Agenda Item: 3

NHS
Calderdale
Clinical Commissioning Group

Minutes of the Public Section of the Governing Body Meeting held on 11 August 2016, 2pm, at The Shay Stadium, Halifax.

DRