
- The Right Care, Right Time, Right Place (RCRTRP) Strategic Outline Case (SOC)
- The Director of Public Health Annual report and low wage/zero hours contacts
- The CCG's Quarter 2 review meeting with NHS England (NHSE) and Improvement (NHSI)
- And the CCG's Contract with Pinnacle Performance Development

The questions had been received after the submission deadline and, due to their length and complexity, the CCG had been unable to prepare responses in time for the meeting and would instead provide a written response. The member of the public had been notified.

05/20 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

PB presented the Director of Public Health Annual Report for 2018/19. The report consisted of a written report on workplace health, which contained a number of recommendations, and a film concerning good mental health in the workplace, the primary audience for which was employers and Trade Unions.

A section of the film was shown. Following the film PB encouraged Governing Body members to view the whole film which included a number of other stories from local people.

Comments and questions were invited.

The Governing Body recognised:

- The role that the CCG and other commissioners could play in supporting providers in delivering good workplace mental health, and that this should be a consideration in tendering and procurement processes.
- The positive impact pf the Wellness Advisor scheme in North Halifax. The Governing Body was supportive of this being rolled out more widely.
- The role that the CCG could play in modelling good practice to partners and employers.
- How data could be used to demonstrate the positives of engagement for employers, for example, days lost and days saved data were suggested. The various types of areas where employees might require support (loneliness, bereavement, retirement) were also highlighted.
- The potential value of developing a Calderdale wide approach to workplace mental health in primary care and the need to support local practices.
- The work already taking place across the system and at local CCGs in support of the workplace mental health agenda (CHFT's "The Cupboard" and the Mental First Aiders programme championed by the Calderdale, Greater Huddersfield and North Kirklees CCGs were mentioned specifically).
- The amounts paid for services and the costs associated with living wage were recognised to impact negatively on providers and their staff creating pressures within the system. The collective responsibility across the system to ensure a fair price was paid was noted.
- Calderdale was noted to have a high proportion of smaller businesses (of less than 20 employees). The Governing Body recognised the need to engage with and support this group in accessing services and support, noting that that financial considerations would be a barrier for many.

In response to a question concerning the number of local employers who had invested in occupational health support for employees, PB responded that this wasn't known but that the Council's Business and Skills Team was targeting smaller businesses through its contacts to highlight the film and its content to them.

In response to a question regarding how the Council might be able to incorporate the aims set out in the report into other areas of council policy, for example, reducing travel to work times into local transport policy to improve people lifestyles and well-being, PB advised that the Council did this in areas where it could while having lobbying responsibility for things not under its control, such as transport.

DECISION

The Governing Body:

1. **RECEIVED** the Director of Public Health Annual Report 2018/19.
2. **ADOPTED** the relevant recommendations outlined in the report.
3. **AGREED** that The Director of Public Health's recommendations be **ACTIONED** and **MONITORED** within the revised Health and Wellbeing Strategy.

06/20 CHIEF OFFICER'S REPORT

NS in presenting the report highlighted the following key issues:

Outcome of General Election

The recent General Election result and its implications for NHS Leaders were noted.

Public Sector Equality Duty

DECISION

The Governing Body **DELEGATED** approval of the annual Equalities Report to the Quality, Finance and Performance Committee (QFPC) in order that the publication deadline during March 2020 could be met.

Suicide Bereavement Service

A new service to support people bereaved or affected by suicide across West Yorkshire and Harrogate (WYH) had gone live from 2 December 2019.

Autistic Spectrum Disorder (ASD)

The CCG's second ASD summit was scheduled for the 5th February 2020.

Emergency Planning Lead for the CCG

RG, Risk, Health and Safety Manager, had taken on the role of Emergency Planning Lead for the CCG.

CCG Improvement and Assessment Framework (IAF) Quarter 2 Review

The IAF Quarter 2 Review letter had been provided at Appendix 2.

West Yorkshire and Harrogate (W&H) Health and Care Partnership (HCP) Memorandum of Understanding (MOU)

NS explained that the HCP was different to the Joint Committee of CCG's, and concerned the running of the ICS across West Yorkshire and Harrogate. A light touch review of the Partnership MOU had taken place. The Governing Body was asked to approve the updated MOU for the next 12 months. Reference was made to a piece of commissioning work taking place in response to national pressure for there to be "ideally" one CCG per coterminous location. It was noted that there was now a recognition that this was not always the best option.

Questions and comments and invited:

- It was noted that the revisions to the MOU were minimal and arrangements were

still bedding in and developing.

- PW welcomed the inclusion of the Quality Surveillance Group (QSG) in the governance schematic. There were discussions taking place as to whether the membership of these groups (currently just CCGs and regulators) was future fit. PW was leading a workshop on the 31 January 2020 when this would be addressed.
- In response to a question concerning the engagement of the Leeds City Region, NS confirmed that the region linked into the HCP via its local councils who were all members of the HCP.

DECISION:

The Governing Body **APPROVED** the revised MOU and **AUTHORISED** the Chief Officer to sign the final version.

Staff Forum Update

KB presented an update from Staff Forum, as supplied at Appendix 1, reporting on its diverse work on staff engagement and wellbeing within the CCG in 2019. She recommended that the CCG should be proud of the leadership it has shown on staff wellbeing and recognise the role that this had played in enhancing the CCG's reputation as an employer. A number of recommendations had been set out in the report.

Questions and comments were invited.

- Staff Forum's delivery of an annual Time to Talk event was noted.
- The sharing of the work done by the forum with GP Practices and Primary Care Networks (PCNs) was invited.
- KB and the forum were invited to consider the additional support it might want from the Governing Body and Governing Body members so that it could continue to develop its work into new areas. KB responded that there was an open invitation to Governing Body members to be involved in any existing activity and asked that they promote Staff Forum's work when acting as a spokesperson on behalf of the organisation.
- In response to a question concerning measuring the impact of activities, reference was made to the outcomes of the national NHS Staff Survey which captured and reflected staff views on wellbeing. The CCG was noted to benchmark well. The CCG's Annual Workforce Report was also noted to provide relevant insights.

DECISION:

The Governing Body:

1. **NOTED** the importance of staff wellbeing in enabling NHS Calderdale CCG to be a high-performing organisation and employer of choice.
2. **RECOGNISED** the significant contribution of all colleagues in voluntarily delivering a diverse Staff Forum programme during 2019.
3. **RECOGNISED** the value of the Wellbeing Half Hour, and **COMMITED** to promoting it, and its benefits.
4. **COMMITTED** to championing Staff Forum activities internally and externally.
5. **CONSIDERED** whether, and how the learning and best practice developed by the CCG could be shared with Calderdale Primary Care Networks as noted above.

KB was thanked for her attendance.

DECISION:

The Governing Body **RECEIVED** and **NOTED** the content of the report.

07/20 CALDERDALE AND KIRKLEES CAMHS CRISIS/INTENSIVE HOME BASED TREATMENT EXTENDED HOURS, AND ALL-AGE LIASON SERVICE MODEL

RG in presenting the report explained that all Age-Age Liaison Model spoke to the strategic direction of travel for mental health services in Calderdale. The Business Case, which had been co-produced with providers and children and young people across WYH, had been circulated at Appendix 2. It was noted to be part of a national crisis initiative and part of the new care model. The engagement paper had been provided at Appendix 1. The paper proposed that the existing crisis home based service be extended to children and young people and their families. There had been an increase in attendances into hospital of children and young people in crisis. The service would aim to reduce and prevent these admissions in the future. It would also aim to avoid Tier 4 hospital admissions which tended to be out-of-area admissions. Also, to reduce A&E attendances overall. The service would also allow an earlier supported discharge via links into the Community Crisis Service which would be extended to include an out-of-hours service, seven days a week. The service was already implemented in Wakefield and in Kirklees from November which could be extended to Calderdale should the proposal be approved. The Kirklees footprint had already begun to benefit from the enhanced offer including the management of more complex cases in the community and providing an alternative to A&E attendance during out-of-hours and on the weekends.

Questions and comments were invited:

- NS advised the Governing Body that the proposal was being brought to Governing Body for decision as it would involve the direct award of contract to an existing provider. Also, because whole life costs had to be taken into account, which would increase the value to a level where it required Governing Body approval I in accordance with the organisation Standing Financial Instructions (SFIs). There had been a thorough debate at QFPC and NS recommended the proposal as the correct course of action.
- PW concurred that there had been a thorough discussion at QFPC and that the new service would help prevent the sorts of incidents happening that had previously been reported on incident dashboards and would improve the experience of children and young people.
- MA sought assurance that the service would see the integration of teams across providers. RR responded that the intention was to bring greater integration, for example, between in-hours and out-of-hours and the Community Crisis Team. She confirmed that she would take away this feedback. **RR**
- AM welcomed the changes around the Community Crisis Team but sought assurance that the team would have the patient information they require after a person is handed over to avoid them having to re-tell their story. There was confirmation that an integrated IT system was being used. The Governing Body asked that arrangement be made to monitor this. **RR**
- There was agreement concerning the importance of monitoring the impact of the investment. **RR**

DECISION

The Governing Body:

1. **NOTED** the content of the report and attached business case;

2. **RECOGNISING** Standing Financial Instructions, and within the delegated limits of the Governing Body, **APPROVED** the financial investment required by the business case as direct award of contract to an existing provider.

3. **NOTED** that the mobilisation and impact would be reported and monitored through existing mental health governance processes.

08/20 CALDERDALE EXTENDED ACCESS CONTRACTS 2020/21

DL took the Chair due to SC and other GP members having a direct financial interest in the item.

DL proposed that GP members take part in the initial discussions concerning the item, as they would provide valuable input, particularly in relation to current service provision, but that they not take part in the decision making, pushing back their chairs to indicate their withdrawal. The Governing Body was happy with the proposed arrangement for the management of the conflicts of interest.

DR in presenting the paper explained that it set out three options on the future provision of extended access to GP services for decision. The paper was noted to provide background, the national context and expectations and three options for consideration and decision. The recommended option was option 3.

MP added that there had been a plan to procure a five year contract for extended access provision which had been effected by changes introduced by the publication of the revised GP contract. Consequently, the paper was seeking to extend the current provision through a direct award of contract to the existing provider until 31 March 2021.

Comments and questions were invited from GP Members.

- NS commented that the paper and recommendations spoke to the level of maturity in the system around partnership working.
- CT agreed that the additional time provided by the extension would allow Primary Care Networks (PCNs) to prepare to take on the responsibility later.
- The recommendation was also noted to make sense from the point of the planned national access review.

GP Members pushed their chairs back from the table.

DL confirmed that CCG's alternative quoracy arrangements were now being applied. The meeting was confirmed to be quorate under these arrangements.

Further comments and questions were invited.

- The current service provision was noted to be operating to the expected levels for 100% of the population with no issues of concern and that the proposal was simply to extend the arrangement for a further 12 months.
- It was noted that further guidance during the next 12 month was expected and that there was a need for the CGG to track what the proposed changes to the model might be in order that the eventual provider could succeed in delivery. **DR**
- In response a question concerning a value of money assessment, MP replied that some of this was determined by instructions for NHSE and that an analysis would indicate that costs were similar across the relevant options. NS added that when commissioning the service the CCG had been very clear about the number of additional appointments it would deliver.
- In response to a question concerning what other CCG's were doing, North Kirklees and Greater Huddersfield CCG's were noted to be in the same position and were

having to extend their contract to cover the interim period. MP advised Governing Body that there was a risk of moving away from a district wide approach to a fragmented model in the future.

DECISION:

The Governing Body:

1. **NOTED** the contents of the paper.
2. **SUPPORTED** the recommendation that Option 3 be selected as the most appropriate approach to secure the continuation of extended access to general practice services.

GP Member re-joined the meeting.

SC took the Chair.

09/20 CHIEF FINANCE OFFICER'S REPORT

NS in presenting the report highlighted the following:

Finance

The CCG was forecasting to exceed its financial plan which would support the ICS in meeting it control total. The ability of the ICS to meet its financial targets was imperative to ensure receipt of transformation money into the Calderdale system. Potential areas for investment would be addressed at future Governing Body Development sessions.

Contracting

There were no significant issues concerning the Aligned Incentive Contract (AIC) with CHFT. However, the early view of month 9 indicated an overtrade in activity levels for Calderdale as an outcome of winter pressures.

Activity at other acute providers was not adversely affecting the CCG's financial position.

An update on procurements had been provided at 2.9 in the report. Pulmonary and Podiatry Clinic Transport was highlighted as one the more significant procurements.

Performance

Calderdale, while not achieving the A&E 4 hour target, remained one of the strongest performers nationwide. There were no significant spikes in activity but there had been an increase in short stays and less than 24 hour admissions. Work was taking place through Care Closer to Home and PCN's as to how to support people away from the hospitals and A&E. There had been some slight deterioration on the Delayed Transfers of Care (DTOC) position but investment through the Better Care Fund (BCF) and work with the Council was seeking to address this.

Long waits at Leeds Teaching Hospital continued to affect the 52 week wait target; discussions and activity with the Trust were ongoing.

A pilot feedback session concerning the requirement to implement a 26 wait choice had not provided significant insights. The Governing Body would receive further information in future reports.

Comments and questions were invited:

- A question was raised regarding the high levels of pathology requests. MP suggested that the work required to address this might exceed the cost savings. MA commented that the four hour targets may be encouraging a greater degree of testing than required, as tests were ordered during triage to ensure the four hour target was not breached. Interested members were invited to explore this further outside the meeting.
- In response to a question regarding the Posture and Mobility Services, NS confirmed that feedback to date was positive and there had been a reduction in referrals. The investments made were reported to be making a difference. The working relationship between the CCG and provider were also noted to be positive.

DECISION:

The Governing Body **NOTED** the content of the report.

10/20 QUALITY AND SAFETY DASHBOARD

PW in presenting the report highlighted the following:

Yorkshire Ambulance Service (YAS) Care Quality Commission (CQC) Inspection Report

The inspection report had been published in October 2019 awarding a rating of "good". Improvements, particularly in relation to Patient Transport Services which had been previously rated as "requires improvement" were noted. YAS was now only one of two ambulance services nationally to be rated as "good" by the CQC.

Complaints

The CCG was explained to assure provider complaints processes through the Clinical Quality Board (CQB). The CCG also handled complaints ranging from Levels 1-4. QFPC had received notification of an increase in the number of level 1 complaints over the last 3 years. This was thought to be due to better internal administrative processes. The increase would be monitored.

Parliamentary and Health Services Ombudsman

PW reported that the one complaint dealt with by the CCG had been referred to the Ombudsman. An internal action plan had been developed in response. Further information concerning this would be provided to the Governing Body through the Complaints Annual Report.

Antimicrobial Resistance

The new plan to tackle Anti-Microbial resistance had been provided as at 7.2 in the report. At the time of the meeting, the CCG was engaged in a number of activities with colleagues in Public Health and across the IHP sharing best practice and learning. A local campaign called "Get A Grip" was in development. The Quality Dashboard now included measures on levels of anti-biotic prescribing.

Quality Dashboard

Regarding CHFT, discussions at QFPC had focused on its performance on fractured neck of femur and assurances concerning the central alerting system.

In regard to the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), there would be another review of its complaints processes, with assurance being received by the CQB in February. Also, an improving position in relation to the usage of out-of-area beds was reported.

Comments and questions were invited:

- In response to a question concerning the length of time taken to resolve complaints at SWYPFT, PW confirmed that some complaints could be in this system for some time due to their complexity. She also referred to the process improvement work that the Trust had undertaken and work that had taken place with staff to avoid issues escalating to the level of a formal complaint.

DECISION:

The Governing Body **NOTED** the contents of the report.

11/20 CCG CONSTITUTION

SC reminded the Governing Body that JM and AM had a direct professional interest in relation to this item as one of the amendments specified that the CCG Deputy Chair would be either the Lay Member (Finance and Performance) or Lay Member (Patient and Public Engagement). The Chair proposed that they both take part in the discussion and decision making but that he would continue to manage the interest. The Governing Body was happy with the proposed arrangement for the management of the conflicts of interest.

AOC in presenting the report explained that the paper recommended changes to the CCG Constitution to bring it in line with the New Model Constitution for CCGs. The New Model Constitution was explained to take account of the changes in legislation since the CCG was formed to ensure it was future ready and to provide it with a greater degrees of flexibility, whilst still ensuring high levels of transparency and accountability. Attention was drawn to changes to the Constitution already agreed with CCG members and NHSE as set out at 1.5 and 1.6. Details of the proposed changes were reported as set out 2.1. Attention was drawn to a series of additional optional amendments at 2.2 which were either recommended by NHSE for reasons of increased flexibility or to reflect the local landscape in which the CCG was operating. Next steps were reported as set out at 4.0.

Comments and questions were invited:

- DL confirmed that NHSE guidance was that the Chair of Audit should not be the CCG Deputy Chair when there were other options available.
- PR suggested that the Audit Chair might be considered as a member of the Remuneration and Nomination Committee in future (Nomination items only).

DECISION

The Governing Body **ENDORSED** to the CCG Membership the proposed revisions to the CCG Constitution

12/20 GOVERNING BODY MEMBERSHIP – APPOINTMENT OF THE CCG DEPUTY CHAIR

JM left the room at this point.

In presenting the report, AOC reminded the Governing Body that it had just endorsed the constitutional change that would enable either the Lay Member (Finance and Performance) or Lay Member (Public and Patient Engagement) to take on the role of CCG Deputy Chair. It was noted that this change brought the CCG in line with NHSE guidance which recommended that, where there was a choice of Independent Lay Members, CCG's avoid combining the roles of Audit Chair and CCG Deputy Chair. JM was noted to be the proposed candidate but that, subject to the support of the Governing Body, it could not be officially confirmed until NHSE had approved the

constitutional variation permitting the appointment although he would be operating in the role with the Governing Body and CCG Membership's support. The CCG Membership had been informed of the proposed nomination and no objections had been received.

SC invited comments on the nomination. The Governing Body was fully supportive of the nomination recognising the value and experience that JM would bring to the role of Deputy Chair.

There was a short discussion which recognised the need to take into account succession planning for the role the Deputy Chair and other roles on the Governing Body. It was noted that succession planning fell within the remit of the Remuneration and Nomination Committee.

DECISION:

The Governing Body **APPOINTED** John Mallalieu, Lay Member (Finance and Performance) as the CCG Deputy Chair.

JM re-joined the meeting and was informed of the decision.

13/20 INTEGRATED RISK MANAGEMENT FRAMEWORK

RG in presenting the report explained the Integrated Risk Management Framework had been reviewed and that the key changes were set out for Governing Body approval. The main changes were noted as set out in the covering paper. Attention was drawn to the reduction in the number or risk reporting cycles following changes to the CCG's formal governance arrangements. Also, that any new risks scoring 15 or 16 would be reported to the CCG's Senior Management Team's next available meeting when added outside of the new governance review periods.

Comments and questions were invited:

- It noted to be a logical review of the current position, which was in line with the CCG's current structure and provided assurance regarding escalations to SMT.
- There was recognition that some of the names and roles would need updating, as pointed out by the report author in the report.
- There was agreement that the framework may require further changes prior to the next scheduled review in November 2022.
- There was a suggestion that the framework may benefit from the inclusion of cumulative risk. The potential value of this was recognised. Interested members were invited to pursue this outside of the meeting.
- There was recognition of the inclusion of a section on Joint Commissioning Risks. RG confirmed there were some early stage discussions concerning a Joint Assurance Framework.

DECISION:

The Governing Body **REVIEWED** and **APPROVED** the revised CCG Integrated Risk Management Framework subject to amendments concerning roles and responsibilities identified by the report author.

14/20 HIGH LEVEL RISK LOG AND REPORT – RISK CYCLE 4 2019-20

RG presented the report as circulated. A critical risk report for risk 62 (Critical) had been supplied at Appendix 2. Since publication, the tariff associated with Risk 1373 (Access to Psychological Therapies) had been increased. RG explained that this may result in the risk rating being reduced the next cycle. Section 2.9 was noted to provide information on risks no longer rated as Serious.

Comments and questions:

- Risk 62 (24 hour A&E Target) was suggested to provide some evidence of the need to consider cumulative risk for inclusion in the Integrated Risk Management Framework.
- In response to a question concerning the scoring of risk 62, it was confirmed that the tolerance for the risk was high although the CCG was not complacent in its management. The A&E Delivery Board was explained to manage the actions in response to risk 62; however, it was recognised that timescales and expected outcomes for these that might provide some further assurance were not included in the report.

DECISION:

The Governing Body **CONFIRMED** that it was **ASSURED** that the High Level Risk Register represents a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 4 of 2019-20. This is following a review of the risks at the combined Quality, Finance and Performance Committee meeting on 19 December 2019.

15/20 EXTERNAL AUDITOR PROCUREMENT, AUDITOR PANEL AND AUDITOR PANEL TERMS OF REFERENCE

MP in presenting the report explained that the CCG had procured an external audit service in 2017 in response to legislative changes. The procurement took place in conjunction with Greater Huddersfield CCG. KMPG had been appointed on a three year contract with the option of a two year extension. Following internal discussions and with colleagues at Greater Huddersfield and North Kirklees CCGs, there was a preference to go back to market for a new provider. It was proposed that a mini-composition be undertaken against one of the procurement frameworks available. As part of the process, the CCG's Auditor Panel would need to be convened. The Panel's Terms of Reference and been reviewed and was submitted with amendments for the Governing Body's approval. Due to the reduction in the number of Governing Body meetings, it was requested that the Governing Body delegate authority to the Auditor Panel to both oversee the process and make the award on its behalf due to the timelines involved.

The Governing Body noted the recommendation, the recommended process, the proposed changes to the Auditor Panel Terms of Reference and the request to delegate authority.

MP confirmed that the contract value for Calderdale over three years would be less than the Governing Body threshold as set out in the CCG Standing Financial Instructions. NS clarified that each CCG would appoint individually but that the procurement would be undertaken jointly in order to achieve economies of scale.

DECISION:

The Governing Body:

1. **APPROVED** the undertaking of a procurement process in conjunction with Greater Huddersfield and North Kirklees CCGs to select and appoint an external auditor to the CCG.
2. **APPROVED** the revised Auditor Panel Terms of Reference as amended.
3. **DELEGATED** authority to the Auditor Panel to select and appoint an external auditor for the CCG having agreed and overseen a robust procurement process in line with the organisations normal procurement rules.

16/20 COMMITTEE MINUTES

DECISION:

The Governing **RECEIVED** the minutes of:

- The Audit Committee on 26 September 2019
- The Quality, Finance and Performance Committee on 26 September 2019
- The Commissioning Primary Medical Services Committee on 7 November 2019

AOC confirmed the process that would be used to approve minutes electronically so that they could flow through to the Governing Body.

17/20 EXTERNAL MINUTES

DECISION:

The Governing **RECEIVED** the minutes of the West Yorkshire and Harrogate Joint Committee of CGG meetings held on the 1 October 2019 and 5 November 2019.

18/20 KEY MESSAGES FOR PRACTICES

DECISION:

The Governing Body **AGREED** the following key messages: **Comms**

- Calderdale and Kirklees CAMHS Crisis/Intensive Home-Based treatment Extended Hours and All Age Liaison Service Model.
- Calderdale CCG Extended Access Contract 2020/21
- Public Health Annual Report and recommendations
- Staff Forum Update

19/20 DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

The Governing Body **NOTED** that the next meeting would take place as follows:

Governing Body Meeting
Thursday 2020, 2.00pm
Elsie Whitely Innovation Centre

The Governing Body thanked MA, HD, DL and PB for their contributions to the Governing Body on the occasion of their last meeting.

20/20 EXCLUSION OF THE PUBLIC

DECISION:

The Governing Body **AGREED** that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Governing Body Meeting – 23 January 2020 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
CHIEF OFFICER'S REPORT	77/19	▪ Andy's Man Club to be the subject of a future Patient Story.	PW	Ongoing	Contact has been made. Discussions ongoing. Update to GB on 23.01.20
CRISIS/ INTENSIVE HOME BASED TREATMENT	07/20	The Governing Body asked that ▪ Comments regarding the importance of integration across teams are fed back. ▪ Arrangements be put in place to monitor the use of the integrated systems being used to ensure that people are not having to re-tell their story each time they are referred into a new team. ▪ Arrangements are put in place to monitor the impact of the investment.	RR	COMPLETE	Have been raised with the provider and are being progressed as part of the implementation of this service.
CALDERDALE EXTENDED ACCESS CONTRACTS 2020/21	08/20	▪ It was noted that further guidance during the next 12 month was expected and that there was a need for CGG to track what the proposed changes to the model might be in order that the eventual provider could succeed in delivery.	DR	COMPLETE	Requirement has been picked up.
KEY MESSAGES FOR PRACTICES	18/20	The Governing Body **AGREED** the following key messages: ▪ Calderdale and Kirklees CAMHS Crisis/Intensive Home-Based treatment Extended Hours and All Age Liaison Service Model. ▪ Calderdale CCG Extended Access Contract 2020/21	Comms	COMPLETE	Published on Member Connect

		▪ Public Health Annual Report and recommendations ▪ Staff Forum Update			

Name of Meeting	Governing Body	**Meeting Date**	24/4/20
Title of Report	**Calderdale Complex Mental Health Community Rehabilitation Service Business Case**	**Agenda Item No.**	6
Report Author	Sarah Antemes - Head of Continuing Healthcare, Mental Health and Learning Disability Services	**Public / Private Item**	Public
GB / Clinical Lead	Dr Caroline Taylor, GP Member	**Responsible Officer**	Lesley Stokey, Head of Finance

Executive Summary							
Please include a brief summary of the purpose of the report	This report introduces a business case for the development of a complex mental health community rehabilitation service. The purpose of the business case is to seek approval for recurrent financial investment by the CCG for the establishment of the service.						
Previous consideration	**Name of meeting**	SMT	**Meeting Date**	23/03/2020			
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: 1. **APPROVES** the business case to develop a complex mental health community rehabilitation service; 2. **AGREES** the recurrent financial investment by Calderdale CCG for a complex mental health community rehabilitation service provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications						
Quality & Safety implications	The proposed service will improve the quality of service for individuals. A Quality Impact Assessment has been completed.					
Engagement & Equality implications (including whether an equality impact assessment has been completed)	An Equality and Engagement checklist has been completed, and an Equality Impact Assessment has been developed.					
Resources / Finance implications (including Staffing/Workforce considerations)	The business case sets out the staffing and additional investment required for the proposed service. It is anticipated that the additional investment would be provided through the diversion of funding for out of area placements as more people are supported to remain in or return to Calderdale.					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	✓

Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value	**Risk**	Any conflicts arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.
Legal / CCG Constitutional Implications	The service will be commissioned as part of the South West Yorkshire Partnership Foundation Trust (SWYPFT) contract	**Conflicts of Interest**	None identified

1.0 Purpose of Report

1.1 This report introduces a business case for a complex mental health community rehabilitation service. The purpose of the business case is to seek approval for recurrent financial investment by the CCG for the establishment of the service.

2.0 Background/Detail

2.1 The business case sets out evidence to support the development of a local rehabilitation service for people with complex mental health needs. This is based upon national evidence and best practice and builds upon existing work already carried out in Calderdale and evidence from a 12 month CCG funded pilot which focused upon the a cohort of people already in out of area (OOA) hospital placements.

2.2 Work during the pilot expedited the discharge of a number of people and prevented the unnecessary admission of others. It demonstrated that some of the current costs of Out of Area placements could be reduced through the provision of a dedicated team in charge of the whole pathway and more importantly the positive impact that this had upon quality of life for the individuals concerned.

2.3 Investment in this service will be provided through maximising the effectiveness of existing mental health spend.

2.4 The development of this local service is in line with planned developments at an Integrated Care System level for a new pathway for people with complex mental health needs.

3.0 Next Steps

3.1 If the business case and recurrent investment are approved, the service will be varied into the CCG's contract with South West Yorkshire Partnership NHS Foundation Trust (SWYFPT) and the CCG will work with SWYPFT on mobilisation.

4.0 Recommendation

4.1 It is recommended that the Governing Body:

- **APPROVES** the proposal to develop a complex mental health community rehabilitation service;

- **AGREES** the recurrent financial investment by Calderdale CCG for a complex mental health community rehabilitation service provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

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5.0 Appendices

5.1 The paper has one appendix:

Appendix 1 – Business case for Calderdale Complex Mental Health Community Rehabilitation Service

Appendix 1

NHS Calderdale Clinical Commissioning Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Calderdale Complex Mental Health Community Rehabilitation Service

Business case

April 2020

1.	**Purpose** The purpose of this Business Case is to seek approval for recurrent financial investment from NHS Calderdale CCG for the development of a new service to provide rehabilitation services for adults with complex mental health needs.
2.	**Background** **Strategic Objectives and Drivers for Change** **Five Year Forward View for Mental Health[1] (2016)** The 5YFVMH sets out the need for change in attitudes towards mental health and investment in mental health services, with a shift towards prevention and an ambition to achieve parity of esteem between mental and physical health for children, young people, adults and older people. The section on the adult mental health secure care pathway states that "NHS England will invest to increase funding to improve pathways in and out of mental health secure care, with a focus on expanding community-based services for people who require them. This is intended to prevent avoidable admissions and support 'step down' and ongoing recovery in the community as soon as appropriate for the individual and as close to home as possible". "People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely and well, as close to home as possible. More 'step-down' help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams". **Care Quality Commission's State of Care in Mental Health Services – 2104-2017[2]** Key findings were that many people with complex needs are dislocated from their home areas. Placements are often in the independent sector with long lengths of stay with a limited focus on discharge and at high cost. There is significant variation in the rehabilitation models and outcomes for people across the country.

[1] Independent Mental Health Taskforce to the NHS in England **Five Year Forward View for Mental Health** (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[2] Care Quality Commission **The state of care in mental health services 2014-17** (2017) https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017

The NHS Long Term Plan[3] (2019)

The NHS Long Term Plan further builds on the Five Year Forward View for Mental Health stating that "For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. Purposeful, patient-orientated and recovery-focused care is the goal from the outset. Units operating beyond capacity may struggle to offer such care and cannot admit new patients, who are then looked after further away from home or in non-specialist settings. The recent Crisp Commission highlighted a wide variation in the quality and capability of these acute mental health units across the country".

Care Quality Commission's State of Health Care and Adult Social Care[4] (2019)

We also know that people with the most severe and enduring mental ill-health do not always have access to local, comprehensive rehabilitation services and are often in inappropriate placements far from home. This weakens support networks and the ability of family and commissioners to stay in close contact, sometimes with devastating consequences.

Guidance for commissioners of rehabilitation services for people with complex mental health needs[5] (2016)

Around two-thirds of people supported by rehabilitation services progress to successful community living within 18 months of admission to an inpatient rehabilitation unit, two-thirds sustain this over five years without requiring further hospital admissions, and around 10% achieve independent living within this period. People receiving support from rehabilitation services are eight times more likely to achieve/sustain community living, compared to those supported by generic community mental health services.

NICE guidance

In 2020, NICE created draft guidance[6] with regard to mental health rehabilitation for adults aged 18 and over with complex psychosis and related severe mental health conditions.

The guidance aims to ensure people can have rehabilitation when they need it and promotes a positive approach to long-term recovery.

[3] **NHS Long Term Plan** (2019) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[4] Care Quality Commission **The State of Care in Health and Social Care 2018/19** (2019) https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

[5] Joint Commissioning Panel for Mental Health **Guidance for commissioners of rehabilitation services for people with complex mental health needs (2016)** https://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf

[6] https://www.nice.org.uk/guidance/indevelopment/gid-ng10092

	West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) - Integrated Care System (ICS) The Mental Health, Learning Disability and Autism Programme Board is one of the boards of the WYHHCP. The board has several key workstreams to lead the development of an ICS approach for mental health, one of which is the Complex Care work programme which was initiated in 2019. The rationale for this work was based upon national findings and drivers for change. This found that the situation across West Yorkshire was similar to those described in previous findings and CQC reports. The aim of this work has been "To develop an understanding of the cohort of people currently cared for in long- term, restrictive rehabilitation setting and how they may be better supported closer to home and (where possible) in the community." This programme has been part of the national NHS England Complex Care Transformation Programme and Get It Right First Time (GIRFT)[7] programme – reducing variation and improving outcomes. The aim of the latter is " To develop an understanding of the needs of the people currently supported in long-term, restrictive rehabilitation/residential care settings and how they might be better supported closer to home and (where possible) in the community" The outcomes of this work and proposals for change were presented to WYHHCP on 10/03/20 and included a number of proposals for developments at an ICS level but also recommendations of the need for place based community rehabilitation services and accommodation solutions.
3.	**Local background and context** **Background** In 2017 a multi stakeholder working group was created in order to review local services that provided rehabilitation and recovery services. The work of this group built upon previous work by the council to review accommodation for mental health service users. This work took into account national drivers about quality, in particular CQC reports, and also consideration of new models for community rehabilitation services that were starting to emerge. This led to a proposal for a new model that would provide a more modern approach to rehabilitation and recovery, moving away from traditional bed-based services. The proposal involved enhancing community services, mixed model of 24 hour care, flexible community services and a range of housing solutions. Individuals would be

[7] https://nhsproviders.org/the-getting-it-right-first-time-programme

supported throughout this pathway through peer support and there would still be access to specialist inpatient beds for those people for whom a community service is not clinically appropriate at the time.

This proposal was submitted to NHS England and also reviewed by the Yorkshire and Humber Clinical Senate and, following their support, a proposal was presented to Governing Body in 2018. The proposal to develop community services was agreed in principle and it was recommended that work between partners continued to improve and develop upon existing services.

Progress up to date

Since that time Calderdale Clinical Commissioning Group (CCG) South West Yorkshire Partnership Foundation Trust (SWYPFT) Calderdale Council (CMBC) have worked together to review services and improve ways of working and accommodation.

This has included trialling the development of some outreach support from the Lyndhurst Community through a flexible use of existing staff. Whilst this has only been able to provide a limited service, the positive impact that it has made has provided us with the evidence of the need for a specialist community rehabilitation team as part of the overarching service model.

Following a review of the patient cohort in services at that time and ongoing, an accommodation plan has been developed that is flexible to the needs of service users. A key success has been the development of ten flats with support which opened in late 2019 in central Halifax. This has enabled people to move successfully from 24 hour care into their own tenancies. The transition period was supported by the outreach of staff from Lyndhurst.

Calderdale wellbeing strategy 2019- 2024.

This document sets out the ambition to improve health and wellbeing through all life stages. The development of the draft Calderdale emotional health and wellbeing strategy uses evidence to identify 3 key priorities for all life stages:

1) Prevention and proactive support to enable people to stay well and independent at home

2) Swift and appropriate access to care and support where people require a step up or urgent or crisis response

3) Step down support for people who need transitional or on–going care at home or in a temporary or new residence.

	Work with stakeholders has identified a desire to move towards a focus on prevention of crisis whilst acknowledging the need for access to the right services during and after crisis is also necessary. Calderdale CCG has made a commitment to commission health services that provide Care Closer to Home (CC2H). This will require all providers, statutory and non-statutory, to work together to develop new ways of working and services. This work is led by the CC2H Alliance and SWYPFT is a key partner in this work.
4.	**Community mental health rehabilitation services in Calderdale** **Current service provision** Lyndhurst is a mixed sex inpatient unit for people with serious mental health conditions who require assessment, treatment and rehabilitation back into the community. It supports people in their recovery from mental illness. The service is based in the community and currently has 14 inpatient beds. Patients admitted to Lyndhurst have usually already been in hospital, on an acute ward or in a more secure hospital environment with complex psychosis and related severe mental health conditions that have treatment-resistant symptoms and functional impairments that affect their activities of daily living and social participation. This group of people include: • People who have experienced recurrent admissions or extended stays in acute inpatient or psychiatric units, either locally or out of area • People living in 24-hour staffed accommodation whose placement is breaking down. The purpose of the service is to provide a recovery-orientated approach for someone to support them in achieving the best quality of life they can, while living and coping with their symptoms. It is an on-going process whereby the person is supported to build up their confidence, skills and resilience, through setting and achieving goals to minimise the impact of mental health problems on their everyday life. The approach involves a shared ethos and goals that ensure individualised, person-centred care through collaborative working and shared decision making with services users and their carers involved, but recognises that not everyone regains the same level of function they had before the illness and may need to stay in supported accommodation in the long term.

Service pre April 2019

The service had provision for 14 inpatient beds with no outreach service. People admitted to Lyndhurst had usually already been in hospital, on an acute ward or in a more secure hospital environment with complex psychosis and related severe mental health conditions that have treatment-resistant symptoms and functional impairments that affect their activities of daily living and social participation. People could be admitted informally or detained under the Mental Health Act.

People admitted to Lyndhurst often required high level support to enable them to have a successful placement in the community, due to the limited appropriate outreach service and the average length of stay would be for 18-24 months.

Due to the length of stays and limited availability of beds, the flow of service users moving back from out of area and from other mental health placements back to their local area and into the community has been hindered.

The development of a community rehabilitation model

In April 2019 the CCG commissioned a 12 month pilot to reduce the number of people in Out of Area locked rehabilitation services. A business proposal was agreed to make an investment of £70,000 on the assumption that this investment would generate savings above the cost of the pilot through a reduction in spend on out of area placements.

The purpose of this pilot was to prove that, by focused work on the pathway of recovery and rehabilitation for people currently in an acute ward or in a more secure hospital environment, some people could be supported to return to community and/or have a shortened length of stay in hospital. In addition, some unnecessary admissions from acute services into locked rehabilitation services might be prevented.

The aim of the pilot was to:

- Develop a clinical advisor role to improve systems working across the trust, including community acute and forensic, supporting the referrals of people at the right time, to the right place and preventing delays in accessing the appropriate service.
- Reduce the length of stay in restrictive settings and support repatriation to the person's local area.
- Have clinical oversight of all service users in 'locked rehabilitation placements' to ensure that all service users had a clear discharge plan, were appropriately place and had clear aims and objectives for their placement.
- Improve the patient pathway across the inpatient journey so that clinicians who did not work in the rehabilitation service could better understand the benefits that rehabilitation could offer

The clinical advisor pilot commenced in April 2019 and firstly looked at the services delivered across Lyndhurst and other mental health units and found that they shared common issues which impacted on their ability to deliver an effective rehabilitation service.

The pilot recognised the need to:

- Identify the potential for reducing inpatient provision and maximising capacity for supporting people in their own tenancies
- Improving patient/service user flow within the whole pathway

As result of the findings a decision was made to pilot a rehabilitation outreach service from Lyndhurst and it was agreed to initially trial with one person.

At the CCG funding panel it was agreed to work differently with an individual who over a few years had received 'locked rehabilitation' several times, as well as a specialist personality disorder placement. This service user had diagnoses of emotionally unstable personality disorder with coping mechanisms of significant self-harm.

After extensive work with the service user, family, community mental health teams and the acute ward it was agree to discharge the person to their own tenancy supported with daily rehabilitation intervention. The aim of the rehabilitation input was to assess the level of support the person would require to live independently and long term in their own home. It was agreed that an outreach provision would be provided for three months, and would be reviewed every four weeks with the service user receiving daily visits.

Over this period of time the person's long term needs were identified and referrals made to the appropriate home care provider using the collaborative care planning approach. At the end of the three months the service again worked collaboratively with the home care provided to ensure that the transition from the community rehabilitation service to care provider was supported and effective.

The person is still successfully living well in their own tenancy. Previously the person had spent most of their adult life in acute hospital settings. Without this intensive rehabilitation support this person would have been unable to make the transition from acute hospital to living in their own tenancy. The approach therefore saved a significant amount on inpatient stays, and associated costs.

Prior to the pilot there were a number of issues in the system:

- **Clinical demand on acute and community** – Staff were carrying high caseloads, with the demand for acute beds outstripping the availability. The pilot aimed to reduce the length of time a person waited for the appropriate service (for discharge). A screening process with the discharge co-ordinators on the ward was implemented; this identifies any discharge barriers at an earlier point allowing measures/actions to be put in place earlier, including referrals to the most appropriate services. This process has increased patient flow and reduced the pressure on staff by collaboratively identifying the most appropriate onward referrals.
- **Risk Management** – Clinicians were often risk averse at managing people with complex needs and risks in the community; this was often due to the limited resources available to support both the clinician and the service user. Clinicians are slowly becoming less risk averse due to the collaborative approach to shared ownership of care and robust risk management.
- **Embedded custom and practice** – Clinicians found it difficult to envisage how a new model might work and staff reported that they were concerned about what impact this might have on their roles and additional workload. To address this, a rehabilitation project group was established which included representation from all parties, with the group having involvement in development of the model, policies and procedures. This joint ownership has helped developed strong professional relationships.

An intrinsic part of the pilot was to not only work collaboratively with clinical staff but to develop relationships with other providers/services and the voluntary and community sector. Work has taken place with the Local Authority to develop pathways, discharge destinations and collaboratively support the transition of people into local communities. Work has also taken place with private providers to establish the repatriation pathway work stream; this was also developed working with private landlords and the local authority housing team to look at trends in demand to predict future housing needs.

During the pilot it was recognised that the referral processes were complex and hard to navigate for clinicians, therefore as part of the pilot the referral criteria were redesigned so they were clear, the referral form for local rehabilitation services and the funding panel were redesigned, and a signposting recommendation form for those not appropriate for rehabilitation services was developed. A Multi Disciplinary Team discharge summary form for service user and care coordinator with recommendations on how to keep the service user well/ at optimum level was developed, and a gatekeeping role for all placements in line with NICE guidance was implemented to reduce the number of inappropriate funding requests to panel.

	Work has taken place with Healthy Minds, the Women's Centre, Active Calderdale and the Recovery College to develop links with the local community which support service users to develop a routine away from mental health services and feel socially included in their own communities. **Impact** Since the start of the pilot the average the length of stay as an inpatient in Lyndhurst has begun to reduce, due to the support of the limited outreach offer and close management of patient progress. This has allowed for increased utilisation of inpatient care and has freed some capacity for service users to return from out of area placements. To date three people have been repatriated from out of area into their local community. In addition to funding the cost of the clinical advisor role, this work also generated some additional savings. This work provided evidence that current spend on out of area placements could be used more effectively through providing a community rehabilitation service, supporting people to remain in the community and reducing the numbers of people in costly locked rehabilitation hospital services. The average cost of one of these placements ranges from £134,000 to £164,000 per annum.
5.	**Case for Change** **Context** Currently West Yorkshire and Harrogate Health and Care Partnership are carrying out a review of complex care rehabilitation across the ICS West Yorkshire footprint and proposals went to Mental Health, Learning Disability and Autism Programme Board on 10/03/2020. These proposals were for the development of ICS models of care that would then need to be underpinned by place-based solutions for community rehabilitation and accommodation. **Evidence** The place-based work development undertaken by the interim Clinical Advisor /pathway rehabilitation lead has already made huge steps in developing the initial stages of the local offer; from this work, key areas of work have already commenced and are starting to have an impact in the local system. This momentum needs to continue to enable Calderdale to have an effective local rehabilitation offer. In line with the proposed NICE guidance a gate-keeping process for all out of area placements (Rehabilitation) has been developed, this has recently been implemented. As this process embeds it will be need to be continually reviewed.

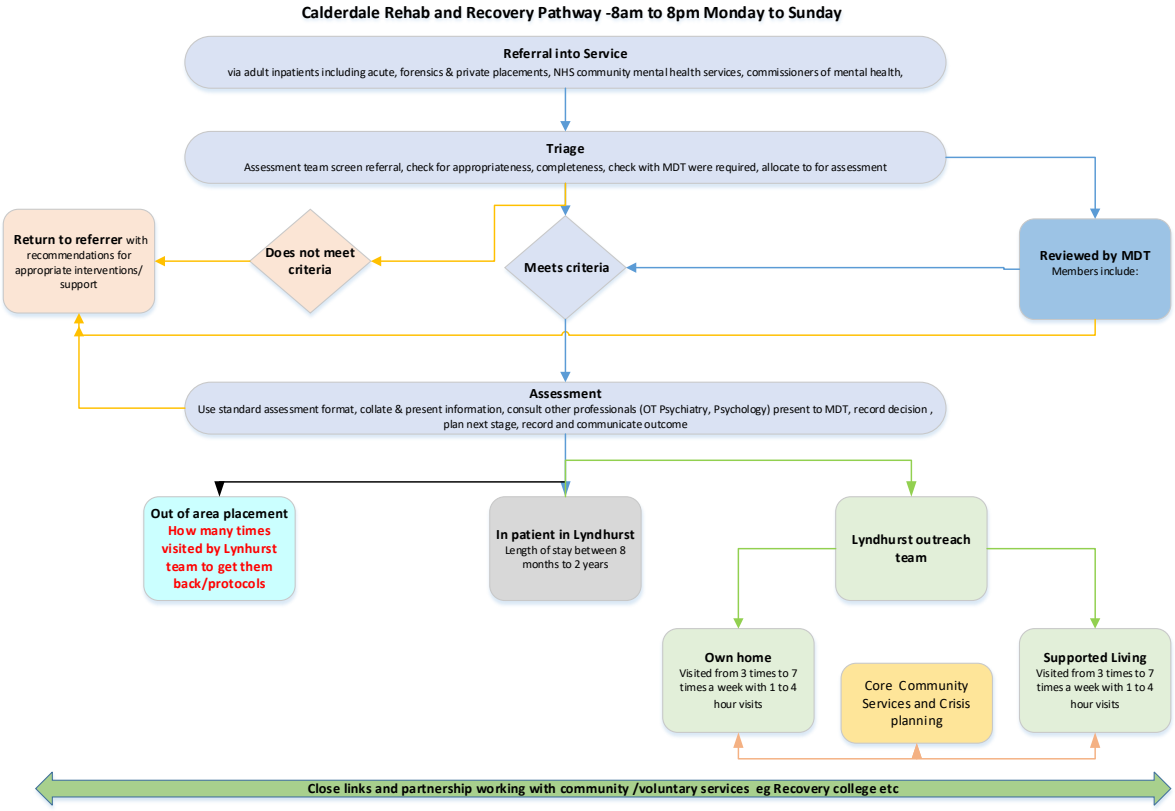
	Prior to the pilot the funding panel for out of area placements did not have a robust referral process in place which led to an influx of inappropriate referrals from care coordinators and the panel ended up acting as gatekeeper and advisor to staff rather than a decision making group. This has now been addressed with robust governance procedures and an audit process in place. This work has taken delays out of the system and ensured the entire process is clinically led. Proactive case finding has created efficiencies within the system, with decisions being made on a person's care pathway. The future ambition would be to have a dedicated assessment team, who would then respond within 72hrs. The rehabilitation lead implemented a new approach to working with individuals in the right place to explore their needs. This has resulted in more people having access to community rehabilitation services; however this offer is limited due to the staffing capacity. Work still needs to be undertaken with service users and the community mental health team with people already living in the community who have the potential for further re-enablement to increase independence. Clear discharge planning has been implemented at Lyndhurst, which has improved patient flow and reduced length of stay. To ensure this process is as efficient as possible further work needs to be undertaken with other health care professionals. Prior to the pilot there was little consistency in following people from admission to discharge, resulting in people not progressing through the system in a timely manner. The development of the pilot community rehabilitation team has ensured that there is a consistent approach, with a person followed and supported throughout their journey, which has ensured timely discharge or repatriation. There is strong evidence that rehabilitation services are effective with around two-thirds of people supported by rehabilitation services progress to successful community living within 18 months of admission to an inpatient rehabilitation unit, two-thirds sustain this over five years without requiring further hospital admissions, and around 10% achieve independent living within this period. The importance of providing a local rehabilitation care pathway to minimise the use of out-of-area placements has been emphasised in a number of policy and guidance documents. These are set out in section 2 of this business case. .

6.	**The Proposal** To develop a complex mental health community rehabilitation service which builds upon the flexible use of Lyndhurst community beds with the development of an outreach service This proposal aims to expand on the work that has already been accomplished through the CCG commissioned pilot and further extend this working to reduce the need for service users to go out of area and to facilitate their rehabilitation into the community. It is proposed that the bookable bed base at Lyndhurst **operates at 8 beds**, with the option to use **2 to 4 beds flexibly**. These flexi beds would be used for supporting people who are with the rehabilitation and recovery service, but who may be struggling with compliance, etc. This flexible provision gives the service the capacity to be able to quickly admit people to an inpatient setting for a very short period of time, helping them over a difficult period and preventing a breakdown in tenancy/placement. The flexi beds would also be used for those who are in OOA placements, but are now ready to be repatriated to Calderdale. By providing this extended and comprehensive rehabilitation pathway, service users will be able to go back into the community, allowing them to have the best life they can living with their conditions. The service aims to reduce the length of stay within Lyndhurst to 6 to 12 months compared to 18 month to 2 years at present and reduce out of area length of stay from over 2 years to 6 to 12 months. This service will be enhanced by creating an outreach service from within the Lyndhurst staff team. Staff within this service already have the skill set and understanding of patient needs to provide an effective rehabilitation service. Intensive support can be provided for service users in order to step them down through services and support their successful rehabilitation into the community. The service already has good working relations with the local authority with five council support workers working within the team. These workers are able to provide invaluable support and lead on social care interventions, benefits, and housing issues. **Aims** • To enhance the staff team in order to increase the outreach offer. • To reduce the length of time spent in beds/length of stay in hospitals • To increase fluidity across the inpatient pathways • To reduce replication of assessment • To offer intensive input to complex service users that require rehabilitation within their own environment.

Service Model

The extended Lyndhurst team will provide a rehabilitation offer within an individual's own home within the Calderdale locality. This can be offered as a transitional package from hospital to own tenancy/support living, either reducing the length of stay in hospital care or preventing admission. The service will help people to work towards their aspirations and make the most of their abilities, while giving them support and encouragement wherever needed.

The Service Pathway



Aim of the rehabilitation service is :

- To provide a rehabilitation service for people who require rehabilitation due to the impact that their mental health is having on their life
- To re-establish the individual's abilities and independence in all aspects of their daily life to an optimal level suitable for them and which supports each individual's recovery process
- To prevent admission to complex care rehabilitation.
- To reduce the length of stay in inpatient care.
- To repatriate from out of area to local area.
- To support and re-able service users to their optimum health and wellbeing.

	To deliver this service it would be a requirement to increase the numbers of staff in the current team, whilst maintaining a wide skill mix. Staff would include: **Rehabilitation pathway lead** - for clinical oversight of service/pathway and continued development of the service both operationally and strategically. **Clinical team manager** – oversight of the day to day management of the service delivery, staff management and staff development. **Clinical team leaders** – leading on assessments and care planning and responsible for the day to day service delivery, ensuring it is safe and clinically led for both inpatient and community offer. **Registered mental health nurses** – delivering service user care and the co-ordination of inpatient and outreach care. **Specialist Occupational Therapist** – involved in all assessments of service users providing the specialist assessment and intervention. **Occupational Therapists**– responsible for managing the day to day case load, completing functional assessments and directing interventions. **Occupational Therapy assistants** – to deliver OT specific interventions and deliver one-off OT assessments. **Local authority support workers** – leading on social care interventions such as housing benefits, social inclusion and anything related to future social care needs. **Health Care assistants** – delivering interventions directed by the MDT, supporting with cooking, delivering direct patient care etc. **Referral into Service** The rehabilitation and recovery service is a provision that will be available to service users receiving secondary care mental health services who require additional input to return to the community. This is a secondary mental health service, where referrals are accepted from other adult inpatient units including acute, forensics and private placements, NHS community mental health services or commissioners of mental health services. The service will not accept referrals from primary care services.

Rehabilitation and recovery services will accept referrals for specialist opinion and recommendations, and will offer specialist advice to support secondary mental health services in signposting/ recommendations for appropriate services.

If the local rehabilitation pathway is unable to support the needs of an individual, they will complete a screening and recommendations form that can support further referrals to appropriate services.

No direct referrals to complex care or private providers will be completed unless they have been gate kept by the locally provided rehabilitation pathway.

A dedicated assessment team made up of the Rehabilitation pathway lead, Nurses, OT, Medic and Psychologist will screen all referrals, check for appropriateness, completeness. Referrals will be checked with the MDT where required before being allocated for assessment.

The criteria

The rehabilitation service will assess service users that present with;

- Potential for further enablement and to increase independence.
- The motivation and willingness to engage in rehabilitation interventions.
- An identified need for further assessment to establish future needs.

Inclusion

- There is no upper age limit to the service – rehabilitation services will offer support if the presenting needs can be met by the rehabilitation team.
- There must be a clear need for rehabilitation involvement in the care.
- The service user must be allocated to a care coordinator/healthcare professional and receiving support from the enhanced, forensic or core pathway.
- Service users must require a minimum of three visits a week (if outreach) for rehabilitation focused interventions.

In addition to the client group characteristics listed, the following factors also require consideration prior to admission to the unit:

The service user should:

- Be able to keep themselves safe without immediate risk to others;
- Have a defined Section 17 leave plan, which includes unescorted leave, or a clear plan to work towards this;
- Be able to reside in a mixed sex environment;
- Be able to co-produce and engage in their care plan including discharge planning.

To be accepted for outreach, the following factors also require consideration prior to acceptance for the service;

- Have their own tenancy;
- Be able to co-produce and engage in their care plan including identifying areas for input and discharge planning
- Require a minimum of three visits per week.

If referred from inpatients:

- There needs to be a clear defined report of ongoing functional needs from OT;
- If detained – must be utilising unescorted leave without incident from the ward that they are based on;
- A clear rationale for assessment and intervention by the rehabilitation team.

If referred from community services;

- The service user must be consenting and aware of the referral;
- A clear rationale for assessment and intervention by the rehabilitation team.

Assessment

A comprehensive multi-disciplinary assessment will be undertaken with the service user, based on presentation and need rather than diagnosis. The assessment will be undertaken using a trauma-informed approach. The assessment will identify clear rehabilitation needs and will determine the appropriate service offer (inpatient rehabilitation or community rehabilitation).

If the individual is not ready for rehabilitation at the time of the referral, the service will provide advice on what needs to be achieved for the individual to be ready for rehabilitation.

If the local rehabilitation pathway is unable to support the needs of an individual, the service will complete a screening and recommendations from that can support further referrals/signposting to appropriate services.

Personalised care planning

All service users will be involved in their care planning. Personalised care plans are based on an understanding of the service user's needs and condition. The care plans made are achievable, reflect on the progress the service user has made qualitative indications of progress and explore obstacles to recovery. Discharge planning starts at the point of admission/service offer. NICE guidance will be used as a reference tool for care planning

Each service user has an initial care plan on admission based on the Recovery Star (used by many mental health Trusts as a tool for optimising individual recovery). Lyndhurst also follows the Care Programme Approach.

Service users who have been repatriated from out of area placements and/or secure placements have their care needs identified and their care plans written prior to visits commencing.

Dependent on the outcome of the assessment service users will be allocated to one of the following;

Out of area placement
When placed out of area a clear care plan will be produced detailing how and when they will be repatriated to the area as required.

Inpatient at Lyndhurst
Where the assessment has identified a need for the service user to stay as an inpatient the care plan will provide a complex care plan incorporating a discharge plan. As and when the service user is ready to move into the community the service user will move into the Lyndhurst outreach service.

Outreach Team
Service users identified as being suitable to move straight into the community may move into their own home or into supported living as appropriate. A care plan will already be in place to provide a stepped down progress to discharge. With support provided dependent on the need of the service user this could be High Level support initially (with 3- 4 hours visits every day for 2 to 4 weeks), stepping down to Medium level support (Less than 3 hours a day 7 days a week for up to 12 months) and as the service user becomes further independent Low level support (Less than 3 hours a day 3 to 5 days a week for up to 18 months).

The hours and visits will be dependent on the service users' needs and are offered as an example.

Interventions
Treatment and interventions will be determined by individual assessment and the service user's needs.

Offered interventions are likely to include:

- Individual goal setting to improve quality of life.
- Risk assessment and risk management incorporating positive risk taking.

- Physical health monitoring.
- Maintenance or acquisition of daily living skills.
- Access to vocational opportunities.
- Relapse prevention and symptom management.
- Self-administration of medication.
- Development of positive coping strategies including adherence to treatment.
- Social inclusion and re-integration to the community.
- Individualised structured routine and planning
- Budget management.
- Psycho-social interventions.
- Medication management and monitoring.
- Medication reviews.
- Occupational Therapy.
- Support with spirituality needs.
- Mindfulness.
- Group work.
- Psychological formulation and intervention.

These interventions will be delivered by the MDT and, where required, a multi-agency team approach will be utilised to aid the service user in achieving their optimal recovery.

Reviews

Care Programme Approach (CPA) meetings are held on or prior to admission and at a minimum of every six months to discuss the service user's assessment, progress and outcomes. A detailed report is produced for each CPA meeting by the service user's key worker. Service users retain their community care co-ordinator throughout their admission. MDT reviews are conducted weekly, with individuals reviewed a minimum of every month.

MDT reviews are attended by the service user, a Consultant Psychiatrist, Clinical Psychologist, Occupational Therapist (OT), Registered Mental Health Nurse (RMN), Physiotherapist and Pharmacist as needed. Other attendees could include advocacy, carers and any other support networks as identified by the service user.

Nursing and OT reports are produced prior to the MDT reviews.

Care co-ordinators are invited to all reviews.

Outreach Reviews

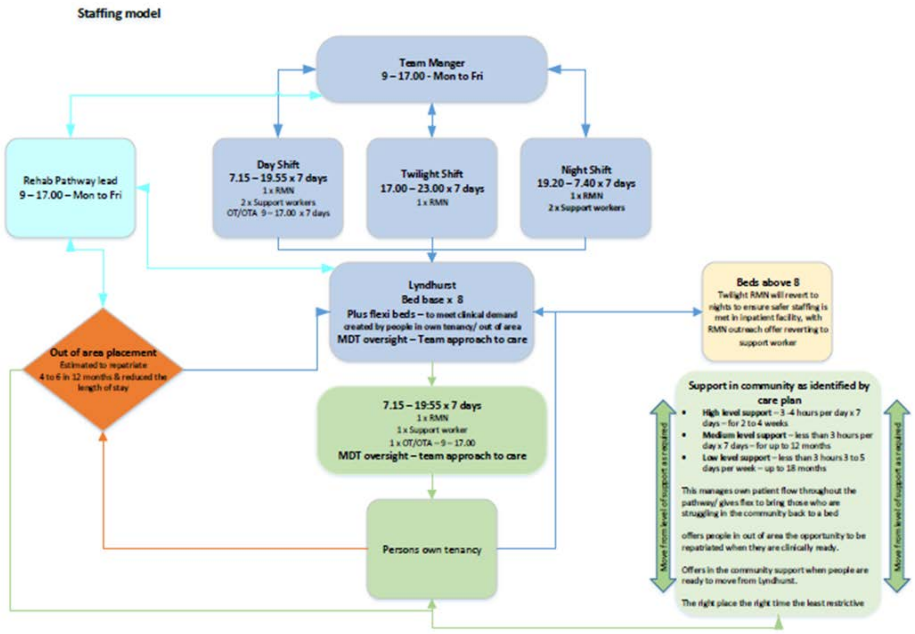
If a service user agrees to engage in outreach, MDT reviews will be completed every 4-6 weeks dependent on need.

The reviews are attended by the service user, care co-ordinator, and relevant professionals from the outreach team, such as Nursing, Occupational Therapy, and Psychology. Other attendees could include advocacy, carers, other services involved in the care delivery or as identified by the service user.

The medical responsibility for the service user receiving outreach will remain with their community Responsible Clinician, and the care co-ordination responsibility will remain with their identified care co-ordinator from their local team.

Lyndhurst will undertake weekly outreach meetings which will review the weekly input the individual requires, level of engagement and any issues.

Staffing levels are monitored by E-rostering and senior managers.



The level of support provided in the community will be identified through individual care plans for the purposes of this business case we have based this on 3 levels although this may increase or decrease dependent on the individual's needs. The service would provide a stepped down approach of support as required by the individual.

Caseload size variable dependent on need. Max 9 people per day could be on intensive outreach – equivalent of 3 to 4 hour visit daily. As the intensity level decreases and the service users require less intervention the service would have additional capacity.

Below is an estimate of the amount of contact time that may be required during a typical week:

Level of Need	No. Of hours per day	No of people requiring care:	No. Of Daily contact hours required	No. Of weekly contact hours required
High Level	4	3	12	84
Medium Level	2	7	14	98
Low Level	1	5	5	35
		14	26	217

High Level support
This would be likely provided for people that have newly moved into a community setting and would comprise of
3- 4 hours visits every day for 2 to 4 weeks

Medium level support
Less than 3 hours a day 7 days a week for up to 12 months

Low level support
Less than 3 hours a day 3 to 5 days a week for up to 18 months.

Initially it is expected that the number of higher level support will be higher as the Lyndhurst team start to integrate people out into the community however as service users started to step down on the level of support they require more service users will move into medium and lower level support needs.

The pilot was only able to deliver a limited number of hours of outreach due to staffing capacity and the inpatient staff requirements. The proposed model has been designed to offer a comprehensive community rehabilitation offer, whilst maintaining flexibility, ensuring service users who are living in the community but need a very brief inpatient stay to support their mental wellbeing can be accommodated in a timely manner. The current service can only support 14 people at any one time. The new model at a minimum can always offer 8 inpatient beds and at minimum 9 outreach and at maximum 22 outreach This would substantially increase the Calderdale rehabilitation offer. By developing a flexible model it will ensure that the service users will have access to the rehabilitation pathway whenever they need it, reducing the length of stay on acute wards and acute hospital admissions.

Funding requirement (based on 20/21 pay rates)

Calderdale Rehab Service Including Outreach		
	Proposal	
	WTE	Total Cost 2020/21
Consultant (with on call)	0.33	53,524
Specialty Registrar CT1-3	0.50	22,863
Psychologist Band 8a	0.50	33,579
Rehab Pathway Lead Band 8a	1.00	67,159
Team Manager Band 7	1.00	58,874
Nurse Band 6	3.00	170,555
Nurse Band 5	6.05	310,960
Nursing Associate Band 4	1.00	40,267
Occupational Therapist Band 6	1.80	93,376
Occupational Therapist Band 5	1.00	46,888
Therapy Assistant Band 3	2.00	67,027
Health Care Support Worker Band 3	9.36	342,839
Health Care Support Worker Band 3 (recharged by Local Authority)	5.00	183,140
Housekeepers Band 2	1.60	47,945
Admin Support Band 3	0.50	14,888
Non-Pay		
Drugs		8,050
Clinical Equipment		2,760
Hotel Services Provisions		24,438
Agile Working kit		4,600
Travel		6,900
Other Non pay		23,920
Total Annual cost	**34.64**	**1,624,552**
less current Investment as per Service Schedule Lyndhurst		(1,069,665)
less current Investment as per Service Schedule Wells House		(323,407)
less CQUIN 1.25%		(17,413)
Additional Price		**214,066**

Service costs
It is proposed that the additional cost of £214,066 per annum for this service would be met through a planned reduction in the use of out of area hospital beds and by more people being supported to remain/return to Calderdale. This would be funded through the reduction of these placements from 12 to 10 the cost of which equates to a minimum of £264,000. This will be monitored through the QIPP process.

It is therefore proposed that we take the cost of the additional service from the out of area budget. The new pathway will aim to have no more than 9 people in an out of area placement at any one time In order to reduce the likelihood of any additional spend.

The process for admission to hospital beds is managed through the OOA mental health panel and chaired by the CCG commissioner for specialist mental health. This will enable close oversight of all activity and spend on OOA placements.

In addition to providing the outreach service the manager of the team will be expected to maintain oversight of the whole pathway ensuring maximisation of available resources and step down through services.

It is therefore expected that at the least, this service will be cost neutral but it is anticipated that it may make additional savings which will allow further opportunities. We will consider any additional savings as part of the mental health standard and therefore able to be used for other investments in line with local mental health priorities.

CCG spending on mental health will be closely monitored to ensure that the funding released through the reduction in the use of out of area beds does not lead to additional costs in other parts of the system which would impact on the ability of the CCG to use that funding for this service.

Outcomes
The Service Outcomes would be:

People will no longer be admitted to locked hospital placements simply because there are not the right services in the local community available to support them.

For those people who do require an inpatient placement their length of stay will be reduced All people in hospital will have a discharge plan that will be actively monitored.

People will be supported to make informed choices about their discharge plans and have increased choice and control in their lives.

	There will be an improved quality of experience for service users and carers More people will be able to live in community accommodation rather than long term care People will have greater choice through the development of more community accommodation with access to the support of the community rehabilitation service. **Proposed measures** A number of measures have been identified that would be developed and reviewed throughout the implementation phase. Thereafter they would reported against on a quarterly basis through existing contract monitoring arrangements • Number of successful repatriations from out of area placements • Reduction in the length of stay in out of area placements • Reduction in those sent out of area due to resources not available • Number of beds occupied at Lyndhurst, month by month • Waiting times for access to Lyndhurst /community rehabilitation service • Number of people supported to transition into own tenancy/community • Number of people who have maintained their own tenancy/community placement • Number of people who have accessed the flexible beds and for how long • Length of stay within Lyndhurst - maintain an average of between 6 to 12 months • Number of people not accepted to Lyndhurst by reason • Number of referrals made to funding panel, reporting by accepted and refused • Report on outcome measures The measures above have been used during the pilot and so a baseline is already in place on which to measure future progress.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/4/2020
Title of Report	**Access to infertility treatment 2020-2023**	**Agenda Item No.**	7
Report Author	Helen Wraith, Programme Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby (CCG Chair, GP Member)	**Responsible Officer**	Rhona Radley, Deputy Head of Service Improvement

Executive Summary							
Please include a brief summary of the purpose of the report	• In December 2017 Calderdale Clinical Commissioning Group (CCG) approved local adoption of the Access to infertility treatment commissioning policy document jointly recommended following work by all CCGs in Yorkshire and Humber (Y&H) and the Y&H Expert Fertility Panel. • In 2017, one CCG faced a legal challenge in relation to the equity of the policy and further inequities were identified in relation to emerging treatments. • In October 2018, the Y&H revised Access to Infertility Treatment policy was presented to Calderdale CCG's Quality Committee (QC). • There were a number of changes and issues brought to the attention of the QC and escalated to Y&H. (Appendix one) • In July 2019 Y&H shared a further updated policy which still contained the changes above but also updates on the issues raised. • The updates to the policy are in relation to eligibility and not the number of cycles which remains the same (one).						
Previous consideration	**Name of meeting**		**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that Governing Body: 1. **APPROVES** the revised policy including the updates and revisions;						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications	Included in the updated policy; reviewed by Calderdale CCG's Quality Team		
Public / Patient / Other Engagement	Aligned to NICE guidance		
Resources / Finance implications	No change		
Strategic Objectives	• Improving Quality • Improving Value	**Risk**	No risk has been identified on the CCG risk register

Legal / CCG Constitutional Implications	In 2017, one CCG faced a legal challenge in relation to the equity of the policy and further inequities were identified in relation to emerging treatments. The policy has been amended to address this risk.	**Conflicts of Interest**	Any conflicts of interest will be managed in line with the CCG Management of Conflicts of Interest Policy.

1.0 Introduction

1.1. In 2013 following transfer of commissioning responsibility for specialist fertility services from the Yorkshire and Humber (Y&H) Specialised Commissioning Group to local CCGs, a Y&H wide access to infertility policy was developed to encourage consistent access thresholds.

1.2. During 2016, a panel of local commissioner and provider experts was convened virtually in order to review the current policy and align to latest NICE guidance.

1.3. NHS Calderdale CCG approved adoption of the policy in December 2017.

1.4. In 2017, one CCG faced a legal challenge in relation to the equity of the policy and further inequities were identified in relation to emerging treatments.

1.5. In October 2018, the Y&H revised Access to Infertility Treatment policy was presented to Calderdale CCG's Quality Committee, there were however a number of changes and issues brought to the attention of the committee and subsequently escalated to the Y&H team.

1.6. In July 2019 Y&H shared a further updated policy which still contained the changes above but also updates on the issues raised.

1.7. In October 2019 further guidance was issued regarding the application of the health surcharge where one partner was eligible to incur the surcharge. West Yorkshire & Harrogate Integrated Health Partnership have agreed that as this is a couples policy where one partner is ordinarily resident and the other not that the service would be freely available to them as a couple.

1.8. The outstanding issue in the July 2019 update was funded cycles, this has been re-worded in the January 2020 version.

2.0 Detail

2.1. Appendix 1 outlines the issues raised in 2018 and the outcome in July 2019.

2.2. The main changes to note include:

- Eligibility of overseas visitors (pg 2 – 3). Health surcharge will not apply and as this is a couples policy and the couple will be eligible if one of them is ordinarily resident.
- Changes to the definition of infertility for same sex and patients with psychosexual issues and disabilities to be clearer (pg 7). This is an enhancement/positive change to the policy.
- Care pathway updated (pg 10).
- Definition of cycles updated (pg 12).
- Smoking status updated to recommend referral to smoking cessation and adverse impact on fertility (pg 16).

- Updates to NHS funded and self-funded cycles (pg16); paragraphs merged.

1.3 The updated policy has now addressed all concerns and issues raised by Calderdale CCG's Quality Committee in October 2018.

1.4 We have not undertaken patient engagement as all the proposed changes are in line with NICE guidance or are positive changes to make the policy more clear to patients and the public.

1.5 A leaflet which communicates the main changes has been produced. This has been provided at Appendix 3.

1.6 The updated policy including the Equality Impact Assessment has been shared with the CCG's Quality Team.

3.0 Next Steps

3.2 Publish the updated policy and communication leaflet on the Calderdale CCG website.

3.3 Circulate to stakeholders including primary care, public health and secondary care.

4.0 Implications

4.1 Public / Patient / Other Engagement

We have not undertaken patient engagement as all the proposed changes are in line with NICE guidance or are positive changes to make the policy more clear to patients and the public.

4.2 Legal / CCG Constitutional Implications

In 2017, one CCG faced a legal challenge in relation to the equity of the policy and further inequities were identified in relation to emerging treatments. The policy has been amended to address this risk. The new policy has been reviewed legally and a new Equality Impact Assessment (EIA) has been written.

5.0 Recommendations

5.1 It is recommended the Governing Body:

- **APPROVES** the revised policy including the updates and revisions

6.0 Appendices

Appendix 1 - Issues raised in 2018 and the outcome in July 2019.

Appendix 2 - Access to infertility treatment. Commissioning Policy Document Yorkshire and Humber (February 2018 – January 2021)

Appendix 3 - Leaflet

Appendix One - Issues raised in 2018 and the outcome in July 2019

ISSUE October 2018	**OUTCOME July 2019**
1. Pg 5 Contents. Missing section: 6.5 Pre-referral requirement to Specialist Care	Updated but still incorrect. I would just correct this in the final version.
2. Pg 6 section 1.2: what is the evidence base being used to define 'most in need'.	Wording added: in keeping with current eligibility
3. Pg 6 section 2.4: does 80% still reflect the percentage of couples following the removal of the word heterosexual ie the number of couples will have increased so is 80% still correct.	Wording added: in the general population
4. Pg 8 green box: 'sensitive' disabilities should read 'sensory' disabilities	Sentence reworded and typo removed
5. Pg 10 section 5.2.1 3rd bullet pointed section: CW has suggested alternative wording as the first sentence does not read easily. Current wording is: *Offer those who would benefit from this, a referral to Lifestyle Services using local arrangements to make a referral.* Suggested wording is: *Offer those who would benefit from this, a referral to local well-being services*	Sentence reworded as suggested
6. Pg 12 section 5.6.4: 'an ovulatory' should read 'anovulatory'	Typo corrected
7. Pg 15 section 6.5.2: non-smoking status for both partners will be tested. Concern regarding the availability of carbon monoxide breath testing equipment. Clarity about the test needing to take place in both primary and secondary care	Section rewritten; removed instruction for primary care to undertake a carbon monoxide test.
8. Pg 15 section 6.9: confirmation of length of relationship by checking a utility bill or bank statement is not confirmation of a stable relationship. Doubt compliance and recording of this would happen.	Section rewritten; removed the instruction to confirm length of relationship via a utility bill or bank statement.

Item 7 Appendix 2

Access to Infertility Treatment –

Commissioning Policy Document

Yorkshire and Humber

Adopted by
Calderdale CCG

January 2020 – April 2023

Document Title:	Access to Infertility Treatment – Commissioning Policy Document Yorkshire and Humber
Author/Lead **Name:** **Job Title:**	 Michelle Thompson Assistant Director Women's and Children's Services
Version No:	V10
Latest Version Issued On	December 2019
Supersedes:	All previous Access to infertility treatment policies
Date of Next Review:	April 2023
Completion Equality Impact Statement **Name:** **Job Title:** **Date:**	 Philippa Doyle Hempsons Solicitors August 2018 (Update based on notes)
Target Audience:	Public
Dissemination:	CCG Weekly Bulletin, Internet & Intranet

APPROVAL RECORD		
	Committees / Groups / Individual	**Date**
Consultation:	Yorkshire and Humber Expert Fertility Panel	2 March 2017 31 January 2018 25 June 2018 25 January 2019
	Hempsons Solicitors	August 2018
Ratified by Committees:	Quality, Finance & Performance	

CHANGE RECORD			
Version	**Author**	**Nature of Change**	**Date placed on Intranet**
V11		Update as per local CCG; local services included	

Any locally held old paper copies must be destroyed. ***When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on www.calderdaleccg.nhs.uk***

Commissioning Policy Statement:

Commissioning

This document represents the commissioning policy of Calderdale CCG for the clinical pathway which provides access to specialist fertility services. This commissioning policy has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel. It is intended to provide a framework for the commissioning of services for those couples who are infertile and require infertility interventions.

The policy was developed jointly by Clinical Commissioning Groups in the Yorkshire and Humber area and provides a common view of the clinical pathway and criteria for commissioning services which have been adopted by Calderdale CCG.

Funding

The policy on funding of specialist fertility services for individual patients is a policy of Calderdale CCG and is not part of the shared policy set out in the rest of this document. The number of full IVF cycles currently funded by the Calderdale CCG for patients who meet the access criteria set out in the shared policy is one. This is unchanged from the previous funding policy in March 2016. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

Immigration Health Surcharge; Removal Of Assisted Conception Services

Amendments to the NHS (Charges to Overseas Visitors) Regulations 2015 were introduced into Parliament on 19 July 2017. As a result, from 21 August 2017, assisted conception services are no

longer included in the scope of services.

However, the October 2019 Guidance on Implementing Overseas Visitors Regulations says that: 'Where two people are seeking assisted conception services with NHS funding, and one of the two people is covered by health surcharge arrangements and the other is ordinarily resident in the UK and therefore not subject to charge, the services required by the health surcharge payer will be chargeable. Any services required by the ordinarily resident person will continue to be freely available, subject to the established local or national commissioning arrangements'.

Our eligibility criteria for access to assisted conception services relates to couples rather than individuals. Therefore in light of this guidance, to enable the ordinarily resident person to have freely available access to services, where at least one partner is eligible for these services, the couple will be considered as eligible for services.

Panel Members: (March 2017)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Chris Edward	Accountable Officer - Rotherham CCG
Dr Steve Maguiness	Medical Director - The Hull IVF Unit, Hull Women and Children's Hospital and honorary contract with HEY
Dr John Robinson	Scientific Director - IVF Unit, Hull and East Yorkshire Hospitals FT
Prof Adam Balen	Professor of Reproductive Medicine and Surgery - Leeds Teaching Hospitals NHS Trust
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Richard Maxted	Service Manager, Directorate of Obstetrics, Gynaecology and Neonatology - Sheffield Teaching Hospital NHS Trust
Dr Margaret Ainger	Clinical Director for Children, YP and Maternity - NHS Sheffield CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Dr Clare Freeman	Medical Advisor to IFR Panel - South Yorkshire and Bassetlaw CCGs

Panel Members (amendments January 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East

	Lincolnshire CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Karen Thirsk	Fertility Policy Manager – NHS England
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG.
Clare Freeman	Lead Medical Advisor – Sheffield CCG.

Panel Members (amendments June 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Dr Bryan Power	(GP) - NHS Leeds CCG
Adam Balen	(Consultant) - Leeds Fertility
Clare Freeman	Lead Medical Advisor – Sheffield CCG

Panel Members (amendments January 2019)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG

Martine Tune	Acting Chief Nurse – NHS Barnsley CCG
Liz Micklethwaite	Business Manager IFR - NHS Leeds CCG

Commissioner Final Proof Read Panel (Amendments November 2019)

Michelle Thompson	Assistant Director, Women's and Children's Services – NHS North East Lincolnshire CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Clare Freeman	Lead Medical Advisor – Sheffield CCG
Karen Leivers	Head of Strategy and Delivery, Planned Care - Doncaster CCG
Debbie Stovin	Commissioning Manager – Elective Care – Sheffield CCG

Conflicts of Interest

See appendix E

For Further Information about this policy.

Please contact Calderdale CCG.

Contents

1. Aim of Paper

1.1 This document represents the commissioning policy for specialist fertility services for adults registered with a Clinical Commissioning Group (CCG) in the Yorkshire and Humber region.

1.2 The policy aims to ensure that those most in need in keeping with current eligibility, are able to benefit from NHS funded treatment and are given equitable access to specialist fertility services across the Yorkshire and Humber Area, by identifying the clinical care pathway and relevant access criteria.

2. Background

2.1 On April 1st, 2013 Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy[1]. In February 2013 NICE published revised guidance[2] which was reviewed and updated in 2016.

2.2 CCGs across the Yorkshire and the Humber agreed to work collaboratively to update the existing policy in light of the new NICE guidance and changing commissioning landscape.

2.3 In this policy document infertility is defined as:

Definition of Infertility:

The inability to conceive through regular sexual intercourse for a period of 2 years in the absence of known reproductive pathology, or less than 2 years if there is specific reproductive pathology identified.

Where attempting to conceive by regular sexual intercourse is not possible (for example for people with a physical disability, people with psychosexual disorders or transgender and same sex couples) this will be considered as inability to conceive for the purposes of this policy.

2.4 Fertility problems are common in the UK and it is estimated that they affect 1 in 7 couples with 80% of couples in the general population conceiving within 1 year, if:

- The woman is aged under 40 years and
- They do not use contraception and have regular sexual intercourse (NICE 2013)

Of those who do not conceive in the first year about half will do so in the second year (cumulative pregnancy rate is 90%).

The remaining 10% of couples will be unable to conceive without medical intervention and are therefore considered infertile.

2.5 In 25% of infertility cases, the cause cannot be identified. However, it is thought that in the remaining couples about 30% of cases are due to the male partner being unable to produce

[1] Yorkshire and the Humber Commissioning Policy for Fertility Services, 2010.

[2] Fertility: Assessment and treatment for people with fertility problems 2012, NICE Clinical Guideline 156.

or ejaculate sufficient normal sperm, 30% are due to problems found with the female partner such as failure to ovulate or blockage to the passage of the eggs, and 10% are due to problems with both partners.

2.6 The most recent DH costing tool estimates that there are 98 attendances at a fertility clinic for every 10,000 head of population. In Yorkshire and the Humber, this could range between 4000 and 5000 attendances per year which would result in approximately 1450 couples likely to be assessed as eligible for IVF treatment.

2.7 Specialist fertility services include IUI, ICSI and IVF. They may also include the provision of donor sperm and donor eggs. The majority of treatment in the UK is statutorily regulated by the Human Fertility and Embryo Authority (HFEA)[3]. All specialist providers of fertility services must be licensed with the HFEA in order to be commissioned under this policy.

2.8 NICE Clinical Guidelines 156 (2013) covering infertility recommends that:

> Up to three full cycles of IVF will be offered to eligible couples where the woman is aged between 18 and 39 and 1 cycle for eligible couples where the woman is aged 40 - 42.

Calderdale CCG will fund *one c*ycle of IVF treatment. Where an individual feels that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an individual funding request to their local CCG.

2.9 In addition to commissioning effective healthcare, CCGs are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore CCGs will need to exercise discretion as to the number of cycles of IVF that they will fund up to the maximum recommended by NICE.

3. Clinical Effectiveness

It is considered to be clinically effective by NICE to offer up to 3 stimulated cycles of IVF treatment to couples where the woman is aged between 18 – 39 and 1 cycle where the woman is aged between 40 – 42 and who have an identified cause for their infertility or who have infertility of at least 2 years duration.

4. Cost Effectiveness

4.1 Evidence shows (NICE 2013) that as the woman gets older the chances of successful pregnancy following IVF treatment falls. In light of this, NICE has recommended that the most cost effective treatment is for women aged 18 – 42 who have known or unknown fertility problems.

4.2 As research within this field is fast moving, new interventions and new evidence needs to be considered on an on-going basis to inform commissioning decisions.

[3] https://www.hfea.gov.uk/

4.3 Risks

Fertility treatment is not without risks. A summary of potential risks is outlined below:

Risks

- There are risks of multiple pregnancies during fertility treatment, which is associated with a higher morbidity and mortality rate for mothers and babies.
- Women who undergo fertility treatment are at slightly higher risk of ectopic pregnancy.
- Ovarian hyper stimulation, which is a potentially fatal condition, is also a risk. The exact incidence of this has not been determined but the suggested number is between 0.2 – 1% of all assisted reproductive cycles.
- Current research shows no cause for concern about the health of children born as the result of assisted reproduction.
- A possible association between ovulation induction therapy and ovarian cancer in women who have undergone treatment is uncertain.
- Further research is needed to assess the long-term effects of ovulation induction agents.

5 Description of the Treatment

5.1 Principles of Care

5.1.1 Couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment.

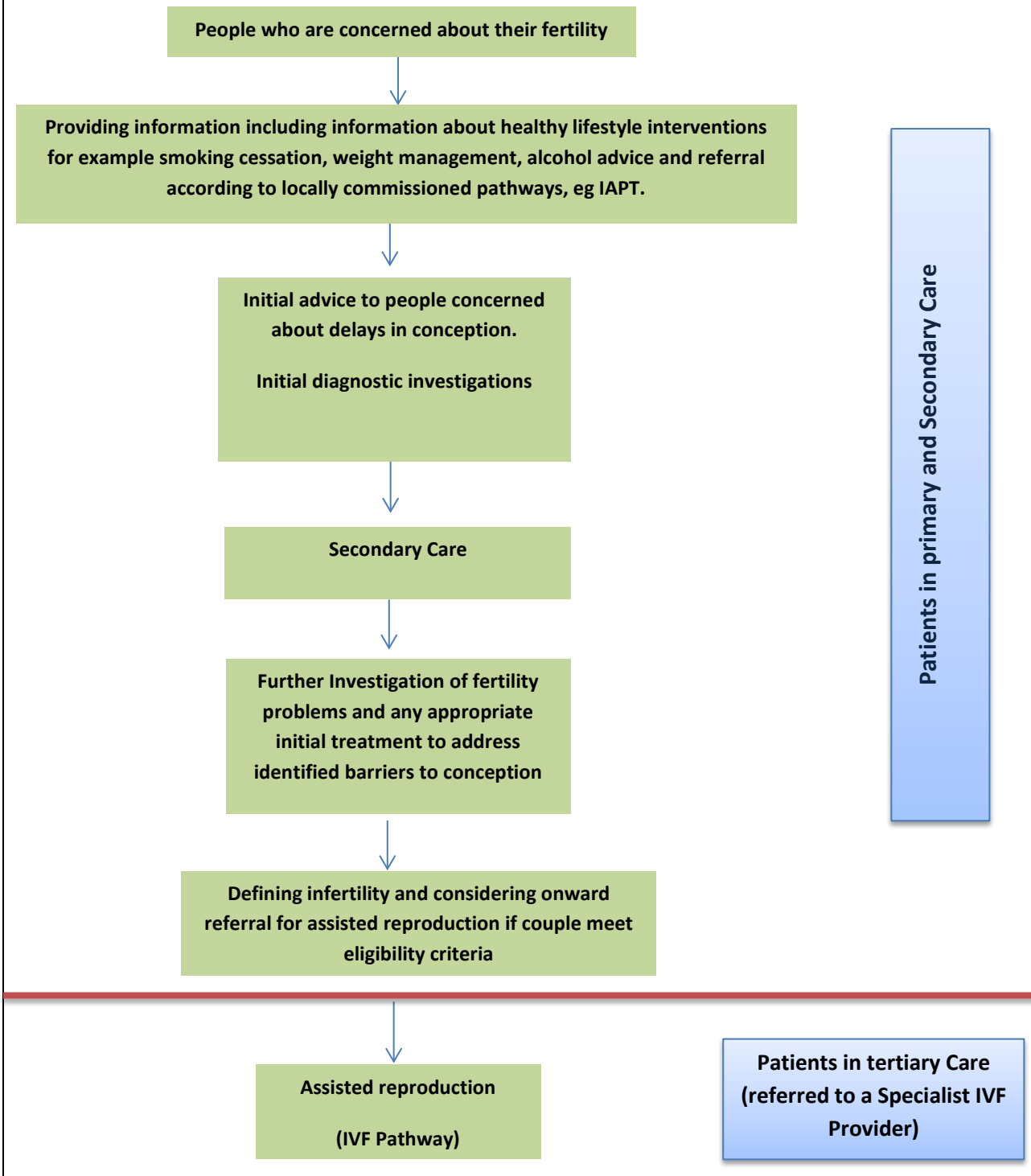
5.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Information should be provided in the following formats:

- Face to face discussions with couples
- Written information and advice
- Culturally sensitive
- Sensitive to those with additional needs e.g. physical or cognitive, or those for whom English is not their first language.

5.1.3 As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway, for example IAPT.

5.2 The Care Pathway for fertility investigation and referral (fig, 1)



The Care pathway for fertility investigation and referral will take account of NICE guidance.

5.2.1 Treatment for infertility problems may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF.

- Providers of specialist fertility services are expected to deliver appropriate interventions to support lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies. Recommendations covering screening, brief advice and onward referral are outlined in NICE Public Health Guidance (PH49) and, specifically in relation to fertility and pre-conception, smoking (PH 26, PH48), weight management (PH27, PH53), healthy eating and physical activity (PH11, NG7) and alcohol (PH24).

- Use any appointment or meeting as an opportunity to ask women and their partners about their general lifestyle including smoking, alcohol consumption, and physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle.

- Offer those who would benefit from this, a referral to local wellbeing services and/or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information such as the national 'One You' website or local websites.

- Record this in the hand-held record or accepted local equivalent.

The care pathway (fig 1) begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention.

If primary care interventions are not effective, initial assessment such as semen analysis will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed.

If secondary care interventions are not successful and the couple fulfils the eligibility criteria in section 6.0, they may then be referred through to specialist care for assessment for assisted conception techniques, such as IVF, DI, IUI, and ICSI.

5.2.2 IVF involves:

- Controlled ovarian stimulation
- Monitoring the development of the eggs in the ovary
- Ultrasound guided egg collection from the ovary
- Processing of sperm
- Production of a fertilized embryo from sperm and egg cells in the laboratory
- Culture of embryos to blastocyst (*if clinically appropriate*)
- Single embryo transfer (subject to multiple birth minimisation policy)
- Use of progesterone to make the uterus receptive to implantation
- Transfer of selected embryos and freezing of those suitable but not transferred

The panel will review annually, following the HFEA[4] annual review via their traffic light report, any other emerging technologies which may then need consideration for incorporation in this policy.

5.3 Definition of a Full Cycle

Full cycle is the term used to define a full IVF treatment; it should include one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s) (NICE 2013). Or

The definition of a single full treatment cycle is the replacement of a fresh embryo and subsequent sequential replacement of all frozen embryos derived from the cycle until pregnancy is successful or harvested embryos have been exhausted.

Adherence in this way to the NICE guidelines would encourage and not disadvantage patients agreeing to single embryo transfer.

5.4 Frozen Embryo

Embryos that are not used during the fresh transfer should be quality graded using the UK NEQAS embryo morphology scheme and may be frozen for subsequent use within the cycle.

All stored and viable embryos should be used before a new cycle commences. This includes embryos resulting from previously self-funded cycles.

5.5 Abandoned Cycles

An abandoned IVF/ICSI cycle is defined as the failure of egg retrieval, usually due to lack of response (where less than three mature follicles are present) or excessive response to gonadotrophins; failure of fertilisation and failure of cleavage of embryos. Beyond this stage, a cycle will be counted as complete whether or not a transfer is attempted. One further IVF/ICSI cycle only will be funded after an abandoned cycle. Further IVF/ICSI cycles will not be offered after any subsequent abandoned cycles.

5.6 IUI and DI

IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.

5.6.1 People with physical disabilities, psychosexual problems, or other specific conditions with infertility (as defined in section 2.3 Definition of Infertility):

Where a medical condition exists, such as physical disability up to 6 cycles of IUI may be funded, followed by further assisted conception if required. In some circumstances, IUI may be impractical and so is not a requirement for further fertility treatment.

[4] https://www.hfea.gov.uk/

5.6.2 IUI and DI in same-sex relationships:
Up to 6 cycles of IUI will be funded as a treatment option for people in same-sex relationships, followed by further assisted conception if required.

5.6.3 People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse:
IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance.

5.6.4 Gonadotrophin Therapy - for women with anovulatory infertility, ovulation induction with gonadotrophin therapy should be funded for up to 6 cycles, with or without IUI depending on the circumstances of the couple.

5.6.5 Donor Gametes including azoospermia:
Patients who require donor gametes will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria is still met. If it is anticipated that there will be difficulty finding a suitable donor exceptionality would need to be considered. At this point consideration may need to be given to sourcing from alternative providers via IFR.

Donor Sperm

Where clinically indicated up to six cycles of donor insemination will be offered. This is dependent on the availability of donor sperm which is currently limited in the UK.
The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG.

Donor Eggs

Patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment with donor eggs. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment.

5.7 Gametes and Embryo Storage

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG. Storage will be funded by the CCG for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.
Any embryos frozen prior to implementation of this policy will be funded by the CCG to remain frozen for a maximum period of 3 years from the date of policy adoption.
Any embryo storage funded privately prior to the implementation of this policy will remain privately funded.

5.8 HIV/HEP B/ HEP C

People undergoing IVF treatment should be offered testing for HIV, hepatitis B and hepatitis C (NICE 2013).

People found to test positive for one or more of HIV, hepatitis B, or hepatitis C should be offered specialist advice and counselling and appropriate clinical management (NICE 2013).

5.9 Surrogacy

Any costs associated with use of a surrogacy arrangement will not be covered by funding from CCGs. We will, however, fund provision of fertility treatment (IVF treatment and storage) to identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the couple meets the eligibility criteria for specialist fertility services set out in this policy.

5.10 Single Embryo Transfer

Please refer to 5.3 for the definition of a full cycle.

Multiple births are associated with greater risk to mothers and children and the HFEA[5] therefore recommends that steps are taken by providers to minimize them. This is currently achieved by only transferring a single embryo for couples who are at high risk.

We support the HFEA guidance on single embryo transfer and will be performance monitoring all specialist providers to ensure that HFEA targets are met. All providers are required to have a multiple births minimisation strategy. The target for multiple births should now be an upper limit of 10% of all pregnancies.

We commission ultrasound guided embryo transfer in line with NICE Fertility Guideline.

5.11 Counselling and Psychological Support

As infertility and infertility treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment.

5.12 Sperm washing and pre-implantation diagnosis

Sperm washing and pre-implantation genetic diagnosis are not treatments for infertility and fall outside the scope of this policy. Prior approval is required.

5.13 Service Providers

Providers of fertility treatment must be HFEA registered and comply with any service specification drawn up by Yorkshire and the Humber Clinical Commissioning Groups.

6.0 Eligibility Criteria for Treatment

6.1 Application of Eligibility Criteria

Eligibility criteria should apply at the point of referral to specialist care. Women aged between 40-42 will need further assessment within specialist care in order to ascertain whether or not they are eligible, see section 6.4.

[5] https://www.hfea.gov.uk/

6.2 Overarching Principles

6.2.1 All clinically appropriate individuals/couples are entitled to medical advice and investigation. Couples may be referred to a secondary care clinic for further investigation.

6.2.*2* Assisted conception is only funded for those couples who meet the eligibility criteria.

6.2.3. Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in heterosexual and same-sex couples.

6.3 Existing Children

Neither partner should have any living children (this includes adopted children but not fostered) from that or any previous relationship.

6.4 Female Age

Age as a criterion for access to fertility treatments is applied in line with the NICE Clinical Guideline on Fertility which is based on a comprehensive review of the relationship between age and the clinical effectiveness of fertility treatment.

The woman intending to become pregnant must be between the ages of 18 – 42 years. No new cycle should start after the woman's 43rd birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles.

Women aged 40–42 years who meet the eligibility criteria for infertility in Section 2.3, will receive 1 full cycle of IVF, with or without ICSI, provided the following criteria are fulfilled:

- they have never previously had IVF treatment and there is no evidence of low ovarian reserve (defined as FSH 9 IU/l or more (using Leeds assay); OR antral follicle count of 4 or less; OR AMH of 5 pmol/l or less
- there has been a discussion of the additional implications of IVF and pregnancy at this age
- where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, women aged between 40-42 should be referred directly to a specialist team for IVF treatment

6.5 Pre – Referral Requirement for Specialist Care

6.5.1 Female BMI

The female patient's BMI should be between 19 and 30 prior to referral to specialist services. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range.

6.5.2 Smoking Status

GP should discuss smoking with couples prior to referral to secondary care, support their efforts in stopping smoking by referring to a smoking cessation programme.

People should be informed that maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF treatment.

6.6 Reversal of Sterilisation

We will not fund IVF treatment for patients who have been sterilised or have unsuccessfully undergone reversal of sterilisation.

6.7 Previous Cycles

Previous cycles whether self-funded or NHS funded will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be offered by the NHS. This includes where either person has had a previous cycle with a previous partner.

6.8 Length of Relationship

The stability of the relationship is very important with regards to the welfare of children; as such couples must have been in a stable relationship for a minimum of 2 years and currently co-habiting to be entitled to treatment.

6.9 Welfare of the child

HFEA guidance concerning the welfare of the child should be followed.

Appendix, A

Abbreviations

Abbreviations used	
BMI	Body Mass Index
DI	Donor Insemination
GP	General Practitioner
HFEA	Human Fertilisation and Embryology Authority
IAPT	Improving Access to Psychological Therapies
ICSI	Intracytoplasmic sperm injection
IUI	Intra-uterine insemination
IVF	In vitro fertilisation
NICE	National Institute of Clinical Excellence
CCG	Clinical Commissioning Group

Appendix, B

Contents

Term	Definition	Further information
BMI	The healthy weight range is based on a measurement known as the Body Mass Index (BMI). This can be determined if you know your weight and your height. This is calculated as your weight in kilograms divided by the square of your height in metres. In England, people with a body mass index between 25 and 30 are categorised as overweight, and those with an index above 30 are categorised as obese.	BBC Healthy Living http://www.bbc.co.uk NHS Direct http://www.nhsdirect.nhs.uk
ICSI	**Intra Cytoplasmic Sperm Injection (ICSI)**: Where a single sperm is directly injected into the egg.	Glossary, HFEA http://www.hfea.gov.uk
IUI	**Intra Uterine Insemination (IUI)**: Insemination of sperm into the uterus of a woman.	As above
IVF	**In Vitro Fertilisation (IVF)**: Patient's eggs and her partner's sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the female patient.	As above
DI	**Donor Insemination (DI)**: The introduction of donor sperm into the vagina, the cervix or womb itself.	As above

Appendix D, Version Control

VERSION	DATE	AUTHOR	STATUS	COMMENT
V10	November 2019	M Thompson on behalf of Panel		Changes to: - Page 2 & 3 – Immigration Health Surcharge – sentences reworded - 6.5.2 – Smoking Status – sentences reworded - 6.7 – Previous Self-funded Cycles – titles changed to Previous Cycles - sentences reworded - 6.8 – Previous Self-Funded Cycles - sentence removed - 6.10 – Welfare of the Child - sentence reworded

V9	January 2019	M Thompson on behalf of Panel	Draft	Changes to: - Funding - Immigration health surcharge – sentence added - 1.2 - sentence reworded - 2.3 – change of order in sentence in brackets - 5.2 – sentence included after pathway - 5.2.1 – third bullet point, wording changed - 5.2.2 – first two bullet points replaced with Controlled Ovarian Stimulation - 5.4 – heading changed to Frozen Embryo - 5.6.1 – sentence reworded - 5.6.3 – link to mild male factor infertility removed - 5.6.3 – wording added - 5.6.4 – spelling corrected - 5.6.5 – new paragraph inserted - 5.6.5 - Donor Sperm - sentence reworded - 5.7 – sentence reworded - 6.2.1 and 6.2.2 - swopped around and reworded - 6.5.2 – title changed - 6.5.2 – sentence reworded - 6.9 – sentence reworded

v8	June 2018	M. Thompson on behalf of Panel	Draft	Changes to:- - 2.3 Definition of Infertility - 5.2.2. – IVF involves – additional bullets added - 5.3 – Definition of cycles – removed sentence in brackets - 5.6.4 - Gonadotrophin Therapy added - 5.6.5 – renumbered – added “all couples” where this is a clinical requirement (to replace the reference to male azoospermia) added limited to UK Added additional sentence - 6.5 – title updated to – Pre-referral requirement to specialist care - 6.5.2 – non-smokers section added. - 6.9 – Updated to include the stability of the relationship

v7	Jan 2018	M. Thompson on behalf of Panel	Draft	- Changes to 5.2 pathway - Changes to funding – adding refugees and asylum seekers - Removal of summary of CCGs - 2.3 – clarification of definition of infertility - 6.7 updated to NHS Funded full cycles - 6.10 – added section - Change tertiary to specialist throughout the policy.

Review 2017	22.2.17	F Day on behalf of panel	Final draft	- changes to the definition of infertility for same sex and patients with psychosexual issues and disabilities to be more clear - the addition of public health requirements for providers in line with NICE guidance - clarification of the definition of an abandoned cycle - sections on intrauterine insemination and also egg donation updated in line with NICE guidance - Addition of People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse in line with NICE guidance - wording changed in various sections based on patient feedback to be more clear, not materially changed in content - embryo transfer wording updated to reflect NICE guidance - Addition of definition of low ovarian reserve (previously undefined)

Appendix E Relevant Conflicts of Interest Declared:

Dr Steve Maguiness:

IVF in Hull is provided by a private company (ERFS Co Ltd), of which I am a Director and employee.

Prof Adam Balen:

NHS Consultant in Reproductive Medicine and Clinical lead for the Leeds Centre for Reproductive Medicine, which performs all fertility treatments funded by the NHS. Partner in Genesis LLP, the private arm of the Leeds Centre for Reproductive Medicine, which performs self-funded fertility treatments using identical protocols to the NHS. Chair, British Fertility Society. Chair, NHS England IVF Pricing Development Expert Advisory Group. Chair World Health Organisation Expert Working Group on Global Infertility Guidelines: Management of PCOS. Chair, British Fertility Society. Consultant for ad hoc advisory boards for Ferring Pharmaceuticals, Astra Zeneca, Merck Serono, Gideon Richter, Uteron Pharma. Research funding received in the past. Pharmasure / IBSA- Key note lecture at ESHRE 2016 & hospitality to attend meetings. OvaScience- Member of international ethics committee. Clear Blue National medical advisory board. IVI, UK- Chair, Clinical Board

Virginia Beckett FRCO:

I have a private practice where I see fertility patients.

I have received sponsorship from Pharmasure, Ferring & Serono to attend conferences.

NHS
Calderdale
Clinical Commissioning Group

What Next?

Hopefully this leaflet has given you enough information about the changes to the joint policy. If you choose, you can read the full version of the new policy on the Publications page of the Calderdale CCG website at www.calderdaleccg.nhs.uk

Or these documents can be sent to you if you do not have access to the internet. You can request this by:

Writing to us: NHS Calderdale Clinical Commissioning Group, 5th floor, F Mill, Dean Clough, Halifax, HX3 5AX

Sending an email to: calccg.contact@nhs.net

By telephone: 01422 307400

Changes to the Access to Infertility Treatment Policy

Changes to our joint Access to Infertility Treatment policy

Clinical Commissioning Groups (CCGs) in the Yorkshire and Humber area are making changes to our shared approach to supporting people who are experiencing infertility to access specialist interventions to help them conceive.

Background

A joint commissioning policy was developed in partnership with the Yorkshire and Humber Expert Fertility Panel (a panel predominantly made up of clinicians and fertility experts) and adopted in 2013. Recently CCGs across the Yorkshire and the Humber agreed to work together again to update this policy in light of new NICE guidance and other policy changes.

What the policy is

The shared policy sets out who is eligible for specialist fertility services.

What the policy is not

This shared policy is not about how many cycles of infertility treatment are paid for by individual CCGs. This is covered by each CCG's own local policy around funding of specialist infertility treatment.

What this document is

This document highlights and explains the changes in the new policy.

The majority of changes are simple wording to make the policy easier to read and reflect changes to clinical terminology as infertility treatment develops.

There are two changes that affect eligibility for NHS funded specialist fertility treatment. These are positive changes which will make access to specialist fertility treatment more equitable.

So what are the changes?

Eligibility of Overseas Visitors

The NHS (Charges to Overseas Visitors) Regulations 2015 and further 2019 Guidance on Implementing Overseas Visitors Regulations will not apply, providing one partner in the couple is ordinarily resident in the UK

This policy relates to couples not individuals. This means a couple is now eligible for NHS funded assisted conception providing one of them resides in the UK. This includes initial fertility investigations.

Definition of Infertility

The definition of infertility has been explicitly amended to include transgender and same sex couples, recognising that it is not possible to conceive by regular sexual intercourse. This broadens access to NHS funded specialist infertility treatment.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**West Yorkshire and Harrogate Memorandum of Understanding for Collaborative Commissioning**	**Agenda Item No.**	8
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite (Chief Finance Officer / Deputy Chief Officer)	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer / Deputy Chief Officer)

Executive Summary							
Please include a brief summary of the purpose of the report	This report asks the Governing Body endorses the revised Memorandum of Understanding for Collaborative Commissioning between CCGs ('the MoU') and workplan to the CCG Membership for approval. The main changes reflect: ▪ Changes in the configuration of the CCGs in West Yorkshire and Harrogate and in the membership of the Joint Committee and its voting arrangements; ▪ The proposal that North Yorkshire CCG becomes an associate member of the Joint Committee, with no voting rights; ▪ Proposals that new commissioning decisions – both service and non-service specific - are delegated to the Joint Committee; and ▪ The Partnership's changing priorities and agreed ways of working, as set out in the draft Five Year Plan and Memorandum of Understanding.						
Previous consideration	**Name of meeting**		**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: 1. **ENDORSES** the revised MoU and Joint Committee work plan to the CCG Membership for approval. 2. Subject to the support of the CCG Membership, **AUTHORISES** the Chief Finance Officer/Deputy Chief Officer to sign the MoU.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications	
Quality & Safety implications	Quality and Safety implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.
Engagement & Equality implications	Public and patient engagement implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.
Resources / Finance implications	Resource and finance implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.

Has a Data Protection Impact Assessment (DPIA) been completed?		Yes		No		N/A	x
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**			Robust, transparent voting arrangements are needed to minimise the risk of Joint Committee decisions being challenged.		
Legal / CCG Constitutional Implications	Amendments to the Joint Committee's work plan and to the MoU must be approved by the CCG membership until such time as the CCG revised Constitution (as endorsed by the Governing Body in January 2020) is approved by NHS England.	**Conflicts of Interest**			Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.		

1.0 Introduction

1.1 This report has been provided to West Yorkshire CCG members of the Joint Committee by the WY&H Health and Care Partnership Governance Lead, Stephen Gregg, asking that they agree the revised Memorandum of Understanding for Collaborative Commissioning between CCGs ('the MoU'). The main changes reflect:

- Changes in the configuration of the CCGs in West Yorkshire and Harrogate (WY&H) and in the membership of the Joint Committee and its voting arrangements;
- The proposal that North Yorkshire CCG becomes an associate member of the Joint Committee, with no voting rights;
- Proposals that new commissioning decisions – both service and non-service specific - are delegated to the Joint Committee; and
- The Partnership's changing priorities and agreed ways of working, as set out in the draft Five Year Plan and Memorandum of Understanding.

2.0 Detail

2.1 Background

2.1.1 The WY&H CCGs established the Joint Committee to take commissioning decisions to support the aims and objectives of the WY&H Sustainability and Transformation Plan (STP). To enable this, the CCGs delegated authority to the Joint Committee to take decisions on their behalf. The original MOU set out the framework for collaborative working and was agreed by the CCGs in May 2017.

2.1.2 In June 2018, the CCGs agreed amendments which included a refreshed work plan and changes to the voting arrangements following the creation of the new Leeds CCG. In March 2019, Accountable Officers extended the MoU to 31 March 2020.

2.1.3 The current MoU expires on 31st March 2020. Changes in the WY&H commissioning landscape mean that substantive changes in the MoU are required. Accountable Officers have agreed to extend the current MoU until 30 June 2020 to allow sufficient time for the CCGs to consider the revised MoU, which is attached at **Appendix 1**. All material changes are highlighted in track changes.

2.2 Main changes to the MoU

2.2.1 Context

2.2.2 The MoU commits the Joint Committee to work with partners across WY&H to deliver shared objectives. The context within which the Joint Committee operates has changed since the MoU was agreed in 2017. Partnership working across WY&H has been formalised in the Partnership MoU and the WY&H Sustainability and Transformation Plan (STP) has been succeeded by the Partnership's Five Year Plan. The MoU has been revised to reflect these changes.

2.2.3 **Parties to the MoU and membership of the Joint Committee**

2.2.4 Clause 13.2 of the MoU allows that statutory successor bodies of one or more CCGs, including merged bodies, shall become parties to the MoU without the need for the formal agreement of the remaining parties. No formal agreement is therefore needed for the merged Bradford district and Craven CCG to become a party to the MoU and a member of the Joint Committee.

2.2.5 Harrogate CCG will merge to become part of a new North Yorkshire CCG in April 2020. NHSE/I requires the new CCG to sit within one ICS/STP system for the purposes of financial planning, operational and strategic planning and reporting. This will be the Humber Coast and Vale Partnership. This has implications for the relationship of Harrogate as a place within the WY&H system and means that the MoU and the membership and voting arrangements for the Joint Committee of CCGs need to be reviewed.

2.2.6 Clinical relationships, services and patient flows are deeply embedded between Harrogate, Leeds and other parts of West Yorkshire. It is important that these are maintained. It is therefore proposed that North Yorkshire CCG is not a formal party to the MoU, bound by its obligations, but becomes an Associate Member of the Joint Committee of CCGs. It would not delegate decisions to the Joint Committee and would not contribute to the costs of the collaborative. The CCG would agree to the objectives and principles set out in the MoU, be invited to all Joint Committee meetings and be able to participate in the discussion of all matters relevant to Harrogate. But as an Associate Member, it would not be able to vote on any matter.

2.2.7 **Voting arrangements**

2.2.8 At its meeting on 5 November, the Joint Committee recommended that Committee voting arrangements should revert to the original position of one vote per CCG. The Committee also noted that this was a transitional arrangement, with the long term objective being one vote per place.

2.2.9 **Delegation to the Joint Committee**

2.2.10 We have already made significant progress in commissioning strategically across WY&H. We have shown that 'Doing things once' across WY&H makes the best use of scarce resources to improve outcomes, whilst maintaining our strong connection to our places and local communities.

2.2.11 The CCG Accountable Officers have been exploring how we can further develop our approach to commissioning and build on our successes to move further and faster. The Accountable Officers presented the headline messages from the work to the Joint Committee development sessions on 3rd December 2019 and 4 February 2020.

2.2.12 Schedule 2 of the MoU sets out the **'non-service specific matters'** delegated to the Joint Committee. It now includes proposals for the Committee to have delegated responsibility for developing the arrangements for commissioning at scale across WY&H.

2.2.13 The work plan (Schedule 4 of the MoU) sets out the **service-specific** commissioning decisions that the CCGs have delegated to the Joint Committee. The Joint Committee has made significant progress in delivering its existing work plan. Key achievements include:

- agreeing the configuration of hyper acute stroke services

- agreeing the commissioning approach to Integrated Urgent Care services
- agreeing WY&H clinical thresholds, commissioning policies and pathways
- recommending adoption of the Healthy Hearts project

2.2.14 Following consultation with CCG Accountable Officers and programme Senior Responsible Officers (SROs) the work plan has been reviewed to ensure that it reflects the progress made to date and the Partnership's changing priorities and direction of travel. The draft refreshed work plan is attached as an Appendix to Schedule 4 of the MoU.

2.2.15 Schedule 4 of the MoU also outlines the process by which the work plan will be reviewed and agreed by the CCGs. This process includes CCGs testing whether proposals for any ***new*** service matters meet agreed 'Gateway conditions'. The Joint Committee has recommended that the gateway conditions comprise the '3 tests' that we use to determine whether working at WY&H level will add value:

a. **Commissioning at scale** (e.g. cancer services, acute stroke reconfiguration, Integrated Urgent Care procurement)
b. **Tackling wicked issues** (e.g. standardising commissioning policy, evidence based interventions, ending the postcode lottery)
c. **Learning from each other** (e.g. atrial fibrillation, Healthy Hearts, Quality and equality impact assessment)

2.2.16 It is proposed that the following ***new*** matters are added to the work plan:

- **Cancer** - amendments to better reflect the Programme's changing priorities and ways of working, including specific commissioning policies impacting on cancer care.
- **Mental Health (now Mental Health, learning disability and autism) –** the addition of commissioning decisions relating to Assessment and Treatment Units.
- **Maternity** – agreeing the approach to commissioning maternity services.
- **Urgent and emergency care** – the WY CCGs have already agreed to take a range of decisions collaboratively through the Yorkshire and Humber-level MoU for urgent and emergency care services. These are set out in the work plan and it is proposed that the Joint Committee is the mechanism by which these decisions are taken. The work plan also includes a WY-specific decision on GP out of hours services.

2.2.17 For all of these proposed ***new*** service matters, an assessment against the 3 tests is attached at **Appendix 2** for consideration by CCGs.

2.2.18 In addition to these new matters, amendments to the **Elective care and standardisation of commissioning policies (now Improving planned care)** reflect changes in the Programme's priorities and ways of working.

2.2.19 **Approving the MoU and workplan**

2.2.20 Any substantive changes to the MoU and the work plan must be agreed by each WY CCG, which must also ensure that all matters in the Joint Committee work plan are properly and lawfully delegated.

2.2.21 Under Calderdale CCG current Constitution, changes to the work plan needed to be approved by the CCG's membership.

2.2.22 **Reporting arrangements**

2.2.23 Decisions of the Joint Committee will continue to be reported to the CCGs by means of a summary of key decisions, minutes of the meeting and an Annual report.

3.0 Next Steps

3.1.1 Should the WY CCGs approve the proposed changes to the MoU and the workplan, the revised MoU will be presented to the Accountable Officer of each CCG for signature.

3.1.2 As the current MoU expires on 31st March, Accountable Officers have agreed to extend it until 30 June to allow time for the revised MoU to be formally considered by all CCGs. The current MoU will cease to apply as soon as the revised MoU is approved by all WY CCGs.

4.0 Recommendations

4.1 It is recommended that the Governing Body:

1. **ENDORSES** the revised MoU and Joint Committee work plan to the CCG Membership for approval;
2. Subject to the support of the CCG Membership, **AUTHORISES** the Chief Finance Officer/Deputy Chief Officer to sign the MoU.

5.0 Appendices

Appendix 1 - MOU (Tracked Changes) including workplan
Appendix 2 - Gateway Tests

APPENDIX 1

Dated – 1st April 2020

MEMORANDUM OF UNDERSTANDING

FOR

COLLABORATIVE COMMISSIONING

BETWEEN

CLINICAL COMMISSIONING GROUPS

ACROSS

WEST YORKSHIRE AND HARROGATE

VERSION 1.2

Version	Variations and amendments	Date
1.0	Original version	2 May 2017
1.1	Variations to reflect changes to the Committee voting arrangements and Work Plan, as agreed by the membership of each CCG and set out in Schedule 8. Administrative amendments to reflect the merger of the 3 Leeds CCGs, update membership details and correct drafting and typographical errors.	25 June 2018
1.2	Variations to reflect: Changes in the configuration of the CCGs in West Yorkshire and Harrogate, the membership of the Joint Committee and its voting arrangements. The establishment of the status of Associate Member of the Joint Committee of CCGs. New service and non-service specific matters delegated to the Joint Committee. The priorities set out in the West Yorkshire and Harrogate Five Year plan.	1 April 2020

CONTENTS

THIS AGREEMENT is dated the xx day of xxxx 2020

BETWEEN

(1) **NHS Bradford district and Craven Clinical Commissioning Group** whose principal office is at Scorex House (West), 1 Bolton Road, Bradford, BD1 4AS ("**Bradford district and Craven CCG**");

(2) **NHS Calderdale Clinical Commissioning Gr**oup whose principal office is at 5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX ("**Calderdale CCG**");

(3) **NHS Greater Huddersfield Clinical Commissioning Group** whose principal office is at Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ ("**Greater Huddersfield CCG**");

(4) **NHS Leeds Clinical Commissioning Group** whose principal office is at Suites 2-4, Wira House, Wira Business Park, Leeds, West Yorkshire, LS16 6EB ("**Leeds CCG**");

(5) **NHS North Kirklees Clinical Commissioning Group** whose principal office is at 4th Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ ("**North Kirklees CCG**"); and

(6) **NHS Wakefield Clinical Commissioning Group** whose principal office is at White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT ("**Wakefield CCG**"),

each a "**Party**" and together the "**Parties**". ~~,~~

ASSOCIATE MEMBERS

NHS North Yorkshire Clinical Commissioning Group ("**North Yorkshire CCG**") is **not** a **"Party",** but is an Associate Member of the West Yorkshire and Harrogate Joint Committee of CCGs. It is signatory of this document to signify its commitment to the objectives of the collaborative and its agreement to the principles, values and behaviours set out in the West Yorkshire and Harrogate Partnership Memorandum of Understanding.

BACKGROUND

(A) The Parties wish to enter into an arrangement to collaboratively commission the delivery of healthcare services across the geographic area covered by the Parties. Under section 14Z3(2A) of the NHS Act 2006, the Parties may establish a joint committee of the Parties to exercise the Parties' commissioning functions jointly.

(B) Under 'Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21[1] published in December 2015, all health and care systems nationally ~~must~~ produced a Sustainability and Transformation Plan (STP), setting out how they would ~~will~~ accelerate ~~its~~ implementation of the Five Year Forward View up to 2021.

(C) This was followed in 2019 by the NHS Long Term Plan. Health and care systems were required to produce a Five Year Plan, setting out how they would implement the Long Term Plan. This Agreement sets out a framework for collaborative decision-making by the Parties in accordance with section 14Z3 of the NHS Act 2006 through a joint committee of the Parties. It ~~and~~ will play a crucial role in underpinning the Five Year Plan of the ~~Sustainability and Transformation Plans across the~~ West Yorkshire and Harrogate Health and Care Partnership ~~geography~~.

(D) From 1st April 2020, Harrogate and Rural District CCG will merge with Hambleton, Richmondshire and Whitby CCG and Scarborough and Ryedale CCG to form North Yorkshire CCG. North Yorkshire CCG are not Party to this agreement, but have the status of Associate Member of the Joint Committee of CCGs.

IT IS AGREED:

1. **DEFINITIONS AND INTERPRETATION**

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

"Agreement"	this agreement between the Parties comprising these terms and conditions, together with the Schedules;
"Annual Contribution"	the annual financial contribution of each Party (as set out in Schedule 6) to the Programme Management Budget and such other costs of the Collaborative as the Joint Committee may agree;
"CCG Decisions"	has the meaning set out in Clause 6.1.1;
"Claim"	any legal proceedings or claim including but not limited to: (a) pre-action correspondence and claims for judicial review and any enforcement action brought by the Information Commissioner; and (b) any referral of a dispute to the Secretary of State for Health in accordance with section 9(6) of the National Health Service Act 2006;
"Clinical Chair"	the GP chair of a Party;
"Collaborative"	the collaborative commissioning arrangements set out in this Agreement;
"Commencement Date"	1st April 2020;
"Commissioning Contract"	any agreement with a Provider for any Services listed in the Workplan;
"Commissioning Contract Variation Report"	has the meaning set out in Clause 10.8;
"Data Protection Legislation"	the Data Protection Act 1998, the Data Protection Directive (95/46/EC), the General Data Protection Regulation (Regulations (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016) once in application, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Electronic Communications Data Protection Directive (2002/58/EC), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Defaulting Party"	a Party that commits a persistent or material breach of this

	Agreement;
"Deputy"	has the meaning in paragraph 2.12 of Schedule 3;
"First MoU"	the memorandum of understanding entered into by the Parties dated 14 June 2016 in respect of collaborative commissioning across West Yorkshire and Harrogate;
"Exiting Party"	has the meaning in Clause 15.1;
"Expiry Date"	31 March 2021~~9~~;
"FOIA"	the Freedom of Information Act 2000, as amended from time to time;
"Five Year Plan"	the Five Year Plan of the West Yorkshire and Harrogate Health and Care Partnership
"Functions"	the commissioning functions of each of the Parties in arranging for the provision of the Services, and "commissioning functions" has the meaning set out in section 14Z3(7) of the NHS Act 2006;
"Guidance"	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Parties and/or a Provider have a duty to have regard (and whether specifically mentioned in a relevant Commissioning Contract or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Parties and/or any relevant Regulatory or Supervisory Body;
"Holding"	in relation to each of the Parties, the percentage by value attributable to it of the annual contract value of the relevant Commissioning Contract, calculated at the start of the relevant financial year;
"Host Party"	the Party which hosts the Programme Management Office from time to time, being NHS Wakefield CCG as at the Commencement Date;
"Information Sharing Agreement"	the information sharing agreement to be entered into between the Parties on or about the date of this Agreement;
"Initial Term"	the period beginning on the Commencement Date and ending on the Expiry Date;
"Joint Committee"	the joint committee established by the Parties for the purpose of the Collaborative;
"Joint Committee Decisions"	has the meaning set out in Clause 6.1.2;
"Joint Committee Member"	means the nominated representative of a Party who is a member of the Joint Committee, in accordance with the terms of reference set out in Schedule 3;

"Joint Committee Associate Member"	means a CCG which attends the Joint Committee of CCGs but –does not have voting rights or the same responsibilities as the Parties to this agreement.
"Law"	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; (d) Guidance; (e) National Standards; and (f) any applicable code, in each case in force in England and Wales;
"Lead Commissioner/Contractor"	in relation to a particular service, the Party listed as the lead commissioner/contractor in Schedule 4 and/or the Workplan;
"Lead Commissioner/Contractor Decisions"	has the meaning set out in Clause 6.1.3;
"National Standards"	those standards applicable to the Provider under the Law and/or Guidance as amended from time to time;
"Partnership"	the West Yorkshire and Harrogate Health and Care Partnership
"Personal Data"	has the meaning given to it in the Data Protection Legislation;
"Programme Management Budget"	the budget for the Programme Management Costs in each financial year, to be agreed by the Joint Committee in accordance with Clause 8.3.4;
"Programme Management Office"	the programme management office providing Programme Management Support to the Collaborative and the Joint Committee;
"Programme Management Support"	the programme management support provided to the Collaborative and the Joint Committee by the Programme Management Office as further detailed in Schedule 5;
"Provider"	a provider under any Commissioning Contract as may be set out in the Workplan;
"Regulatory or Supervisory Body"	any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party must comply or to which it must or should have regard, including:

	(a) Care Quality Commission; ~~(b)~~ NHS England/Improvement ~~(the umbrella name for Monitor and the NHS Trust Development Authority);~~ ~~(c)~~(b) ~~NHS England;~~ ~~(d)~~(c) the Department of Health; ~~(e)~~(d) NICE; and ~~(f)~~(e) HealthWatch England;
"Services"	the services described in the Workplan;
"Service Users"	any individual for whose benefit the Services are provided;
~~**"STP"**~~	~~the Sustainability and Transformation Plan for West Yorkshire;~~
"Terminating Party"	a Party exercising its rights to terminate this Agreement in accordance with Clauses 14.4 or 14.5;
"Variation"	an addition, deletion or amendment in the Clauses of or Schedules or Appendices to this Agreement, agreed to be made by the Parties in accordance with Clause 10 (Variations); and
"Variation Report"	has the meaning in Clause 10.3;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England and Wales;
"Workplan"	has the meaning set out in paragraph 2.1 of Schedule 4.

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

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

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

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

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

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

1.8 If there is any conflict between the terms of this Agreement and the terms of a Commissioning Contract in respect of a particular Service, the terms of the Commissioning Contract will prevail.

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

2. DURATION OF THE AGREEMENT

2.1 This Agreement comes into effect on the Commencement Date and shall remain in force until the Expiry Date, subject to earlier termination in accordance with Clause 14 (Termination) and any extension agreed in accordance with Clause 2.2. The Parties agree that the First MoU is hereby terminated and this Agreement shall supersede it in accordance with Clause 24.

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

3. PRINCIPLES OF COLLABORATION

3.1 In performing their respective obligations under this Agreement, the Parties will adopt the principles, values and behaviours set out in the West Yorkshire and Harrogate Partnership Memorandum of Understanding. In particular the parties must:

3.1.1 adhere to the principles and objectives set out in Schedule 7;

3.1.2 work proactively with Service Users and the public, actively seeking their engagement at all stages of the commissioning cycle;

3.1.3 at all times act in good faith towards each other;

3.1.4 collaborate and co-operate to work towards ensuring that the commissioning ambitions and intentions of each of the Parties are met;

3.1.5 be ambitious for the populations the Parties serve and the staff the Parties employ;

3.1.6 undertake shared analysis of problems and issues as the basis of taking action;

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

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

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

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

3.1.11 adopt a positive outlook and behave in a positive, proactive manner;

3.1.12 act in an inclusive manner with regards to collaboration;

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

3.1.14 work effectively with internal and external stakeholders;

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

3.1.16 focus on quality;

3.1.17 seek best value for money, productivity and effectiveness;

3.1.18 develop towards a level of commissioning that is equal to best international practice; and

3.1.19 promote innovation.

3.2 Associate Members of the Joint Committee agree to adopt the principles of collaboration set out in Paragraph 3.1 and to seek the objectives set out in Paragraph 4.1 and at Schedule 7. They have no formal obligations in relation to this Agreement, in particular those set out at Section 5 – Roles and Responsibilities, Section 6 - Governance and Monitoring and Section 8 - Collaborative Costs and Resources.

4. OBJECTIVES OF COLLABORATION

4.1 The Parties agree that the main objective of the Collaborative is to contribute to the development and implementation of the Five Year Plan of the West Yorkshire and Harrogate Health and Care Partnership, set out in Schedule 7. It will do this by ensuring that the work of the Collaborative aligns with place-based commissioning and the Partnership arrangements set out in the West Yorkshire and Harrogate Partnership MoU. .

4.2 The Parties agree to seek to achieve the main objective of the Collaboration through:

4.2.1 planning for the provision of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Parties' respective commissioning intentions and ambitions and all relevant Law and Guidance applicable to the Parties;

4.2.2 agreeing the extent of the Services, and procuring the Commissioning Contracts (where relevant);

4.2.3 where relevant, managing and maintaining the Commissioning Contracts, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as

to obtain best performance, quality and value from the Services; and

4.2.4 where relevant, managing variations to the Commissioning Contracts in accordance with national policy, the needs of Service Users and clinical developments.

5. ROLES AND RESPONSIBILITIES

5.1 The Parties agree that where a Deputy assumes the role of its nominated Joint Committee Member for a meeting, all references in this Agreement to a Joint Committee Member that are relevant to the meeting will be read as referring to the Deputy.

5.2 Each Party must:

5.2.1 ensure its Joint Committee Members attend every meeting of the Joint Committee;

5.2.2 ensure its Joint Committee Members have considered all documentation and are prepared to discuss matters at meetings of the Joint Committee;

5.2.3 make all reasonable efforts to inform the Chair in advance if its Joint Committee Member or Deputy is unable to attend meetings of the Joint Committee;

5.2.4 ensure it engages with all other Parties in matters related to the Collaborative;

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

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

6. GOVERNANCE AND MONITORING ARRANGEMENTS

6.1 The Parties agree that, for matters relating to the Services, there are three different levels of decision-making:

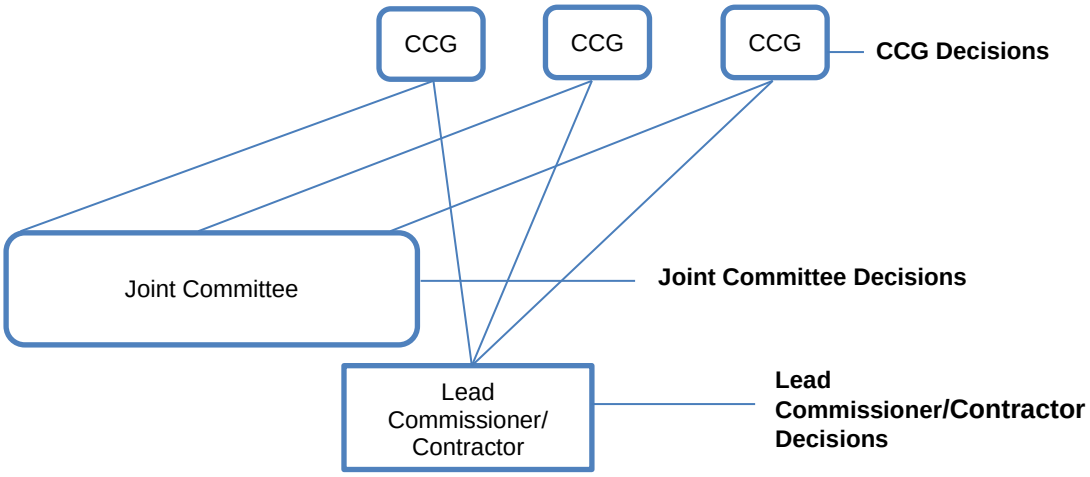
6.1.1 those decisions reserved to each Party ("**CCG Decisions**");

6.1.2 those decisions which are delegated by each Party to the Joint Committee ("**Joint Committee Decisions**"); and

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

6.2 Where, in relation to a particular Service, a Lead Commissioner/Contractor is not appointed, there will be no Lead Commissioner/Contractor Decisions.

~~6.2~~6.3 The following diagram illustrates the levels of decision-making:



~~6.3~~6.4 The Parties agree that matters that are not related to the Services ("**Non-Service Specific Matters**") shall be dealt with in accordance with Clause 6.10.3.

CCG Decisions

~~6.4~~6.5 Each Party must ensure that the matters set out as CCG Decisions in Schedule 4 and/or the Workplan are reserved to each Party (or governing body or committee of each Party as appropriate).

~~6.5~~6.6 The Parties agree that neither a Lead Commissioner/Contractor nor the Joint Committee has delegated authority to make CCG Decisions.

~~6.6~~6.7 Each Party shall put in place mechanisms to ensure CCG Decisions are notified to:

~~6.6.1~~6.7.1 the Lead Commissioner/Contractor (if relevant); or

~~6.6.2~~6.7.2 the relevant Provider,

for action to be taken under the relevant Commissioning Contract, if appropriate.

6.8 Each Party shall report to the Joint Committee through its Joint Committee Member any CCG Decisions that affect the Collaborative.

6.9 Clauses 6.5 – 6.8 do not apply to Associate Members of the Joint Committee. For the avoidance of doubt, this means that Associate Members are not required to take the CCG Decisions in Schedule 4 and/or the Workplan.

Joint Committee Decisions

~~6.7~~6.10 Each Party must:

~~6.7.1~~6.10.1 appoint two representatives to represent it as Joint Committee Members;

~~6.7.2~~6.10.2 provide the names and contact details of its nominated Joint Committee Members and Deputy in Schedule 1;

~~6.7.3~~6.10.3 ensure that the matters set out as:

(a) Joint Committee Decisions in Schedule 4 and/or the Workplan; and

(b) the Non-Service Specific Matters set out in Schedule 2,

are delegated effectively and lawfully to the Joint Committee such that the Joint Committee has the appropriate authority to bind that Party in relation to Joint Committee Decisions and Non-Service Specific Matters;

~~6.7.4~~6.10.4 ensure that the relevant Joint Committee Members are sufficiently appraised of the scope of the delegation by the relevant Party to the Joint Committee in relation to Joint Committee Decisions relating to the relevant Service and the Non-Service Specific Matters; and

~~6.7.5~~6.10.5 ensure the relevant Joint Committee Members are able to give and receive notices and other communications that relate to the relevant Service.

~~6.8~~6.11 Where a Party sends a Deputy to meetings of the Joint Committee in place of a Joint Committee Member in accordance with paragraph 2.12 of Schedule 3, the Parties shall ensure that the Deputy assumes the role of the Joint Committee Member for that meeting.

~~6.9~~6.12 The Parties acknowledge and agree that:

~~6.9.1~~6.12.1 the terms of reference of the Joint Committee will be as set out in Schedule 3; and

~~6.9.2~~6.12.2 it is the Joint Committee that makes Joint Committee Decisions which bind the Parties and not the Joint Committee Members nominated by each Party.

~~6.10~~6.13 The Parties agree that a Lead Commissioner/Contractor does not have delegated authority to make Joint Committee Decisions.

~~6.11~~6.14 The Joint Committee shall implement reporting mechanisms to ensure that Joint Committee Decisions are notified to:

~~6.11.1~~6.14.1 the Lead Commissioner/Contractor (if relevant); or

~~6.11.2~~6.14.2 the Provider,

for action to be taken under the relevant Commissioning Contract, if relevant; and

~~6.11.3~~6.14.3 each Party for onward dissemination to its members and governing body, as each Party deems appropriate.

~~6.12~~6.15 Clauses 6.10 – 6.14 do not apply to Associate Members of the Joint Committee. For the avoidance of doubt, this means that Associate Members do not delegate any matters to the Joint Committee and are not bound by Joint Committee Decisions and Non-Service Specific Matters.

Lead Commissioner/Contractor Decisions

~~6.13~~6.16 Where the Parties have appointed a Lead Commissioner/Contractor for a Service, each Party must ensure that the matters set out as Lead Commissioner/Contractor Decisions Schedule 4 and/or the Workplan are delegated effectively and lawfully to the Lead Commissioner/Contractor.

~~6.14~~6.17 Subject to Clause 6.16, the Parties acknowledge that where the Parties have appointed a Lead Commissioner/Contractor for a Service, the Lead Commissioner/Contractor is able to:

~~6.14.1~~6.17.1 make Lead Commissioner/Contractor Decisions and such decisions will bind all of the Parties in relation to the Service; and

~~6.14.2~~6.17.2 take action under the Commissioning Contracts in relation to Lead Commissioner/Contractor Decisions without reference to the Parties or the Joint Committee; and

~~6.14.3~~6.17.3 implement Joint Committee Decisions as directed by the Joint Committee.

6.18 The Lead Commissioner/Contractor shall report to the Joint Committee in accordance with any reporting requirements as may be set out in the Workplan.

6.19 Clauses 6.16 – 6.18 do not apply to Associate Members of the Joint Committee. For the avoidance of doubt, this means that Associate Members do not delegate any matters to the Lead Commissioner/Contractor.

7. INSPECTION

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

8. COLLABORATIVE COSTS AND RESOURCES

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

8.2 The Parties agree that the Host Party shall host the Programme Management Office which shall provide Programme Management Support to the Collaborative and the Joint Committee as set out in Schedule 5. Such hosting shall include the employment and/or engagement of staff.

8.3 The Parties agree that:

8.3.1 the Host Party shall manage the Programme Management Budget on behalf of the Parties;

8.3.2 each Party shall make an Annual Contribution to the Host Party in respect of the Programme Management Budget in accordance with this Clause 8 and Schedule 6;

8.3.3 the Programme Management Budget shall include (but not be limited to) costs which fall into the categories set out in Schedule 6;

8.3.4 the Joint Committee may agree that costs which do not fall within the categories set out in Schedule 6 will be shared between the Parties and may determine the proportions in which such costs shall be shared between the Parties; and

8.3.5 at least 30 days prior to the start of each financial year, the Joint Committee shall agree:

(a) the Programme Management Budget for the next financial year; and

(b) the proportions in which the Parties shall make Annual Contributions to the Programme Management Budget in the forthcoming financial year.

8.4 The provisions of Schedule 6 shall apply in relation to the management of the Programme Management Budget.

8.5 Clauses 8.1 – 8.4 do not apply to Associate Members of the Joint Committee.

9. **INDEMNITY**

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

~~9.1~~9.2 Each Party undertakes to indemnify each other Party against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses, whether arising in tort (including negligence) or as a result of default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of the indemnifying Party (or its employees, agents or sub-contractors), except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the indemnified Party or (or its employees, agents or sub-contractors).

~~9.2~~9.3 Each Party further undertakes to indemnify the Lead Commissioner/Contractor against any liability, damages, costs, claims or proceedings arising out of or in connection with any act or omission (which is not recklessly negligence, fraudulent or involving criminal liability) committed or omitted by it during the course of performing its obligations under this Agreement, provided that the liability of each Party under such indemnity will be limited to the proportion of the total amount from time to time indemnified under this Clause 9.3 equal to that Party's Holding.

~~9.3~~9.4 In the event that any Party (or Parties) receives a Claim against it which relates to a decision of the Joint Committee made on behalf of that Party (or Parties) (the "Receiving Party") in accordance with this Agreement, then the Receiving Party shall inform the Joint Committee as soon as reasonably practicable. Notwithstanding that such Claims shall be responded to by the Receiving Party, each Party agrees (whether through the Joint Committee or otherwise) to assist and co-operate with the Receiving Party to enable the Receiving Party to respond to the Claim.

~~9.4~~9.5 Each Party shall bear its own costs and expenses incurred in connection with responding to any Claims received by it which relate to decisions of the Joint Committee made on its behalf or otherwise.

~~9.5~~9.6 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer's liability, liability to third parties and all other potential liability under this Agreement.

10. VARIATIONS

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

10.2 If at any time during the term of this Agreement any Party requests in writing any variation to a Commissioning Contract, Clauses 10.8 to 10.10 shall apply.

Variations to this Agreement

10.3 The Party proposing the Variation shall provide a report in writing to the Joint Committee (the "**Variation Report**") setting out:

10.3.1 the Variation proposed;

10.3.2 the date upon which the Variation is to take effect;

10.3.3 a statement of the impact the Variation will have on, and any change required to, this Agreement;

10.3.4 a statement on the individual responsibilities of the Parties for any implementation of the Variation; and

10.3.5 details of any proposed staff and employment implications.

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

10.5 Where the Joint Committee is unable to agree on the terms of the Variation then any Party may refer the matter to dispute resolution under Clause 12 (Dispute Resolution).

10.6 All Variations made to this Agreement shall be agreed between the Parties. Such Variations to this Agreement are only to be effective if made in writing and signed by all the Parties.

10.7 Variations to this Agreement shall be appended to this Agreement at Schedule 8 (Variations).

Variations to a Commissioning Contract

10.8 The Party proposing any variation to a Commissioning Contract shall provide a report (the "**Commissioning Contract Variation Report**") in writing to the Lead Commissioner/Contractor (if relevant) or the Joint Committee (if there is no Lead Commissioner/Contractor) setting out:

10.8.1 the variation proposed;

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

10.8.3 a statement on the individual responsibilities of the Parties for any implementation of the variation.

10.9 Following receipt by the Joint Committee or Lead Commissioner/Contractor (as relevant) of the Commissioning Contract Variation Report and allowing twenty (20) Working Days in which to consider the Commissioning Contract Variation Report, the Joint Committee shall meet to discuss the proposed variation.

10.10 Where the variation is agreed by the Joint Committee, the Lead Commissioner/Contractor (if relevant) or the Party proposing (if there is no Lead Commissioner/Contractor) the variation shall put the variation to the Provider in accordance with the relevant provisions of the Commissioning Contract.

11. NOTICES

11.1 Any notices to be given under the Agreement must be in writing and served on the Parties' first named Joint Committee Member in Schedule 1 either by hand, post, or e-mail to the address for that Joint Committee Member as set out in Schedule 1.

11.2 Notices:

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

11.2.2 by hand will be effective upon delivery;

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

12. DISPUTE RESOLUTION

12.1 Where any dispute arises between the Parties including the Lead Commissioner/Contractor (if relevant) or where the Joint Committee cannot reach a decision in accordance with its terms of reference, the Parties must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the Joint Committee.

12.2 Where any matter referred to dispute resolution is not resolved under Clause 12.1, any Party in dispute may refer the dispute to the Accountable Officers of the relevant Parties, who will cooperate in good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

12.3 If the dispute is not resolved under Clauses 12.1 and 12.2, any Party in dispute may refer the dispute to NHS England and each Party will co-operate in good faith with NHS England to agree a resolution to the dispute within ten (10) Working Days of the referral.

12.4 Any referral to NHS England under Clause 12.3 shall be to Director of Commissioning, NHS England.

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

13. JOINING THE COLLABORATIVE

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

13.1.1 that Party establishing the Joint Committee as a joint committee of the relevant Party and delegating the exercise of its Functions as set out in the Scheme of Delegation;

13.1.2 that Party agreeing to be bound by the terms of this Agreement and entering into a Memorandum of Adherence in the form set out in Schedule 9; and

13.1.3 the agreement of all the existing Parties.

13.2 The Parties agree that statutory successor bodies to any one or more of the Parties shall be deemed to be Parties to this Agreement and the agreement of the remaining Parties in accordance with Clause 14.1 is not required. For the avoidance of doubt, this includes an organisation formed as a result of the merger of two or more Parties.

14. TERMINATION

Termination of this Agreement

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

Termination of a Defaulting Party

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

14.3 The Parties agree that a failure of a Party's Joint Committee Member or Deputy to attend three meetings (whether consecutive or otherwise) of the Joint Committee in any one financial year shall constitute a default which is not capable of remedy in accordance with Clause 14.2.

Termination of a Party in relation to a Service

14.4 Where a Party terminates its participation in a Commissioning Contract, that Party's participation in matters relating to the relevant Service and that Party's inclusion in the Workplan in relation to the Service shall automatically terminate on the same date.

Termination of a Party's participation in this Agreement

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

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

15. CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING

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

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

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

15.1.3 reconciliation of the Programme Management Budget against actual expenditure shall be undertaken in accordance with Schedule 6.

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

16. SURVIVAL

16.1 The provisions of this Agreement which are expressly stated to survive its termination or expiry or which are intended by their nature to survive termination or expiry shall continue in force (including but not limited to Clauses 7, 8, 9, 12, 15, 0, 17, 18, 19, 23, 28 and Schedule 6 together with those other Clauses, the survival of which is necessary for the interpretation or enforcement of this Agreement).

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

17. CONFIDENTIALITY

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

17.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions to enable the efficient operation of the Collaborative.

18. DATA PROTECTION

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

18.2 The Parties may share information with each other which may comprise anonymised and pseudonymised data to support decision-making by the Collaborative, but will not include any patient identifiable data. The Parties shall comply with the terms of the separate Information Sharing Agreement.

19. FREEDOM OF INFORMATION

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

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

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

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

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

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

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

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

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

19.6.1 without consulting with the other Parties; or

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

19.7 Where the Programme Management Office or the Joint Committee receives a request for information in relation to this Agreement then the relevant affected Parties may agree that the response to such request for information shall be co-ordinated by the Programme Management Office on behalf of the Parties involved, such Parties to assist and co-operate with the Programme Management Office in this regard.

20. **STATUS**

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

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

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

21. **ASSIGNMENT AND SUB-CONTRACTING**

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

22. **THIRD PARTY RIGHTS**

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

23. **COMPLAINTS**

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

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

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

24. **ENTIRE AGREEMENT**

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

25. **SEVERABILITY**

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

26. **WAIVER**

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

27. **COSTS AND EXPENSES**

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

28. **GOVERNING LAW AND JURISDICTION**

This Agreement shall be governed by and construed in accordance with English Law and, subject to Clauses 12.1 (Dispute Resolution) and 20.1 (Status), the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

29. **FAIR DEALINGS**

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

30. **COUNTERPARTS**

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

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

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

Signed by _____ _____

(print name) *(signature)*

for and on behalf of **NHS Bradford, district and Craven Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Calderdale Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Greater Huddersfield Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Leeds Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS North Kirklees Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Wakefield Clinical Commissioning Group**

Date of signature _____

ASSOCIATE MEMBERS of the Joint Committee of CCGs

Agree to adopt the principles of collaboration set out in Paragraph 3.1 and to seek the objectives set out in Paragraph 4.1 and at Schedule 7.

Signed by _____ _____

_____ (print name) _____ (signature)

for and on behalf of **NHS North Yorkshire Clinical Commissioning Group**

Date of signature _____

SCHEDULE 1

JOINT COMMITTEE MEMBERS

1. Joint Committee Member details

1.1. The table below sets out the names of each Party's nominated Joint Committee Members.

Name of Party	Name of Joint Committee Members	Name of Deputy
Bradford district and Craven CCG	Helen Hirst	Nancy O'Neil
	Dr James Thomas	Dr Sohail Abbas
Calderdale CCG	To be confirmed	Neil Smurthwaite
	Dr Steven Cleasby	
Greater Huddersfield CCG	Carol McKenna	Ian Currell
	Dr Steve Ollerton	Dr Jane Ford
Leeds CCG	Tim Ryley	Visseh Pejhan – Sykes
	To be confirmed	
North Kirklees CCG	Carol McKenna	Ian Currell
	Dr Khaled Naeem (from 01.05.20)	
Wakefield CCG	Jo Webster	
	Dr Adam Sheppard	

2. Associate Member details

North Yorkshire CCG	Amanda Bloor	
	Dr Charles Parker	To be confirmed

SCHEDULE 2

NON-SERVICE SPECIFIC MATTERS

1. The Parties agree that the matters below are Non-Service Specific Matters and shall be delegated to the Joint Committee in accordance with Clause 6.10.3:

   1.1. consideration, and agreeing or proposing resolutions to, disputes referred to the Joint Committee in accordance with Clause 12 (Dispute Resolution);

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

   1.3. agreeing the Programme Management Budget for each financial year and oversight of management of the Programme Management Budget by the Host Party;

   1.4. development and communication;

   1.5. engagement events;

   1.6. engaging with the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common, other Provider Groups and the West Yorkshire and Harrogate Health and Care Partnership System Leadership Executive Group as appropriate to further the Partnership objectives as set out in Schedule 7; and.

   1.7. agreeing the future arrangements for commissioning at scale for WY&H, ensuring that they align with place-based commissioning arrangements and Partnership structures and contribute to the delivery of the Partnership's five year plan, including:

   - the timescales and milestones for any agreed changes.
   - the implementation plan and programme of transition to any agreed new arrangements.
   - appropriate resourcing of the new arrangements, ensuring that they provide value for money
   - appropriate communications between the Joint Committee and its constituent CCGs on any agreed implementation plan.

SCHEDULE 3

TERMS OF REFERENCE OF THE JOINT COMMITTEE

1. ROLE OF THE JOINT COMMITTEE

1.1. The overarching role of the Joint Committee is to take efficient and effective commissioning decisions on a place basis, where appropriate and in accordance with the delegation of authority from each Party, and, in doing so, to support the aims and objectives of the Partnership's Five Year Plan as set out in Schedule 7. The Joint Committee shall at all times act in accordance with all relevant Law and Guidance applicable to the Parties and relevant to the joint exercise of each Party's Functions.

2. TERMS OF REFERENCE OF THE JOINT COMMITTEE

Frequency and notice of meetings

2.1. Meetings shall be held monthly or other such frequency as agreed by the Parties.

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

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

2.4. Meetings of the Joint Committee shall be open to the public save where the Joint Committee resolves to exclude members of the public from any meeting or part of a meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or there are special reasons as stated in the resolution and arising from the nature of the business of the proceedings.

2.5. The Chair may exclude any member of the public from a meeting of the Joint Committee if they are interfering with or preventing the proper or reasonable conduct of that meeting.

2.6. Members of the public or representatives of the press may not record proceedings in any manner whatsoever, other than writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.

2.7. The right of attendance at meetings by members of the public as referred to in paragraph 2.4 does not give the right to such members of the public to ask questions or otherwise participate in that meeting, unless invited to do so by the Chair.

Joint Committee Members and attendees

2.8. The Joint Committee Members shall comprise:

2.8.1. two voting representatives appointed by each Party; and

2.8.2. three non-voting lay representatives (appointed by the Parties via an open application process) to comprise:

(a) one lay representative who is independent of any of the Parties (the "Independent Lay Representative"); and

(b) two lay representatives who are existing lay members of a Party's governing body (provided that the two lay representatives shall not be lay members of the same Party).

2.9. Associate Members of the Joint Committee shall be invited to attend meetings and may contribute to the discussion of all matters, but shall not be able to vote on a matter.

~~2.9.~~ The Joint Committee shall invite a representative of NHS England to attend meetings and may invite other persons to attend meetings as it deems appropriate.

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

Quorum

2.11. Meetings of the Joint Committee shall be quorate when at least 75% of the Joint Committee Members are present.

2.12. In circumstances where a Joint Committee Member who is not a lay representative is unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the nominating Party may send to a meeting of the Joint Committee a deputy (a "**Deputy**") to take the place of the Joint Committee Member. Where a Party sends a Deputy to take the place of the Joint Committee Member, the references in this paragraph 2 to Joint Committee Members shall be read as references to the Deputy. Parties must ensure that a Deputy attending a meeting of the Joint Committee has the necessary delegated authority.

Voting

2.13. The Joint Committee Members nominated by each Party (referred to in paragraph 2.8.1 above) shall have one vote between them, so that there is one vote per Party. ~~, except that Leeds CCG, which came into existence on 1st April 2018, following the merger of Leeds North, Leeds South East and Leeds West CCGs, will retain the 3 votes of the separate CCGs prior to the merger.~~ The lay representative Joint Committee Members shall not vote on any matter.

2.14. The Joint Committee will make decisions by consensus of those Joint Committee Members present and voting at the meeting wherever possible. If a consensus decision cannot be reached then decisions of the Joint Committee will be made by 75% majority of those Joint Committee Members voting and present at the meeting.

2.15. The validity of any act of the Joint Committee shall not be affected by any defect in its constitution, by any vacancy among the Joint Committee Members or by any defect in the appointment of any of its Joint Committee Members.

Chair

2.16. The Independent Lay Representative shall be appointed Chair of the Joint Committee. The Joint Committee will appoint another of the Joint Committee Lay Members to act as Deputy Chair.

Administration

2.17. The Programme Management Office shall provide administrative support and advice to the Joint Committee including but not limited to:

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

2.17.2. maintaining a register of interests for Joint Committee Members and Associate Members; and

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

Duties

2.18. The Joint Committee will:

2.18.1. make Joint Committee Decisions (as set out in Schedule 4 and/or the Workplan); and

2.18.2. undertake actions as set out in this Agreement.

Relationship with the Parties

2.19. Minutes of meetings of the Joint Committee shall be provided to the members and/or governing bodies of the Parties.

2.20. The Joint Committee shall produce, with the support of the Programme Management Office, an annual report of the work of the Joint Committee which shall be provided to the members and /or governing bodies of each Party.

Special Meetings

2.21. Special meetings of the Joint Committee on any matter may be called by any of the Parties acting through its Joint Committee Member by giving at least forty-eight (48) hours' notice by e-mail to the other Joint Committee Members in the following circumstances:

2.21.1. where that Party has concerns relating to the safety and welfare of Service Users under any Commissioning Contract(s);

2.21.2. in response to a quality, performance or financial query by any Regulatory or Supervisory Body;

2.21.3. to convene a meeting under Clause 12.1 (Dispute Resolution) of the Agreement; and/or

2.21.4. for the consideration of any matter which that Party considers of sufficient urgency and importance that its consideration cannot wait until the date of the next meeting.

Conflicts of Interest

2.22. Each Joint Committee Member and Associate Member must abide by all policies of the Party it represents in relation to conflicts of interest.

2.23. Where any Joint Committee Member or Associate Member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that Joint Committee Member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed. Where the Chair decides to exclude a Joint Committee Member, the relevant Party may send a Deputy to take the place of the conflicted Joint Committee Member in relation to that matter in accordance with paragraph 2.12.

Review

2.24. These terms of reference shall be reviewed by the Joint Committee at least annually and any consequential amendments approved by each Party.~~'s members~~.

SCHEDULE 4

SCOPE OF DECISION MAKING

1. INTRODUCTION

Each Party shall ensure that the matters noted as Joint Committee Decisions in this Schedule 4 and the matters set out in the Workplan in the Appendix are properly and lawfully delegated to the Joint Committee in accordance with the NHS Act 2006 and each Party's constitution and internal procedures.

2. MATTERS WITHIN THE SCOPE OF THIS AGREEMENT

Workplan - general

2.1 The Joint Committee ~~will develop a~~ workplan (the "**Workplan**") ~~which will~~ sets out the ~~proposed~~ scope of the Joint Committee's work. The Workplan ~~for 2018/19~~ effective from the date of this agreement and approved by the Parties is set out in the Appendix to this Schedule 4.

2.2 The Parties agree that the Workplan will be underpinned by a 'gateway' approach for the Services which are the subject of the Workplan, setting out the process and approvals for project initiation, case for change, options appraisal and final decision making.

Workplan review

2.3 The Parties shall ~~review the Workplan in the first six months following the date of this agreement and~~ agree any potential new service areas which all of the Parties agree should be brought within the scope of the Workplan during the term of this Agreement ("Future Joint Committee Matters"), subject to certain conditions ("Gateway Conditions") being met. The Gateway conditions shall require an assessment by the Parties that the new service area meets one or more of the '3 tests' used by the Partnership to determine whether working at WY&H level will add value:

2.3.1 Commissioning at scale

2.3.2 Tackling wicked issues

2.3.3 Learning from each other

~~2.3~~ Each Party shall assess that one or more of the '3 tests' have been met in each case.

2.4 Following such review, the Parties shall agree the Future Joint Committee Matters and the reporting mechanisms as between the Joint Committee and each Party in respect of changes to the Workplan.~~:~~

~~the Future Joint Committee Matters;~~

~~the Gateway Conditions;~~

~~the mechanism through which the Gateway Conditions will be assessed to have been met in order for any Future Joint Committee Matters to be brought within the scope of the Workplan. Such mechanism may include assessment and confirmation by each Party's governing body that the Gateway Conditions have been met in each such case; and~~

~~the reporting mechanisms as between the Joint Committee and each Party's governing body and members, and as between each Party's governing body and members, in respect of changes to the Workplan during the term of this Agreement, as appropriate.~~

2.5 The Parties shall document the matters set out in paragraph 2.4 in this Agreement and in the Joint Committee terms of reference in Schedule 3 by way of a variation to this Agreement in accordance with Clause 10 to be approved by each Party. ~~'s members~~.

CCG Decisions

2.6 The Parties agree that the following matters are CCG Decisions which are reserved to each Party:

2.6.1 approval of the Workplan;

2.6.2 any other matter which is not set out in the Workplan and is not a Non-Service Specific Matter.

Joint Committee Decisions

2.7 The Parties have agreed that decisions in relation to the matters set out below shall be Joint Committee Decisions and shall be delegated to the Joint Committee accordingly:

2.7.1 matters set out in the Workplan; and

2.7.2 Non-Service Specific Matters set out in Schedule 2.

2.8 To avoid doubt, Joint Committee Decisions may be made by the Joint Committee without reference back to each Party.

Lead Commissioner/Contractor Decisions

2.9 The Parties may agree to delegate decisions in respect of a particular Service to a Lead Commissioner/Contractor in accordance with each Party's constitution and scheme of delegation and shall document any such matters in this Schedule 4 by way of a variation to this Agreement.

2.10 To avoid doubt, any Lead Commissioner/Contractor Decisions may be made by the Lead Commissioner without reference back to each Party or to the Joint Committee.

APPENDIX

West Yorkshire and Harrogate Joint Committee of CCGs – Work plan

Decisions delegated to the Joint Committee by the CCGs

Cancer

Develop and agree WY&H commissioning policies impacting on cancer care, including but not limited to:

- *Lynch syndrome testing*
- *Optimal cancer pathways which deliver Constitutional standards*
- *Tele dermatology services for suspected skin cancers*
- *Rapid diagnostic centres*
- *Personalised support for people living with and beyond cancer*

Improving Planned Care

- *Develop and agree WY&H commissioning policies, including, but not limited to:*
  - *Clinical thresholds and procedures of low clinical value;*
  - *Efficient prescribing.*
- *Develop and agree service specifications, service standards and the commissioning and procurement approach to support pathway optimisation, including outpatients transformation.*

Maternity

Agree the approach to commissioning maternity services across WY&H including

- *the specification, service standards and commissioning policy.*
- *the commissioning and procurement approach*

Mental health, learning disability and autism

- *Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds across West Yorkshire and Harrogate.*
- *Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services to ensure risk and benefit can be clearly understood and managed across West Yorkshire and Harrogate.*
- *Agree the plan for the provision of children and young people inpatient units, integrated with local pathways.*
- *Agree a collaborative commissioning model for Assessment and Treatment Units across West Yorkshire for people with learning disabilities to support the new operating model.*

Stroke

Agree the configuration of Hyper Acute and Acute stroke services

- *Review and approve outline business case. Decide on readiness to consult.*
- *Review outcomes of consultation.*
- *Approve full business case*
- *Consider and approve commissioning approach and approve delivery plan.*

Urgent and emergency care

Agree for WY&H the transformational, finance and contractual matters identified as 'CCG decisions to be made in collaboration' in the MoU for the Collaborative Commissioning of Integrated Urgent and Emergency Care Services between CCGs across Yorkshire and the Humber. Namely, for Integrated Urgent Care and 999 services:

Agree:

Transformational matters

- *arrangements for delivery of the commissioners' strategic intentions.*
- *arrangements for assuring the delivery of the providers responses to the agreed commissioning intentions as a whole system*
- *the range of services to be commissioned from the Provider and how they are to be commissioned.*
- *medium to long term planning for the integration of the Service*
- *service redesign to further integrate the Services with other health and social care services.*

Finance matters

- *Negotiate and recommend the Finance schedule for the annual Commissioning Contract*
- *Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend*
- *Agree additional in-year investment from CCGs*

Contractual matters

- *Approve the terms of the annual Commissioning Contract*
- *Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)*
- *Agree communications activity relating to matters governed by the Commissioning Contract*
- *Approve proposals for CQUIN indicators*
- *Agree actions if concerns are identified about actual and contracted activity levels.*

In addition, agree:

- *The specification, business case, commissioning and procurement process for GP out of hours services.*

SCHEDULE 5

PROGRAMME MANAGEMENT SUPPORT

SCOPE OF PROGRAMME MANAGEMENT SUPPORT

1.1 The Host Party shall provide Programme Management Support to the Collaborative and the Joint Committee, to include the following:

1.1.1 secretariat to the Joint Committee, including agendas papers and minutes;

1.1.2 oversight and support to the West Yorkshire and Harrogate Partnership collaborative programmes;

1.1.3 facilitation and co-ordination of West Yorkshire and Harrogate Five Year ~~Sustainability and Transformation~~ Plan activity;

1.1.4 partnership working with the 6 local place based planning units to ensure alignment and connectivity; and

1.1.5 support to the establishment of more formal governance and decision making structures to support the Partnership~~STP~~.

SCHEDULE 6

COSTS AND RESOURCES OF THE COLLABORATIVE

1.1. The Annual Contribution of each Party shall be determined by agreement of the Joint Committee in accordance with Clause 8.3.5.

1.2. The Host Party will issue an invoice to each Party for its respective Annual Contribution for the relevant financial year within 30 days of the beginning of that financial year. Each Party shall pay its Annual Contribution to the Host Party within 30 days of receipt of an invoice from the Host Party.

1.3. The Parties agree that the Annual Contributions may be used to reimburse the Host Party for costs associated with the Programme Management Support, including (but not limited to):

1.3.1. salary and travel costs of Programme Management Office staff; and

1.3.2. administration costs associated with the Collaborative and Programme Management Support, including:

1.3.2.1. office and meeting room hire;

1.3.2.2. IT support and telephony costs;

1.3.2.3. printing and stationery costs.

1.4. The Joint Committee may agree to expand or reduce the scope of the Programme Management Support provided by the Host Party subject to any additional costs incurred by the Host Party as a result of such expansion or reduction being apportioned between the Parties in such proportions as the Joint Committee may agree. In the case of a reduction in the scope of the Programme Management Support such additional costs shall include, but not be limited to, redundancy costs payable by the Host Party as a result of a reduction in the scope of Programme Management Support.

Reporting to the Joint Committee

1.5. The Host Party will provide a monthly written report to the Joint Committee setting out income and expenditure to date in respect of the Programme Management Budget, including identification of and provision of reasons for, any potential overspend or underspend against the Programme Management Budget, and any recommended actions for the Joint Committee to consider.

1.6. The Host Party will provide an annual written report to the Joint Committee setting out the final year-end position in respect of the Programme Management Budget, reconciling expenditure against budget and detailing any overspends or underspends and the reasons for such.

Overspends and underspends during the term of the Agreement

1.7. The Parties agree that any overspends against the Programme Management Budget in any financial year shall be shared between the Parties in the same proportions as the Annual Contributions to the Programme Management Budget in the relevant financial year unless otherwise agreed by the Joint Committee. The Host Party shall issue an invoice to each Party in respect of its share of the overspend within 30 days of the end of the relevant financial year to which the overspend relates. Each Party shall pay the Host Party its share of the overspend within 30 days of receipt of the invoice from the Host Party.

1.8. The Parties agree that any underspends against the Programme Management Budget in any financial year shall be shared between the Parties in the same proportions as the Annual Contributions to the Programme Management Budget in the relevant financial year unless otherwise agreed by the Joint Committee. Each Party shall issue an invoice to the Host Party for its share of the underspend within 30 days of the end of the relevant financial year to which the underspend relates. The Host Party shall pay each Party its share of the underspend within 30 days of receipt of the invoice from the relevant Party.

Reconciliation of Programme Management Budget on expiry or early termination of the Agreement

1.9. In the event that this Agreement expires or terminates (in whole) in accordance with its terms, the Host Party shall undertake a reconciliation of the Programme Management Budget as against actual expenditure and provide a written reconciliation report to each Party no later than 30 days following the expiry date or the date of termination (as relevant).

1.10. Such reconciliation shall set out the balance of any monies owing to each Party (in the event there has been an underspend as at the relevant date) or the balance of monies to be paid by each Party to the Host Party (in the event there has been an overspend as at the relevant date).

1.11. The Host Party shall issue an invoice to each Party, or each Party shall invoice the Host Party (as appropriate) and such invoices shall be paid within 30 days of receipt.

1.12. Where this Agreement terminates partially in respect of one or more Parties only, but not all of the Parties, then the Host Party shall provide the written reconciliation report referred to in paragraph 1.9 above to the Joint Committee setting out the balance of monies owed to or owed by (as the case may be) the Exiting Party (or Exiting Parties) for the Joint Committee's approval. Subject to such approval, the Host Party shall issue an invoice to the Exiting Party (or Exiting Parties) or the Exiting Party (or Exiting Parties) shall issue an invoice to the Host Party (as appropriate) and such invoice shall be paid within 30 days of receipt.

SCHEDULE 7

WEST YORKSHIRE AND HARROGATE FIVE YEAR ~~SUSTAINABILITY AND TRANSFORMATION~~ PLAN – PRINCIPLES AND OBJECTIVES

1.1. The WY&H Five Year ~~Sustainability and Transformation~~ Plan can be found here:

https://wyhpartnership.co.uk/

SCHEDULE 8

VARIATIONS

The Parties will insert agreed variations to this Agreement in this Schedule 8.

Variation	Date of insertion

SCHEDULE 9

MEMORANDUM OF ADHERENCE

Dated_____

MEMORANDUM OF ADHERENCE

FOR THE

COLLABORATIVE COMMISSIONING

BETWEEN

CLINICAL COMMISSIONING GROUPS ACROSS WEST YORKSHIRE AND HARROGATE

THIS MEMORANDUM is dated is dated the day of 20{●}

BETWEEN

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

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

BACKGROUND

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

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

IT IS AGREED:

1. **DEFINITIONS AND INTERPRETATION**

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

2. **CONFIRMATION AND UNDERTAKING**

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

3. **COUNTERPARTS**

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

4. **GOVERNING LAW AND JURISDICTION**

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

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

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

[INSERT NEW PARTY NAME]

AUTHORISED OFFICER **Date**

NHS BRADFORD, DISTRICT AND

CRAVEN CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

NHS CALDERDALE

CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

NHS GREATER HUDDERSFIELD

CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

NHS LEEDS

CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

NHS NORTH KIRKLEES

CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

NHS WAKEFIELD

CLINICAL COMMISSIONING GROUP

Authorised Officer **Date**

West Yorkshire and Harrogate
Health and Care Partnership

Appendix 2

Proposed new service matters to be delegated to the Joint Committee

Mental Health, Learning Disability and Autism

- *Agree a collaborative commissioning model for Assessment and Treatment Units across West Yorkshire for people with learning disabilities to support the new operating model.*

Summarise below how the proposed delegation to the Joint Committee meets one or more of the '3 tests' for joint working across West Yorkshire and Harrogate:

1. Commissioning at scale to ensure the best possible health outcomes for people
2. Tackling wicked issues - working together to tackle complex (or 'wicked') issues.
3. Learning from each other - sharing good practice across the Partnership

Assessment against the '3 tests'

ATUs provide specialist hospital support for adults with moderate to severe learning disabilities, who also have mental health problems and/or behaviour that challenges. Their care needs mean that they cannot always be supported at home, in the community or in other adult mental health wards. Through the national Transforming Care Programme there is an ambition to reduce the numbers of adults with learning disabilities being admitted to ATUs because of their mental health and / or autism needs.

Through the TCP we have been set a trajectory by NHS England to reduce the ATU bed numbers in West Yorkshire from 22 to 15 by March 2020. And at the same time we want to develop a centre of excellence across the ATUs by working in a common way, ensuring that we meet all national specification requirements. Including:

- reducing length of stay when appropriate
- providing an appropriate and therapeutic environment
- having the workforce skill mix to deliver the required assessment, treatment interventions and care - promoting and supporting least restrictive practices

The proposal to agree a collaborative commissioning model for ATUs meets all three of the 3 tests:

Commissioning at scale – by working together we can provide a higher quality service for the low volume of service users who require ATUs, ensuring the right relationships are reflected in the interaction with the WY Transforming Care Programme. There is not sufficient volume in individual places with the bed reduction requirements to provide robust commissioning arrangements for this cohort.

Wicked issues – the issue of how to provide appropriate care for people with a learning disability is complex. It cuts across health and local authority commissioning, both at place (particularly with regard to making reasonable adjustments in the community) and specialist provision on a WY&H footprint when needed. This isn't something that can be resolved in isolation.

Learning from each other – by moving to a centre of excellence model the ATUs will be able to learn from one another to streamline processes and put in place good practice for supporting people's individual needs. As a partnership we will also learn through the process of undertaking this reconfiguration programme to build our knowledge for future reconfiguration both within the Mental Health, Learning Disability and Autism programme and beyond.

Proposed new service matters to be delegated to the Joint Committee

Cancer

Develop and agree WY&H commissioning policies impacting on cancer care, including but not limited to:

- *Lynch syndrome testing*
- *Optimal cancer pathways which deliver Constitutional standards*
- *Tele dermatology services for suspected skin cancers*
- *Rapid diagnostic centres*
- *Personalised support for people living with and beyond cancer*

Summarise below how the proposed delegation to the Joint Committee meets one or more of the '3 tests' for joint working across West Yorkshire and Harrogate:

1. Commissioning at scale to ensure the best possible health outcomes for people
2. Tackling wicked issues - working together to tackle complex (or 'wicked') issues.
3. Learning from each other - sharing good practice across the Partnership

Assessment against the '3 tests'

Context

- Cancer is a national priority programme and the biggest cause of death from illness in every age group in WY&H. It will directly affect 1 in 2 of the population born since 1960 – yet up to 42% of cancers are potentially preventable
- There are c.13,000 new diagnoses in WY&H per year. This is set to rise by around 2% pa to 17,500 over the next 15 years if we do nothing.
- Increasing our early diagnosis rates for cancer is one of the 10 'big ambitions' for the Partnership. The national 'ask' of systems is by 2023/24 to increase early diagnosis rates by 8 percentage points from the current level of c50%, eventually reaching a 75% early diagnosis rate by 2028. This will require huge cross system and cross sector effort to encourage people with symptoms to present and for our primary and secondary care providers to be able to respond in a person centred, cost effective way to rule cancer in or out within 28 days.
- Over 81,000 people are referred each year for investigation with symptoms suggestive of cancer across the WY&H.
- There is significant variation across WY&H in access to and uptake of screening, treatment, support, palliative care and clinical trials.
- Cancer is the 3rd largest disease programme spend for the NHS behind mental health and circulatory disease. FYFV forecast overall budget lines for cancer would increase by 9% pa in absence of efficiency or other changes to impact on the spending profile.

Rationale for joint working across West Yorkshire and Harrogate

- Commissioning at scale - The majority of cancer pathways are delivered by a combination of primary, secondary and tertiary care with patients moving between organisations and places to complete treatment. A consistent approach to commissioning policies across our system is therefore essential to prevent the inequalities in access, outcome and experience which currently exist. Differential policy across our Partnership hardwires the current inequalities.
- Tackling 'wicked' issues – benefits in terms of outcomes and efficiency will only be realised by system-wide collaboration and collective ownership of the key deliverables for cancer. This is due to the need for strategic movement of resources to invest in prevention and earlier diagnosis to reduce the overall burden of disease and reduce the level of growth in treatment costs of late stage disease if nothing is done to make more cancers curable.
- Tackling 'wicked' issues – by addressing some of our key workforce and other capacity gaps comprehensively and consistently on a WY&H footprint, such as in diagnostics, we can generate solutions based on economies of scale rather than each local place attempting to deliver individually.
- Learning from each other – there is considerable variation in access, outcome and patient experience in all parts of cancer pathways across WY&H. That means that for every place that is struggling with some aspect of cancer care, there is another place doing better. Through working together we can actively learn from each other and level up our collective offer to the citizens of WY&H. An example of this in practice is the improvement collaborative approach being led by the Alliance at the request of WYAAT Programme Executive to recover performance of cancer waiting times standards and improve patient experience. To be truly effective this requires the support of consistent commissioning policies.

Proposed new service matters to be delegated to the Joint Committee

West Yorkshire and Harrogate Local Maternity System (LMS)

Agree the approach to commissioning maternity services across WY&H including

- *the specification, service standards and commissioning policy.*
- *the commissioning and procurement approach*

Summarise below how the proposed delegation to the Joint Committee meets one or more of the '3 tests' for joint working across West Yorkshire and Harrogate:

1. Commissioning at scale to ensure the best possible health outcomes for people
2. Tackling wicked issues - working together to tackle complex (or 'wicked') issues.
3. Learning from each other - sharing good practice across the Partnership

Assessment against the '3 tests'

The West Yorkshire and Harrogate Local Maternity System is one of the West Yorkshire and Harrogate Programmes . The principle of the LMS is that providers, local authority, voluntary sector and CCG come together across West Yorkshire and Harrogate to provide the best outcomes for women and their families. Better Births (2016) requires all of these stakeholders to work collaboratively.

Commissioning at scale

Better Births stated there should be a move from a traditional service specification approach to outcome focused commissioning. The guidance highlights the importance of identifying the outcomes which require improvement, developing the key performance indicators and building these into contracts to incentivise collective action across boundaries, often commissioning across boundaries to achieve the best possible maternal and neonatal outcomes.

To date, the partners in the LMS have developed a draft maternity service specification and therefore the optimum time to consider the future commissioning arrangements. Currently clinical commissioning groups have the responsibility for commissioning the maternity provision and work closely with the Local Authorities who commission the Healthy Child Programme. Moving forward services need to be commissioned as a system to address these issues and reduce variation.

Wicked issues - The Local Maternity System plan outlines the many areas that need to be addressed as a system:

- Prevention and Reducing Inequalities
- Choice and Personalisation

- Safer Maternity Care
- Maternity Voices Partnership
- Digital
- Postnatal Care
- Perinatal Mental Health
- Maternal Medicine Networks
- Workforce
- Sustainability
- Preventing Neonatal Birth

Learning from each other – Improving safety is central to the Maternity Transformation Programme. The LMS has responsibility to address clinical variation and have a system wide learning system. Policy also dictates providers should work together as a system to ensure women and infants are safe and they should operate under the same policies and clinical governance. A safety forum is in place and policies with appropriate governance routes are in the development stage.

Proposed new service matters to be delegated to the Joint Committee

Urgent and emergency care

Agree for WY&H the transformational, finance and contractual matters identified as 'CCG decisions to be made in collaboration' in Schedule 4 of the MoU for the Collaborative Commissioning of Integrated Urgent and Emergency Care Services between CCGs across Yorkshire and the Humber. Namely, for Integrated Urgent Care and 999 services:

Transformational matters

Agree:

- *arrangements for delivery of the commissioners' strategic intentions.*
- *arrangements for assuring the delivery of the providers responses to the agreed commissioning intentions as a whole system*
- *the range of services to be commissioned from the Provider and how they are to be commissioned.*
- *medium to long term planning for the integration of the Service*
- *service redesign to further integrate the Services with other health and social care services.*

Finance matters

- *Negotiate and recommend the Finance schedule for the annual Commissioning Contract*
- *Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend*
- *Agree additional in-year investment from CCGs*

Contractual matters

- *Approve the terms of the annual Commissioning Contract*
- *Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)*
- *Agree communications activity relating to matters governed by the Commissioning Contract*
- *Approve proposals for CQUIN indicators*
- *Agree actions if concerns are identified about actual and contracted activity levels.*

In addition, agree for WY&H:

- *The specification, business case, commissioning and procurement process for GP out of hours services.*

Summarise below how the proposed delegation to the Joint Committee meets one or more of the '3 tests' for joint working across West Yorkshire and Harrogate:

1. Commissioning at scale to ensure the best possible health outcomes for people
2. Tackling wicked issues - working together to tackle complex (or 'wicked') issues.
3. Learning from each other - sharing good practice across the Partnership

Assessment against the '3 tests'

The overarching objective of delegating these decisions is to enable the collaborative commissioning of Integrated Urgent and Emergency Care Services which meet the health needs of the people of West Yorkshire and Harrogate, in accordance with Urgent and Emergency Care Network (UECN) delivery plans and Health and Care Partnership Plans.

It will enable the integration of other health and social care services to achieve the outcomes set out in these plans. It will enable the delivery of the national Integrated Urgent Care and urgent and emergency ambulance specifications and ensure that services meet all relevant national standards and guidance and that:

- services provide the best possible performance and quality
- services are cost effective and provide best value for money
- patients, service users, their carers and families have been appropriately engaged.

The proposal to delegate these commissioning decisions meets all three of the 3 tests:

Commissioning at scale – The collaborative approach enables the WY&H CCGs to take a strategic view of the issues affecting local populations, ensuring a clear focus on health outcomes. It ensures that the quality of services and patient safety are delivered consistently and equitably, to agreed standards, meeting the needs of our population

Tackling wicked issues - To make the best use of resources in delivering effective and efficient services within a challenging and demanding environment

Learning from each other - Maximising stakeholder involvement and engagement, creating opportunities to share best practice and enable service transformation.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**Appointment of Clinical Vice Chair**	**Agenda Item No.**	9
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	Steven Cleasby, CCG Chair, GP member	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer/Deputy Chief Officer)

Executive Summary							
Please include a brief summary of the purpose of the report	To recommend to the Governing Body that Dr Caroline Taylor (GP Member) be appointed to the role of Clinical Vice Chair.						
Previous consideration	**Name of meeting**	Remuneration and Nomination Committee	**Meeting Date**	23/04/2020			
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: ▪ **APPOINTS** Dr Caroline Taylor (GP Member) as Clinical Vice Chair of the Governing Body.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications						
Quality & Safety implications	None					
Engagement & Equality implications	None					
Resources / Finance implications	None					
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	X
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**	None			

Legal / CCG Constitutional Implications	The CCG's Constitution specifies the Clinical Vice Chair be selected from one of the GPs/Nurse Practitioners elected to the Governing Body (7.6.1)	**Conflicts of Interest**	The proposed appointee has a direct professional interest in the item. The conflict of interest will be managed in line with the CCG's policy for the management of conflicts of interest.

1.0 Introduction

1.1 The purpose of this paper is to recommend to the Governing Body that Dr Caroline Taylor (GP Member) be appointed to the role of CCG Clinical Vice Chair.

2.0 Background

2.1 The CCG's previous Clinical Vice Chair, Dr Maj Azeb (GP Member), stepped down from the Governing Body as of 31 March 2020. The Governing Body now needs to appoint a new Vice Clinical Chair.

2.2 As described in the CCG's Constitution,

"The Governing Body may appoint a Clinical Vice Chair from one of the GPs/Nurse Practitioners elected to the Governing Body" (7.6.1)

to:

"Take a significant role in supporting clinical leadership and involvement in the CCG". (2.2.3)

2.3 Dr Caroline Taylor (GP Member) has been nominated to the position by the CCG Chair, Dr Steven Cleasby.

2.4 The CCG's Remuneration and Nomination Committee considered the nomination of Dr Taylor at its meeting on the 27 February 2020 in accordance with its responsibility for overseeing and making recommendations on appointments to the Governing Body and its committees. Having considered relevant matters including experience and performance as a Governing Body Member and clinical leader within the system, the Committee was happy to support Dr Taylor's appointment to the position of CCG Clinical Vice Chair.

3.0 Next Steps

3.1 Subject to the approval of the Governing Body, Dr Taylor's appointment will be communicated to the CCG membership, staff, partners and stakeholders.

4.0 Recommendation

4.1 It is recommended that the Governing Body:

- **APPOINTS** Dr Caroline Taylor (GP Member) as Clinical Vice Chair of the Governing Body

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**Reappointments to the Governing Body**	**Agenda Item No.**	10
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	Steven Cleasby, CCG Chair, GP Member	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer/Deputy Chief Officer)

Executive Summary

Please include a brief summary of the purpose of the report

The paper asks that Governing Body approve the reappointment of Governing Body members whose first terms of office are coming to an end on 31 May 2020.

The terms of office relate to:

- John Mallalieu (Lay Member, Finance and Performance)
- Dr Rob Atkinson (Secondary Care Specialist)

The reappointments were considered by the Remuneration and Nomination Committee at its meeting on 27 February 2020. The committee recommends both reappointments to the Governing Body.

Relevant information and recommendations are set out in the individual papers supplied at Appendix 1 (John Mallalieu) and 2 (Rob Atkinson) to this covering report.

Previous consideration	**Name of meeting**	Remuneration and Nomination Committee	**Meeting Date**	27/02/2020
	Name of meeting		**Meeting Date**	

Recommendation (s)

It is recommended that the Governing Body:

1. **APPROVES** the reappointment of John Mallalieu (Lay Member, Finance and Performance) to the Governing Body for a second three year term of office.

2. **APPROVES** the reappointment of Rob Atkinson (Secondary Care Specialist) to the Governing Body for a second three year term of office.

Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications

Quality & Safety implications	None
Engagement & Equality implications	None

<table>
<tr><td colspan="2">Resources / Finance implications</td><td colspan="6">A decision not reappoint would result in the need for recruitment exercises to be undertaken. This would have resource implications for the CCG.</td></tr>
<tr><td colspan="2">Has a Data Protection Impact Assessment (DPIA) been completed?</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>X</td></tr>
<tr><td>Strategic Objectives</td><td>▪ Achieving the agreed strategic direction for Calderdale
▪ Improving quality
▪ Improving value
▪ Improving governance</td><td colspan="4">Risk</td><td colspan="2">None</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>The roles making up the Governing Body's membership are set out in the CCG's constitution and associated regulations. Vacant positions would have implications for quoracy and decision making at a Governing Body and committee level.</td><td colspan="4">Conflicts of Interest</td><td colspan="2">The individual Governing Body members to whom the recommendations relate will have a direct conflict of interest.

Conflicts of interest will be managed in line with the CCG's Management of Conflicts of Interest Policy.</td></tr>
</table>

Item 10 Appendix 1

1. Introduction

1.1 The Governing Body is asked to make a decision with regard to the reappointment of John Mallalieu (Lay Member, Finance and Performance) to the Governing Body. His first three year term of office comes to an end on 31 May 2020.

2. Detail

2.1 As set out in the CCG's current Constitution, the usual term of office of GPs/Nurse Practitioners (including the Chair), lay members, the secondary care specialist and the registered nurse is three years.

2.2 The established practice for lay members, secondary care specialist and the registered nurse on reaching the end of their first three year term has been for them to be reappointed for a further period of three years or less (as agreed between the Chair, Chief Officer and individual) subject to satisfactory annual appraisal.

2.3 The above practice/convention complies with the approach recommended in The *NHS Foundation Trust Code of Governance* (2014) for non-Exec Members and is being incorporated into the CCG Constitution as one of the proposed amendments endorsed by the Governing Body in January 2020 and subsequently agreed by the CCG Members. The revised Constitution has been submitted to NHS England to agree this and other changes.

2.4 The Remuneration and Nomination Committee at its meeting on 27th February 2020 considered:

- The established practice for lay members, secondary care specialist and the registered nurse reaching the end of their first three year term and proposed constitutional changes.
- Performance and contribution to the CCG and Governing Body including as Deputy Chair of the CCG, Chair of the Commissioning Primary Medical Services Committee, Chair of the Remuneration and Nominations Committee and member on the Quality Finance and Performance Committee.
- The completion of a successful appraisal in 2019.
- The current needs and priorities of the Governing Body and CCG following recent changes in Governing Body membership and changes to the CCG's formal governance arrangements.

2.5 The committee agreed to recommend that John Mallalieu (Lay Member, Finance and Performance) be reappointed to the Governing Body for a second three year term of office.

3. Next Steps

3.1 Subject to the Governing Body approval, the necessary paper work will be submitted to confirm the reappointment.

3.2 The reappointment will also be confirmed to Member Practices and CCG staff via Member and CCG Connect.

4. Recommendations

It is recommended that the Governing Body:

- **APPROVES** the reappointment of John Mallalieu (Lay Member, Finance and Performance) to the Governing Body for a second three year term of office.

Item 10 Appendix 2

1. Introduction

1.1 The Governing Body is asked to make a decision with regard to the reappointment of Dr Rob Atkinson (Secondary Care Specialist) to the Governing Body. His first three year term of office comes to on 31 May 2020.

2. Detail

2.1 As set out in the CCG's current Constitution, the usual term of office of GPs/Nurse Practitioners (including the Chair), lay members, the secondary care specialist and the registered nurse is three years.

2.2 The established practice for lay members, secondary care specialist and the registered nurse on reaching the end of their first three year term is for them to be reappointed for a further period of three years or less (as agreed between the Chair, Chief Officer and individual) subject to satisfactory annual appraisal.

2.3 The above practice/convention complies with the approach recommended in The *NHS Foundation Trust Code of Governance* (2014) for non-Exec Members and is being incorporated into the CCG Constitution as one of the proposed amendments endorsed by the Governing Body in January 2020 and subsequently agreed by the CCG Members. The revised Constitution has been submitted to NHS England to agree this and other changes.

2.4 The Remuneration and Nomination Committee at its meeting on 27th February 2020 considered:

- The established practice for lay members, secondary care specialist and the registered nurse reaching the end of their first three year term and proposed constitutional changes.
- Performance and contribution to the CCG and Governing Body including as a member of the Governing Body, Remuneration and Nominations Committee, Commissioning Primary Medical Services Committee and as the nominated Deputy for the Registered Nurse on the other Committees.
- The completion of a successful appraisal in 2019.
- The current needs and priorities of the Governing Body and CCG following recent changes in Governing Body membership and changes to the CCG's formal governance arrangements.

2.5 The committee agreed to recommend that Dr Rob Atkinson (Secondary Care Specialist) be reappointed to the Governing Body for a second three year term of office.

3. Next Steps

3.1 Subject to the Governing Body approval, the necessary paper work will be submitted to confirm the reappointment.

3.2 The reappointment will also be confirmed to Member Practices and CCG staff via the usual routes.

4. Recommendations

It is recommended that the Governing Body:

- **APPROVES** the reappointment of Dr Rob Atkinson (Secondary Care Specialist) to the Governing Body for a second three year term of office.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	23/04/2020
Title of Report	**CCG Committee Membership 2020/21**	**Agenda Item No.**	11
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	Steven Cleasby, CCG Chair, GP Governing Body Member	**Responsible Officer**	Neil Smurthwaite (Chief Finance Officer/Deputy Chief Officer)

Executive Summary							
Please include a brief summary of the purpose of the report	As required by the CCG's Constitution, the Governing Body is asked to approve a number of appointments to its committees following recruitments and other changes to the membership on the Governing Body. In approving these appointments, the Governing Body is asked to ratify changes to the Audit Committee's Terms of Reference (Membership) which were approved by the CCG's Chair and Chief Finance Officer/Deputy Chief Officer between meetings under urgent powers provided by the Constitution.						
Previous consideration	**Name of meeting**	Remuneration and Nomination Committee	**Meeting Date**	27/02/2020			
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: 1. **NOTES** those appointments which are statutory requirements and **APPROVES** all other appointments. 2. **RATIFIES** changes to the Audit Committee's Terms of Reference.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications						
Quality & Safety implications	None					
Engagement & Equality implications	Committee Chairs and Lead Officers have had input concerning committee appointments. Dr Maj Azeb and Dr Caroline Taylor were consulted concerning the use of urgent powers in relation to the Audit Committee Terms of Reference (Membership) as required by the Constitution.					
Resources / Finance implications	None					
Has a Data Protection Impact Assessment (DPIA)	**Yes**		**No**		**N/A**	X

been completed?							
Strategic Objectives?	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**			None		
Legal / CCG Constitutional Implications	The CCG must ensure that the membership and roles on the Audit, Remuneration and Nomination and Commissioning Primary Medical Services Committees comply with the relevant statutory requirements including the NHS CCG Regulations 2012; the Health and Social Care Act 2012; and the *Managing Conflicts of Interest: Revised statutory Guidance for CCGs 2017*).	**Conflicts of Interest**			Any conflicts of interest will be managed in accordance with the CCG's Management of Conflicts of Interest Policy.		

1.0 Introduction

1.1 As required by the CCG's Constitution, the Governing Body is asked to approve a number of appointments to its committees following recruitments and other changes to the membership of the Governing Body.

1.2 In approving these appointments, the Governing Body is also asked to ratify changes the Audit Committee's Terms of Reference (Membership) which were approved by the CCG's Chair and Chief Finance Officer/Deputy Chief Officer between meetings under urgent powers provided by the Constitution.

2.0 Detail

2.1.1 The Governing Body has appointed the following committees and sub-committees:

- Audit Committee (Statutory Committee)
- Remuneration and Nomination Committee (Statutory Committee – Remuneration element)
- Commissioning Primary Medical Services Committee (Mandated Committee)
- Quality, Finance and Performance Committee (CCG Established)

2.1.2 The proposed appointments are in line with the relevant committees' TOR which comply with the relevant statutory requirements and guidance[1].

2.1.4 The proposed changes are set out below at 2.6 and a full list of the amended committee memberships and positions for 2020/21 is provided at Appendix 1.

2.1.3 With regard to the Audit Committee's membership and Terms of Reference, the CCG's Chair and Chief Finance Officer/Deputy Chief Officer agreed a change to these between Governing Body meetings under urgent powers provided by the Constitution. The New Model Constitution for CCGs requires that the Audit Committee Terms of Reference be included as an appendix and is therefore also subject to the approval of the CCG membership and NHS England. Following the Governing Body' decision to endorse a revised CCG Constitution to the CCG membership at its Januarys 2020 meeting, the following changes were agreed to the Audit Committee Terms of Reference (Membership) between meetings in order that an up-to-date version could be included when the Constitution was circulated to CCG members for their approval.

2.1.4 The changes to the Audit Committee Terms of Reference (Membership) for Governing Body ratification are as follows:

Amended Membership	Details of change
▪ Lay Member with expertise/experience in financial management/audit matters (who will act as Chair) ▪ Lay Member (Finance and Performance) ▪ Lay Member (Lay Member – Public and Patient Involvement (PPI) ▪ Lay Advisor	▪ Lay Advisor joins the committee membership. ▪ The PPI Lay Member has been moved to a separate line in the membership. Was previously included under: "Two other non-GP members of the Governing Body (Lay Member – PPI, Registered Nurse or

[1] These include the NHS CCG Regulations 2012; the Health and Social Care Act 2012; the *Managing Conflicts of Interest: Revised statutory Guidance for CCGs 2017* and other relevant guidance

▪ Registered Nurse or Secondary Care Specialist ▪ One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.	Secondary Care Specialist). This change reflects means the PPI Lay Member is now required to attend each meeting.

2.1.5 Appointments were considered by the Remuneration and Nomination Committee at its meeting on 27 February 2020. Having assured itself that the changes are in accordance with the committees' Terms of Reference and that committees would continue to have the appropriate balance of skills, experience, knowledge, perspectives and independence to enable them to discharge their respective duties and responsibilities effectively, recommended them to the Governing for its approval.

2.6 **Proposed Appointments**

Audit Committee

a) Denise Cheng-Carter (Lay Advisor) and Alison MacDonald (Lay Member, PPI) join the committee as required by the Committee's Terms of Reference.

b) Peter Roberts (Lay Member, Audit) joins the committee and will act as committee Chair in accordance with the committee's Terms of Reference and **statutory** requirements.

Quality, Finance and Performance Committee

a) Dr Farrukh Javid and Dr Caroline Taylor are confirmed as the two GP Members on the committee.

b) Dr Farrukh Javid is confirmed as the committee Chair. The committee's Terms of Reference requires that the committee is chaired by one of its two GP members.

c) John Mallalieu (Lay Member, Finance and Performance) is confirmed as the Deputy Chair on the Quality, Finance and Performance Committee. The committee's Terms of reference require that the Deputy Chair is one of the two Lay Members on the committee.

d) Alison MacDonald (Lay Member, PPI) joins the committee in accordance with the committee's Terms of Reference.

Commissioning Primary Medical Services Committee

a) Dr James Gray (GP Member) joins the Commissioning Primary Medical Services Committee as one of the committee's the two GP members. He replaces Dr Helen Davies (GP Member) who stepped down as a Governing Body Member from the 31 March 2020

b) Alison MacDonald (Lay Member, PPI) joins the committee in accordance with the committee's Terms of Reference. She will be the committee's Deputy Chair in accordance with **statutory** guidance. Only a Lay Member can be the committee's Deputy Chair.

Remuneration and Nomination Committee

c) Alison MacDonald (Lay Member, PPI) joins the committee as required by the committees Term of Reference. She will be the Committee's Deputy Chair in accordance with **statutory** requirements. Only a Lay Member can be the committee's Deputy Chair.

3.0 Next Steps

3.1 Subject to the Governing Body approval:

- All lists held by the CCG Corporate Governance Team will be updated, including email address groups, outlook appointments, attendance registers.

4.0 Recommendations

4.1 It is recommended that the Governing Body:

1. **NOTES** those appointments which are statutory requirements and **APPROVES** all other appointments.

2. **RATIFIES** changes to the Audit Committee's Terms of Reference.

5.0 Appendices

Appendix 1 – Committee Membership 2020/21

Appendix 1

CCG Committee Membership 2020/21

AUDIT COMMITTEE	
Membership	**Members**
▪ Lay Member (Audit) (Chair) ▪ Lay Member (Finance and Performance) ▪ Lay Member (Public Patient Involvement) ▪ Lay Advisor ▪ Registered Nurse **or** Secondary Care Specialist ▪ One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.	Prof. Peter Roberts John Mallalieu Alison MacDonald Denise Cheng-Carter Prof. Rob McSherry Dr Rob Atkinson (Deputy to Reg. Nurse) Dr Farrukh Javid
Lead Officer:	Chief Finance Officer/Deputy Chief Officer

REMUNERATION AND NOMINATION COMMITTEE	
Membership	**Members**
▪ Lay Member (Finance and Performance) (Chair) ▪ Lay Member (Public Patient Involvement) (Deputy Chair) ▪ One GP member of the Governing Body ▪ The Secondary Care Specialist **or** The Registered Nurse The Governing Body Chair is a member of the committee for Nomination elements of the Committee business.	John Mallalieu Alison MacDonald Dr Farrukh Javid Dr Rob Atkinson Prof. Rob McSherry (Deputy to Sec. Care Specialist) Dr Steven Cleasby (Nomination Only)
Lead Officer:	Chief Finance Officer/Deputy Chief Officer

COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE	
Membership	**Members**
▪ Lay Member (Finance and Performance) (Chair) ▪ Lay Member (Public Patient Involvement) (Deputy Chair) ▪ Chief Officer ▪ Chief Finance Officer/Deputy Chief Officer ▪ The Secondary Care Specialist **or** the Registered Nurse ▪ Two GP Members of the Governing Body	John Mallalieu Alison MacDonald Vacant Neil Smurthwaite Dr Rob Atkinson Prof Rob McSherry (Deputy for the Sec. Care Specialist) Dr Steven Cleasby Dr James Gray
Lead Officer:	Head of Primary Care Quality and Improvement

QUALITY, FINANCE AND PERFORMANCE COMMITTEE	
Membership	**Members**
▪ Chief Officer ▪ Chief Finance Officer / Deputy Chief Officer ▪ Chief Quality and Nursing Officer ▪ Two GP Members of the Governing Body *(one of whom will act as Chair)* ▪ Lay Member (Finance &Performance) ▪ Lay Member (Public Patient Involvement) *(one of the Lay Members will act as Deputy Chair)* ▪ Registered Nurse **or** the Secondary Care Specialist as nominated deputy	Vacant Neil Smurthwaite Penny Woodhead Dr Farrukh Javid (Chair) / Dr Caroline Taylor John Mallalieu (Deputy Chair) Alison MacDonald Prof. Rob McSherry Rob Atkinson (Deputy for the Registered Nurse)
Lead Officer:	Chief Officer/Chief Quality and Nursing Officer

Item 12 a

NHS Calderdale Clinical Commissioning Group

Minutes of the Quality, Finance and Performance Meeting held on Thursday 19 December 2019, 2.00pm – 5.30pm, Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present:	Neil Smurthwaite	(NS)	Chief Finance Officer/ Deputy Chief Officer
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	John Mallalieu	(JM)	GB Lay Member (Finance)
	Dr Farrukh Javid	(FJ)	GP Governing Body Member
	Dr Caroline Taylor	(CT)	GP Governing Body Member (Chair)
	Alison MacDonald	(AM)	GB Lay Member (PPI)
	Rob McSherry	(RMc)	GB Registered Nurse
In attendance:	Tim Shields	(TS)	Performance Manager
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Head of Finance
	Caron Walker	(CW)	Public Health Consultant, Calderdale Council
	Debbie Winder	(DW)	Head of Quality
	Helen Foster	(HF)	Medicines Management Lead (representative for DR)
	Rhona Radley	(RR)	Deputy Head of Service improvement
	Kym Brearley	(KB)	Project Coordinator Service Improvement
	Andrew Bottomley	(AB)	Programme Manager Service Improvement
	Lucy Walker	(LW)	Quality Manager Calderdale
	Rob Gibson	(RG)	Risk Manager
	Luke Turnbull	(LT)	Designated Professional Safeguarding Adults
	Sarah Antemes	(SA)	Head of Continuing Healthcare, Mental Health and Learning Disability Services
Observing:	Michaela Mallon	(MM)	Quality Manager North Kirklees
	Denise Cheng-Carter	(DCC)	Lay Advisor (Governing Body)
Minute Taker:	Zoe Akesson	(ZA)	Senior Administrator, Corporate Services

020/19 APOLOGIES FOR ABSENCE **Action**

Apologies were received from Debbie Robinson, Debbie Graham, Dr Matt Walsh and Dr Majid Azeb.

021/19 DECLARATIONS OF INTEREST

Members of the Committee were invited to declare any interests relevant to items on the agenda.

The GP members declared their interest in agenda item 7 the GP Access Scheme for Calderdale CCG Member Practices and item 12 the GP incident report. With regards to the latter, if a discussion developed about individual practices the GPs would be required to declare at that point.

There were no further declarations of interest.
The Register of Interests can be obtained from the CCG's website https://www.calderdaleccg.nhs.uk/register-of-interests or from the CCG's headquarters.

022/19 MINUTES OF THE PREVIOUS MEETING

Minutes of the Quality, Finance and Performance Committee meeting on 26th September 2019

DECISION:
The minutes of the 26th September 2019 meeting were **RECEIVED** and **ACCEPTED** as a correct record.

023/19 MATTERS ARISING

The meeting noted that the action relating to minute 106/19-b (CHFT complaints performance) an update would be included in quality dashboard. All other actions were closed.

024/19 REQUEST TO DELEGATE AUTHORITY FOR SIGN-OFF FOR THE FOLLOWING SERVICE SPECIFICATIONS

Due to the scheduled timing of the Quality, Finance and Performance Committee (QFPC) and the number of specifications/ business cases being brought for decision, the Committee was asked to delegate authority to a sub-group to make a decision on its behalf on the following 3 specifications;

a) Calderdale Open Minds Partnership THRIVE, which was a revision to the specification last approved 4 years ago. There was no financial impact.

b) Older Adults Mental Health Intensive Support Service specification, to be created on a broader model and to include funding that was agreed at Governing Body.

c) General Practice Access Scheme for Calderdale CCG Member Practices included finance which would be a Calderdale Primary Medical Services Committee delegated authority decision.

Following a short discussion, the Committee concluded the sub-group would consist of the minimum quoracy of the QFPC. Specifications a) and b) would require the minimum quoracy and c) would require alternative quoracy due to the Clinical Chair's conflict of interest and financial decision.

The Lead/s would be required to send a short paper to all members of the QFPC stating what was required from the sub-group, prior to the meeting. In future where delegation was being sort a paper outlining the request would be required at Committee

ACTION: PW to take a conversation to SMT and would also pick up with the Chair and Accountable Lead regarding the process going forwards. **PW**

DECISION:
The Committee **AGREED** in principle, to delegate authority to sub-groups for a decision on the specifications, subject to the above.

025/19 CALDERDALE AND KIRKLEES CAMHS CRISIS/INTENSIVE HOME-BASED TREATMENT EXTENDED HOURS, AND ALL-AGE LIAISON SERVICE MODEL

RR presented the paper for the All Age Liaison Service model, which builds on the existing service that is already in place. The model would enhance the psychiatric liaison service and develop it into an integrated all age service for crisis. It was noted there is nationally identified funding available and it is one of the CCG's priorities for mental health. The model had already been approved in Greater Huddersfield and was in existence at Wakefield. The Committee was asked to recommend the model for approval.

Questions and comments were invited;

- AM commented on crisis support and how it links to other groups within the community.
- NS clarified that the paper had been discussed at SMT on 16th December 2019 where it was proposed the Committee would recommend to Governing Body for approval.
- PW added the model builds more capacity into the system by providing a place for people, in particular children and young people, before reaching Tier 4.
- There was a short discussion around evidencing the quality of the model and the need for assurance around the pathway and timeline.
- RR explained the Provider is going at risk until the end of March 2020 and funding would be required from April.
- RR confirmed work had commenced on planning and recruitment and would communicate comments received from the Committee to the working group.

DECISION:
The Committee **RECOMMENDED** that Governing Body approves this investment.

026/19 COMMUNITY DERMATOLOGY SERVICE SPECIFICATION FOR CALDERDALE

AB and KB presented the Community Dermatology Service specification for a formal procurement process starting early 2020 with a contract date of 1st October 2020. It had been taken to SMT on 16th December 2019 where comments had been received and had since been addressed. The Committee was asked to approve the quality aspect of the specification taking into account the QIA and EQIA findings and recommend to Governing Body for the approval of investment.

Questions and comments were invited.

- FJ asked for more clarification on tele-dermatology, training and self-care. The Committee agreed these were explanatory rather than material changes to the model. FJ would work with AB on the changes. Following a short discussion, the item concluded with the Committee agreeing it was confident for the procurement to start, subject to some clarification and speaking with primary care colleagues around language and ambiguity. There was also a need to define the training aspect for the purpose of the provider so they know what they would be bidding to do.

DECISION:
The Committee **NOTED** the QIA and EQIA findings. The Committee **REVIEWED** and **RECOMMENDED** the Dermatology specification for Calderdale subject to comment.

027/19 QUALITY & SAFETY REPORT AND DASHBOARD

In presenting the report LW highlighted the following key points:

Yorkshire Ambulance Service Care Quality Commission Inspection Report
There was a positive change for the Patient Transport Services CQC rating from requires improvement to good.

Commissioning for Quality and Innovation (CQUINs)
There had been a change for providers on how they submit CQUINs. The process had been simplified through the use of a portal. Although there was no requirement for CQUINs to be reported on a quarterly basis, main providers agreed to continue providing information to the CCG, which would be reported in the dashboard.

Serious Incidents Quarters 1 and 2
It was noted this would no longer be a standalone report at QFPC and would be included in the Quality and Safety Report going forwards.

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) had its first learning and sharing event in October, which was well received by Trust.
- South West Yorkshire Partnership Foundation Trust was still finding the 60 day timescale challenging but the standard of their serious incident reports continued to be of a high standard. Process mapping work was taking place in internal teams to streamline and reduce the timescales.

Quality Dashboard

- The action plan evidence from the serious incidents and never events regarding air and oxygen had been reviewed and surveillance had moved from enhanced back to normal. Learning had been shared with the WY Association of Acute Trusts Group (WYAAT).
- An update on the ongoing work on complaints had been received at CHFT Quality Board. The Trust was working on patient stories following complaints and feeding back to clinicians to gain impact when investigating complaints.
- Internal audit received a level of assurance when reviewing the updated internal processes for CAS alerts, which would be reflected on the dashboard going forward.
- SWYPFT had been working on a process to investigate complaints within the given timeframe. Following work on the action plan, SWYPFT had invited internal audit back in January to assess the improvements. There have been some data quality issues with the migration of the risk assessments onto SystmOne and an improved position was reported on reducing out of area beds.

Care Homes

- Calderdale Retreat - work continued following the CQC inspection. There would be a collaborative approach to training, which would commence in January.
- Hazelroyd - had appointed a new manager and an action plan was in place. A contract meeting was planned for January.
- Claremount - a safeguarding meeting took place in December and an extensive improvement plan was put in place. A new manager was appointed. The Safeguarding and Continuing Health Care (CHC) teams were due to revisit the home at the end of December and early 2020.
- White Windows - the home was now part of the Valorum Care Group. Their rating had gone from adequate to requires improvement. The Head of CHC

and Calderdale MBC agreed they would work together, sharing their improvement plans.

DECISION:
The Committee **NOTED** the contents of the report and was **ASSURED** with the update.

028/19 FINANCE REPORT

LS presented the key messages for month 8.

The CCG was reporting to achieve its financial plan. With regards to contingency levels and future planning, the CCG was now in a favourable position of being able to deliver its cumulative surplus of £5.6m, which was above its original plan of in-year breakeven position of £4.6m. In light of this, the CCG was now planning to adjust its 2019/20 control total and increase it by £1m.

The delivery of the CCG's quality, innovation, productivity and prevention (QIPP target remained on track.

The CCG is forecasting to deliver £600k in running cost savings against a target of £700k, which was positive however next year there would be a cut in its running cost allocation. The CCG would be required to make a saving of around £1m to make the structure and future costs of the CCG affordable. Significant cost savings of over £800k after taking into account some cost pressures have already been made but there would be a remaining gap of around £368k. LS assured the Committee that progress was being made to close this gap and plans had been developed for a sustainable management structure within the reduced running cost allocation in 2020/21 and beyond.

The Committee was updated on the Long Term Plan (LTP). The CCG submitted its latest plan on 1st November 2019, a summary of which was included in the report. The paper set out a high level national plan and key assumptions that the CCG had made as part of its planning. Asks of the LTP were around the mental health investment standard and to see spending in community care, primary care and continuing healthcare services. There would be a process refreshing in January 2020 when more in-depth planning guidance would be received resulting in a possible resubmission before March, which would include the CCGs contract negotiations for 2020.

There were a number of potential risks, which could materialise during the year however at present the CCG was confident those risks could be managed.

Due to a period of stability and under spending on running costs the CCG was in a net mitigation position, which was at present £2m more than its risks. For that reason, the CCG was planning to release £1m for a non-recurrent investment plan and the remainder to adjust the control total to support the WY&H Integrated Care System's (ICS) financial position. A number of CCGs within the ICS including Calderdale, have improved their positions to support the ICS overall position. Calderdale reviewed its forecast and in light of the reduced level of risk agreed to support the system by £1m with a view that this would be available to draw down in the future.

Comments and questions were invited.

- The Committee recognised the significant amount of work involving planning

and mitigating risk in order to generate £2m.

- JM gave credit to the team for being in control and playing a positive role within the ICS.
- NS informed the Committee that the team would be investing the non-recurrent funding in known priorities within the Operational plan.

DECISION:
The Committee **NOTED** the contents of the report and was **ASSURED** with the update.

029/19 CONTRACT REPORT

In presenting the report, MP highlighted the following key contract updates:

The overall trading positions for the Acute and Independent Sector were positive for month 7.

Calderdale and Huddersfield NHS Foundation Trust (CHFT)
CHFT's position was stable in Calderdale in line with the Aligned Incentive Contract (AIC) and the activity numbers against plan.

- An area of concern was the elective position in Calderdale. If there was an increase in non-elective activity due to winter there could be an impact on routine elective performance at the Trust.
- The non-elective position was showing an under trade and it is thought this was understated due to the profile being on 12ths rather than on a seasonal basis. The CCG was currently waiting for a re-profile delivery line which would then be delivered in subsequent updates.
- The other NHS non-tariffs were being driven by the direct access tests in relation to the numbers.

Independent Sector - Spamedica
Expenditure had increased over the years with the provider Spamedica who provides cataract surgery and outpatient appointments based on non-contracted activity. MP expressed a desire for Calderdale, Greater Huddersfield and North Kirklees to have its own Any Qualified Provider (AQP) list and pathway for this service. Following a conversation with West Yorkshire quality leads, PW confirmed there was no real quality monitoring with this provider, which carried a risk. The Committee shared the view that as risk and additional spend had been identified and the existing current contract arrangement did not give contractual leverage, MP's suggestion would be a way forward. MP would investigate further.

NS left the room. For quoracy purposes, it was noted that no decisions could be made during this time.

Integrated Urgent Care (IUC)
It was reported that IUC, formally NHS 111, was entering a period of increased activity due to winter.

Improving Access to Psychological Therapies
With regards to contract performance, historically Calderdale had always been above target. However on this occasion it failed to achieve due to the access time target increasing from 19% to 22%. MP gave assurance that the annual accumulative target would be met.

Posture and Mobility Service
The strong start by Ross Care around contract delivery, inherited backlog and

customer communications continued. The CCG was working well with Ross Care on future projections.

Comments and questions were invited.

- PW highlighted the procurement activity and contracts due to expire information would be helpful in the QFPC planning process when prioritising specifications or revisions of specifications for the agenda. PW would pick up in the discussion with SMT.

DECISION:
The Committee **NOTED** the update.

030/19 INFECTION PREVENTION AND CONTROL REPORT

The paper was received by the Committee and taken as read.

The main discussion point was the resignation of the Infection Prevention and Control (IPC) Practitioner. Interviews were unsuccessful in November but Calderdale Metropolitan Borough Council (CMBC) would be re-advertising in January. The Committee was concerned about the risk for both Calderdale and West Yorkshire and asked for it to be put on the risk register. The CCG offered to support CW in her plans to appoint.

Comments and questions were invited.

- It was noted there were 2 practices that declined participation in the E.coli bacteraemia data collection process. The Committee advised, to request support from the Primary Care team around this issue.
  ACTION: To discuss E.coli data collection with the Primary Care Team **HF/DR**

- The HCAI workshop did not go ahead as planned in March 2019. CW would follow-up with CHFT.
- There was a short discussion on the flu assurance section of the report. It was noted information was already reported at the monthly A&E Delivery Board. Further thinking was required around this to avoid duplication.

DECISION:
The Committee **NOTED** the update.

031/19 PERFORMANCE REPORT

TS presented the performance update and the key variances in the standards of the NHS Constitution for month 6.

A&E Performance
On entering Quarter 3 performance was strong at 86.8%, although still below the constitutional standard, the system compared favourably against the regional and national position. It was noted there had been a 4% increase in attendances however it was flow through the hospital that had been the main challenge. CHFT had developed a full flow improvement plan, which was being monitored at the Executive Board.

Elective Care
CHFT had been identified as a pilot site for testing the new waiting times standard

for access to elective care from the standard of 92% to average waiting time. The timeline for the pilot has been extended from November to March 2020.

52 Weeks
Breaches at Leeds Teaching Hospital Trust (LTHT) remained an ongoing issue. There were 9 Calderdale patients waiting for spinal surgery. LTHT was exploring all capacity available. LTHT had a GIRFT review and some pathway recommendations were proposed in a way of managing demand.

Diagnostic Waiting Times
There was still a sustained under performance with diagnostic waiting times however it had improved over recent months due to recovery plans at CHFT starting to have an impact and associated timelines that could be sustained going forwards.

NHS Long Term Plan (LTP)
TS informed the meeting that the LTP would be extending the range of priorities the NHS would be focussing on and in turn the constitutional standards would alter to reflect this. The key areas would be mental health and Primary Care.

Previously the Committee had received updates on reporting progress against priorities on the Improvement and Assessment Framework however this was being replaced with the NHS Oversight Framework which would form the basis of reporting into future committees.

Comments and questions were invited.

PW suggested a piece of work to refresh the dashboard for the quality indicators building on a single framework to avoid repetition.

DECISION:
The Committee **NOTED** the update.

032/19 GP INCIDENT REPORT

RG presented the report for quarters 1 and 2 and highlighted the following key points;

- 191 incidents in total, which was higher than average
- Increase in information governance incidents reported
- 121 patient safety incidents reported
- A number of consistent themes had been identified

Comments and questions were invited.

- JM raised the inconsistency of practices recording on DATIX. It was hoped the lack of equality would be corrected once work had embedded across the Primary Care Networks.
- PW recommend a piece of quality work with the Practice Managers Group around the requirements and priorities for reporting incidents.
- Future reporting of GP incidents, including frequency, assurance about the process and learning would be taken into account when reviewing the committee's work plan.

DECISION:
The Committee **NOTED** the contents of the report.

033/19 RISK REGISTER AND REPORT

RG reported a total of 33 risks for cycle 4, of which 6 were marked for closure. There was one critical risk (62) about the 4hour A&E waiting time. There were 7 new risks, 4 of which scored 12 and these were primarily around commissioned primary medical services. There was an average movement in terms of other risks. The risks for closure were noted.

Questions and comments were invited.

- PW asked for the HCAI risk (1317) to be updated to take into account the IPC practitioner risk around capacity and duties, which was discussed earlier in the meeting.
  ACTION: RG to add risk to register prior to GB **RG**

- JM assured the committee that risk1292 (APMS contract expiry) had reached tolerance and would probably be merged into risks 1432 and 1433 when reviewed at the next Calderdale Primary Services Committee meeting.
- The Chair asked RG to amend the labelling to reflect QFPC.

DECISION:

The Committee **REVIEWED** the register and **RECOGNISED** it was a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 4 of 2019-20. The Committee **RECOMMENDED** the register for reporting to Governing Body subject to the amendments above.

034/19 SAFEGUARDING REPORT

LT presented the Joint Safeguarding Children and Adults report for Quarters 1 and 2. The following key points were raised:

The replacement of the Deprivations of Liberties Standards, Liberty Protection Safeguards come into force in October 2020. The safeguarding team was working with CHC to ensure the backlog of Deprivation of Liberty Safeguard applications were completed by this date. The team was planning to bring a paper to SMT and Governing Body to highlight the risks of the implementation of the new Liberty Protection Safeguards. LT would be leading the unified response for Calderdale.

With regards to safeguarding and the mental capacity act within the WY & H Integrated Care System (ICS), 2 meetings had taken place with designated nurses across the ICS footprint. There were named leads for particular topics that linked in with the Directors of Nursing and ICS leads.

Questions and comments were invited.

- PW briefly spoke about the NHSE/NHSI Safeguarding Children and Young People and Adults in the NHS: Safeguarding Accountability and Assurance Framework (SAAF). Following the publication of the new document, a review was undertaken to ensure the CCG continues to demonstrate compliance with the SAAF. It was also be looked at by internal audit around what we are expected to do, the results of which will be reported into QFP.
- With regards to the Liberty Protection Safeguards, PW informed the Committee that resource would be required for support to help GB understand the changes and implications. PW had discussed with LS, Head of Finance, and although it was not in the operational plan project support would be required to help the CCG through this process.

- LT had submitted an application to the NHSE Leadership Academy Training Programme around long term change and transformation. The bid was to allow the safeguarding team to support the implementation of the LPS and PW was pleased to announce the application had been successful.
- The Committee was content with the new style report.

DECISION:

The Committee **NOTED** the update.

035/19 COMPLAINTS REPORT

LW presented the report for quarters 1 and 2. The following points were noted;

There had been an increase in complaint contacts of around 40%, which were mostly level 1 contacts. It was thought the increase was due to a new enquiry system log held by the Corporate Team. The number of contacts was expected to increase in quarters 3 and 4, as the process embeds.

The majority of the complaints related to Continuing Healthcare, which was not a new theme.

In quarter 1, the CCG was notified that the Parliamentary Ombudsman was looking into a historical complaint on wheelchairs. A provisional report had been received. Actions following this would be included in the Complaints Annual Report. SMT would have oversight of the action plan and the QFPC would receive the action plan for assurance.

DECISION:

The Committee **NOTED** the update.

036/19 CONTINUING HEALTHCARE GOVERNANCE ASSURANCE

SA presented a paper which gave an overview of clinical activity and workload of the Continuing Healthcare Team, providing assurance about the safe and effective delivery of continuing healthcare.

The paper provided a summary of performance relating to quality issues and standards, of which Calderdale performed well. The report described how the team was providing active case management for a significant amount of people including many out of area, which was time intensive and a high clinical risk. For those not under case management, reviews are being prioritised and the list is reviewed on a monthly basis.

There was a number of patients identified requiring assessment under the Deprivation of Liberty Safeguards. These assessments would be completed on a priority basis.

The report also made reference to a Subject Access Request and a number of recommendations. The report outlined the process undertaken and it was acknowledged that the team was on track with this work.

SA asked the Committee for their suggestions on future reporting requirements. The following comments were received;

- For the Committee to understand the scale of problems and be able to support the team in the future, it would be helpful to see an analysis of trends over time in relation to numbers and complexity of cases.
- For assurance the Committee would like to see the report include improvement work and narrative to support the data.
- SMT would have operational oversight and decide on the frequency of reporting.

DECISION:

The Committee **NOTED** the content of the report.

037/19 MEDICINES MANAGEMENT 6 MONTHLY REPORT

In presenting the Medicines Management Report for quarters 1 and 2, HF firstly commented on the financial pressure of prescribing. She briefly spoke about the national stock shortages, which resulted in increased costs and the reason the organisation was forecasting to be overspent this year. Further information would be provided at the next meeting.

HF described the team's delivery of QIPP being on track, mainly due to the Primary Care Prescribing action plan. There had been a number of NHSE low priority prescribing guidances that had emerged since 2018 and as a result the CCG had significantly lowered spend in this area however there remained a considerable opportunity to reduce further.

The Pharmacy Leadership Group, as part of the WY&H Planned Care Programme, was working towards a single area prescribing committee across West Yorkshire.

HF concluded the update by informing the Committee of 2 audits that were being carried out by the North of England Commissioning Support (NECS);

- Identifying patients with chronic pain on harmful doses of OPIODs with the challenge to try to reduce the dose.

- Reviewing vaccination history and antibiotics prescribing for asplenic patients– the CCG was working with Local Authority to improve the situation.

DECISION:

The Committee **RECEIVED** and **NOTED** the contents of the report.

038/19 WORKPLAN

The work plan for 2019-2020, was reviewed and the following comments were made;

- The self-assessment, for the Committee's Annual Review, would shape the work plan for 2020/21.
- To review the workings of the combined committee and if causing practical problems, think about how it could be done differently.
- Specifications and business cases for recommendation to be sent to SMT 4 weeks ahead of QFPC meeting.

- GB and QFPC work plans to sit alongside each other to ensure timeframes work.

039/19 MINUTES AND HIGHLIGHT REPORT

The Committee received the following minutes and reports for reference and assurance;

- Highlight report for the A&E Delivery Board meeting held on 10th September 2019 and 8th October 2019.
- Highlight report for the Integrated Commissioning Executive Highlight Report held on 3rd October 2019.
- Minutes of the Partnership Transformation Board held on 27th August 2019 and 22nd October 2019.
- Minutes of the South West Yorkshire Partnership Foundation Trust Clinical Quality Board held on 7th June 2019 and 27th September 2019.
- Minutes of the Patient and Public Engagement Steering Group held on 18th September 2019.
- Minutes from the Primary Medicines Advisory Group 25th July 2019.

There were no further comments.

DECISION:
The Committee **RECEIVED** and **NOTED** the minutes and reports.

040/19 MATTERS FOR THE;

040/19-a Governing Body

- A decision required for item 5 - All Age Liaison Service Model.
- A decision required for item 6 - Community Dermatology Service Specification.
- Quality and Safety report would include a paragraph on complaints, next steps from GP Incident report and the IPC / AMR work.
- The CFO report would include the contract, finance and performance updates.

040/19-b Senior Management Team

- To agree a process for delegating authority to a subgroup for specifications and business cases.
- To agree a timeline for papers to come to SMT for discussion, prior to QFPC.
- To review the workplan, considering areas of duplication and repetition (GP incident report, flu updates, Quality Indicators)
- To have oversight of the Parliamentary Ombudsman complaint's action plan.
- To have oversight of the CHC Governance Assurance Report and decide on frequency of reporting.

040/19-c Partnership Transformation Board
NA

040/19-d Local Medical Committee
NA

040/19-e Calderdale Primary Medical Services Committee
APMS risks, which may be merged.

041/19 ANY OTHER BUSINESS

There were no further items to discuss.

042/19 DATE AND TIME OF THE NEXT MEETING

The Committee **NOTED** that the next meeting would take place as follows:
26th March 2020, 2.00 – 5.30pm, Shibden Room, Dean Clough

Quality, Finance & Performance Committee 2019-20

Action Log **Last updated** 19/12/2019

Report Title	Minute No.	Action Required	Lead	Current Status	Comments / Completion date
Quality and Safety Report and Dashboard	106/19-b	CHFT complaints performance to be considered at the Clinical Quality Board meeting in October 2019.	AW	Closed	On work plan for CHFT CQB to consider in October 2019. Update provided in December's Q&S Dashboard. Closed Decembe 2019.
Review of Workplan	79/19	To check reporting requirements for the approval of the Mental Health Investment Standards report and statement to comply.	LS	Closed	The CCG was still waiting further guidance. It was a national issue. It was closed and would be reported as part of the finance update when notification had been received from NHSE
Contract Report	103/19-a	To define Other NHS non-tariff variance and escalate if required.	MP	Closed	A verbal explanation was provided at the meeting. The action was closed.
Committee Development Session	**03/19-a**	To make amendments to the TOR to reflect discussion and comments.	JS	Closed	10-Oct-19
Committee Development Session	**03/19-b**	To sign-off final draft TOR for QFP Committee with MW / MA.	JS	Closed	10-Oct-19
Committee Development Session	**03/19-c**	To send the suggested membership to Remuneration and Nomination Committee.	JS	Closed	10-Oct-19
Committee Development Session	**03/19-d**	To submit the final draft of the TOR to Governing Body for approval.	JS	Closed	24-Oct-19
Performance Report – Elective Care	**012/19-a**	NS/TS will provide an update on the impact of the 26 week wait choice pilot at the next meeting.	NS/TS	Closed	Still working through the update on the 26 week wait choice pilot. An update to be provided in the performance report. The action was closed
Request to delegate authority for sign-off for service specifications	**024/19**	PW to take a conversation to SMT and would also pick up with the Chair and Accountable Lead regarding the process going forwards.	PW	Closed	Discussed at SMT on 06/01/20
Infection, Prevention and Control Report	**030/19**	To discuss with the Primary Care team the 2 practices that declined participation in the E.coli data collection	HF/DR	Open	
Risk Register	**033/19**	To update the HCAI risk (1317) to take into account the IPC practitioner risk around capacity and duties in time for GB Meeting	RG	Closed	RG noted that risk was already on the regiser. RG to follow up with Lucy. Action complete

NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee Meeting
Held on Thursday, 9th January, 2020
at the Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax HX1 5ER

FINAL MINUTES

Present	John Mallalieu	(JM)	Governing Body – Lay Member (Chair of the Committee)
	Dr Rob Atkinson	(RA)	Governing Body - Secondary Care Specialist
	Dr Steven Cleasby	(SC)	Governing Body - GP Member (CCG Chair)
	Dr James Gray	(HD)	Governing Body - GP Member
	Neil Smurthwaite	(NS)	Chief Finance Officer/Deputy Chief Officer
In attendance			
	Neil Coulter	(NC)	Senior Primary Care Manager - NHS England/Improvement
	Emma Bownas	(EB)	Senior Primary Care Manager
	Helen Hunter	(HH)	Chief Executive, Health Watch, Kirklees and Calderdale
	Debbie Robinson	(DR)	Head of Primary Care Quality & Improvement
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Head of Finance
	Frances O'Sullivan	(FO)	APMS Project Manager
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Andrew O'Connor	(AO)	Corporate Governance Officer (Minutes)

There was one member of the public in attendance.

01/20 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST **ACTION**

JM welcomed those in attendance. He explained the purpose of the meeting and reminded members of the public that whilst the meeting was being held in public, so they could observe the business of the committee, they would not be able to participate in the discussions, voting or put their own views to members of the committee. He thanked the public for their cooperation.

Apologies were received from: Helen Davies (GP Governing Body Member); Matt Walsh (Chief Officer) and Cllr Tim Swift (Representative of Calderdale Health and Wellbeing Board).

Committee members were invited to declare any interests relevant to items on the agenda.

SC and JG declared a **direct financial interest** in relation to Items 5 and 6 (public section) as general practice contract holders in Calderdale who may at some point benefit or be negatively affected by the proposals. Recognising that SC and JG would bring beneficial clinical input and insight to the discussions, JM proposed that they take part in the initial deliberations but not in the decision making and that they be asked to move their chairs back from the table at the relevant point to signal their withdrawal from the proceedings. Both SC and JG had received the meeting papers. The committee was content with the proposed arrangements for managing the declared conflicts of interest.

SC and JG declared a **direct financial interest** in relation to item 1 (private section) as general practice contract holders in Calderdale who may at some point benefit of be negatively affected by the proposals referenced in the minutes of the Private Section of the committee meeting held on 7 November 2019. JM proposed that SC

and JG be asked the leave the room for this item noting that they had not received a copy of the minutes with their papers. The committee was content with the proposed arrangements for managing the declared conflicts of interest.

The Register of Interests can be obtained from the CCG's website: https://www.calderdal ccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters.

02/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 7 NOVEMBER 2019

DECISION

The minutes of the committee meeting held on 7 November 2019 were **RECEIVED** and **ADOPTED** as a correct record.

Matters arising

- **Action 40/19** – EB confirmed the action was complete and could be closed.
- **Action 38/19** - NS confirmed that a committee decision was not required. The request did not constitute a new request and was within the delegated limits of managers. The action was closed.
- **Action 11/19** – DR confirmed that the committee Terms of Reference would not be amended and that clinical leads involved in the development of proposals would be made clearer in reports with lead clinicians attending meetings as required. The action was closed.

03/19 QUESTIONS FROM THE PUBLIC

There were no questions from the public

04/19 APMS POST CONSULTATION DELIBERATION

DR in presenting the report explained that it provided a summary of the consultation process undertaken, the outcomes of the consultation and proposed next steps. She also explained that information additional to that in the circulated report would be provided in the form of an accompanying presentation and that MP would provide a verbal proposal and recommendation concerning a separate solution for patients in the Upper Calder Valley at Todmorden.

JM drew the committee's attention to the four recommendations as set out which they would need to consider during this agenda item.

PW explained the information presented constituted the final stage in what had been an ongoing deliberation process that had preceded and extended beyond formal consultation and that emerging findings and potential mitigations had been discussed with stakeholders, such Adults, Health and Overview and Scrutiny Board, as part of the process. Detailed discussions had also regularly taken place with the CCG's Senior Management Team throughout.

Findings from the Consultation

- The consultation took place over a six week period from 28 October to 6 December 2019 building on pre-consultation engagement activity and targeting identified stakeholders.

- The response to the consultation had been good. More people had taken part than during the pre-consultation engagement. 832 surveys had been received and 5 drop-ins had taken placed attended by 167 people. The CCG's Engagement Champions had helped to address gaps that had emerged during the pre-consultation engagement.
- Overall finding and themes had been consistent throughout all consultation and engagement activities. These included concerns about returning to a practice where patients had previously been registered (for a variety of reasons); availability of appointments and capacity at other GP practices; travel and transport; continuity of care and good quality care (particularly among vulnerable people including those with complex health needs); anxiety about change and next steps.

The committee confirmed it was in agreement with the main findings and themes set out in the report.

- Equalities themes which had emerged were reviewed and considered throughout the process with additional activities put in place in areas with low response rates, particularly in Park Ward. Engagement Champions had helped support targeted activities. Calderdale Adults, Health and Overview and Scrutiny Board considered the consultation to have been comprehensive and robust. Several areas of underrepresentation persisted and steps had been taken to address these where it was possible. The Equality Impact Assessment (EIA) was noted to propose further mitigations for protected groups.

MP addressed the matter of a separate solution for patients in the Upper Calder Valley at Todmorden. He explained that, following the committee's decision in September 2019 to explore an alternative option for Todmorden, a market test had taken place. The response from the market had been very limited. As such, the view was that a competitive procurement process was not suitable option. Work exploring the impacts of reallocation had resulted in there being concerns about capacity and resilience at the co-located practice should patients be dispersed to it. This concurred with the concerns of local people who had expressed a preference for an alternative proposal. Consequently, Locala had been asked to re-consider its position and had subsequently agreed to continue to provide a service in Todmorden. To allow this, the contract would be varied to exclude Park Community Centre for the rest of the contract (two years). The boundary would also be changed so that it coincides with the Upper Calder Valley Primary Care Network (PCN) boundary. The cost of the contract would reflect reimbursement for the full cost of delivery of services. The benefits of commissioning Primary Care from Locala for Todmorden were said to include:

- Continuity of service provision delivered by the current provider;
- A degree of stability in the short term while PCNs are developed;
- Based on an existing working relationship with Locala;
- Continuation of capacity benefits other practices in the PCN;
- Provided and retained required capacity.

MP went on to report that the proposal would be compliant with procurement rules and that the Adults, Health and Social Care Overview and Scrutiny Board agreed that it would help resolve the situation in terms of access to service in the short term.

In terms of disadvantages, a longer term solution would still be required; the cost of the service would continue to be comparatively expensive; and it would not resolve staff recruitment and retention issues.

In conclusion MP asked that the committee note the proposal and approve the

variation to the contract held with Locala to enable their continued provision of primary care in Todmorden.

JM asked that the committee address the provision of primary care for Todmorden. He explained that he had given his consent to the proposal not being set out in the report as conservations were still ongoing at the time of publication.

Comments and questions were invited from the committee.

- NS noted that the proposal responded to what people had said during the consultation and engagement activities and provided the time that would be required to put in place a longer term solution for the Upper Calder Valley.
- PW reported that the Adults, Health and Social Care Overview and Scrutiny Board was concerned about the quality of primary medical services in the Upper Valley overall and was waiting for a meeting with the CCG and partners to discuss improvements.
- In response to a question, MP confirmed that proposal was financially viable but the services were at a premium. However, taken as part of the wider changes, the overall cost to the CCG was lower. LS added that the reserves to support the cost were available in the five year plan but not necessarily in the long term.
- In response to a question, MP confirmed that new patients would be able to register at the practice.
- SC recognised the proposal was right for patients in the short term and reflected the CCG's understanding of the value of investment in access to general practice. However, he also recognised this would not resolve access issues for all patients in the Upper Valley and that serious efforts would need to be made by the system to find a longer term sustainable solution over the course of the two years including the creation of a geography that could attract and can retain, not only GPs, but the wider primary care and community workforce. He suggested that looking to address and change demand may help practices become more resilient.
- JM summarised that the market had been tested without sufficient response; the public's concerns about capacity had been listened to and confirmed with the co-located practice; and that the proposal provided a pragmatic solution in the short term while a longer term suitable proposal was developed for the Upper Calder Valley as a whole.

The committee confirmed that it understood the proposed model and was comfortable with the proposal.

Moving on to the first part of the presentation concerning the engagement and consultation work undertaken, JM recognised the flexibility with which the work had been undertaken in order to listen to people's views. He also recognised that there was more work to be done in response to the findings which would be addressed during the mitigations element of the presentation.

Comments and questions were invited.

- HH raised a concern regarding people from minority communities being asked to attend another practice when they had originally been encouraged to attend a particular practice by organisations who support refugees and asylum seekers (Park Community Practice). She was concerned there may be a disproportionate impact on those patients due to the loss of established relationships with physicians and the impression that the practice had been better placed to meet their needs and was more accessible to them. There were several responses recognising that whilst high level mitigations were in place and the patients would be captured under the mitigations for vulnerable people and groups, the CCG

needed to ensure that the providers engage with one another to share knowledge and skills and that the provider receiving patients engages with support groups to draw on their expertise and help manage the changeover. The offer of help and support from support organisations working directly with the patients in question was welcomed. EB to progress. It was also noted that patients would benefit from greater continuity in terms of care and contacts as a result of reallocation as staffing at the existing providers had fluctuated. **EB**

DR presented to the committee how the impacts of reallocation would be mitigated noting the quality of the communications would be key. Mitigations reported were as follows:

- Patients would receive letters explaining the practices they could register with if they wanted to change from their reallocated practice.
- Practices would receive appropriate funding to provide the required resource as per the CCG's Policy for Discretionary Financial Assistance to General Practices Impacted as a Result of a List Dispersal.
- Patients would be reallocated to the practice nearest to them geographically. Discussions had taken place with the Local Medical Committee (LMC) and patient lists and numbers had been provided to the practices.
- The possible use of existing sites in Sowerby Bridge and Elland to assist with capacity were being explored.
- A co-ordinated needs assessment would be carried out for vulnerable patients.
- An ongoing communications plan was in place.

The following themes and feedback from practices were highlighted:

- **Workforce** – Investment would be made via the policy as described above.
- **Estates** - Consideration would need to be given to investment in premises to increase capacity.
- **Quality and Outcomes Framework (QOF)** - Practices had been advised that patients who move within last three months of the financial year could be exempted from QOF.
- **Boundaries** – There was willingness to expand practice boundaries but with an expectation that they would not need to undertake the full process. Work undertaken by the CCG in the form of Equality Impact Assessment would be able to be used by the practices to support this process.
- **Reallocation approach** - A preference for a phased approach to reallocation.
- **Patient records** - Concerns about the quality of patient records.

Questions and Comments were invited:

- In response to a question, it was confirmed that people had the right to ask to register at any practice but that boundaries could be used by practices as a reasons to refuse an application.
- In response to a question, it was confirmed that the existing properties being considered for use to provided additional car parking and clinical space were owned by NHS Property Services.
- PW confirmed that a Task and Finish Group would have oversight of mitigating actions and work plans as set out in Quality and Equality Impact Assessments with any emerging issues being brought to the attention of the committee via the committee's operational group. The committee confirmed it would like to be kept informed of risks and progress made via future Lead Officer reports. **DR**
- In response to a question, NS confirmed that the concern about patient records arose due to issues that had arisen during a previous dispersal. He confirmed all patient records would be electronic and there was not an expectation of similar problems. He also confirmed there was an ongoing offer of support available for

practices in term of records management via the CCG's Data Quality Team. JM clarified that practices had expressed a concern but that was all it was to date.

- In response to a question, DR confirmed that the phased reallocation must have taken place by the 31 March 2020 (commencing at the end of January 2020). FO confirmed that the rate practices registered patients was at the discretion of the practice.
- HH volunteered her support in terms of reviewing communication materials which were welcomed EB to liaise with HH. **EB**

In concluding the discussions and presentation, DR summarised the next steps as follows:

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- Supporting funding for allocated patients, workforce and recruitment, premises upgrade and securing current premises solutions.
- The phased reallocation of patients.
- Ongoing support and direction by the CCG's Senior Management Team.

At this point in the meeting SC and JG pushed their chairs back from the table to indicate their withdrawal from the proceedings.

DECISION

The Committee;

1. **RECEIVED** and **DISCUSSED** the draft Consultation Report (Appendix 1).
2. **NOTED** the consultation process undertaken and **CONFIRMED** their confidence that the impact upon patients has been captured and mitigations recognised in the recommendations.
3. **APPROVED** the recommendation for a separate solution for patients in the Upper Calder Valley at Todmorden, specifically the variation to the Locala contract to enable its continued provision of primary care in Todmorden for a period of two years.
4. **ENDORSED** the agreed recommendation for the locally managed allocation of the patients registered at the following sites; Park, Ovenden, Elland and Sowerby Bridge

NS asked the committee to note the significant amount of work that taken place across and between teams to date.

In response to a question, NS confirmed that the Lead Officers would now need to address the work that would be required to deliver a longer term solution for the Upper Calder Valley.

SC and JG re-joined the meeting.

05/19 **PRIMARY MEDICAL SERVICES – NON-RECURRENT SPENDING PLAN 2019/20**

DR in presenting the report explained that it provided an update to the committee on proposals to invest non-recurrent funding from the delegated budget and sought approval for additional investment for the General Practice additional on the day appointments scheme. The scheme had already been agreed in principle by the committee at its meeting in September 2019, with part of the investment provided from Primary Medical Services (PMS) premium funding. The paper presented requested the remainder of the required funding of £155k from non-recurrent underspends.

Noting the previous decisions and the clinical leads that had been involved

(Appendix 1), JM invited questions and comments.

- In response to a question about direct bookable appointments being available to A&E, EB confirmed that the IT system would not be in place for the start of the pilot but assured the committee that the ambition was in place. SC added that the ability to direct book was already available to a limited extent but usage was low which needed to be addressed.

At this point SC and JG moved their chairs back from the table to indicate their withdrawal from the proceedings.

DECISION

The Committee:

1. **NOTED** the prioritisation of the plans that took place between august and November 2019.
2. **NOTED** the level of Clinical Leadership invested in developing the plans.
3. **NOTED** the plans for investment of non-recurrent funding.
4. **APPROVED** the investment for General Practice Additional on the day Appointments scheme.

NS asked the committee note of a risk emerging through the A&E Delivery Board. Concerns had been raised regarding the capacity of GPs to cover commissioned activity and he asked the committee note that the decision taken may have an unintentional impact. Conversations were taking place with the Local Medical Committee. DR assured the committee that the PCN Clinical Directors were confident they could deliver what had been proposed. EB added that the shift to allow Prescribing Clinicians to provide the appointments had been useful but that during the pilot the impact on out-of-hours would need to be monitored. NS concurred emphasising that it need to monitor the impact with and on the wider system. The committee was in agreement. SC added that there was a need for a holistic system approach to manage demand. LS confirmed that £3.1m would be invested over the next three years to provide additional roles in Calderdale which would help to build capacity and support delivery of the required system wide changes.

06/19 Date and time of next meetings in public

The Committee **NOTED** that the next meeting would take place on:

Thursday 23rd April 2020, 11am – 1:30pm at the Elsie Whitely Innovation Centre, Hopwood Lane, Halifax. HX1 5ER

07/19 EXCLUSION OF THE PUBLIC

DECISION:

The CPMS Committee **AGREED** that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Commissioning Primary Medical Services Committee Meeting 9th January 2019 – Action Sheet

Agenda item	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
5	**04/20**	Via the Task & Finish Group's communication and engagement plan, CCG to ensure that the providers engage with one another to share knowledge and skills to support vulnerable patients and that the providers receiving patients engage with support groups to draw on their expertise and help manage the changeover.	**EB**	**Complete**	**14/01/2020**
5	**04/20**	The committee confirmed it would like to be kept informed of risks and progress made arising from ongoing mitigations activity via future Lead Officer reports.	**DR**	**Ongoing**	**23/04/2020**
1	**04/20**	Prior to circulation, EB to share and review Easy Read letter with HH.	**EB**	**Complete**	**06/02/2020**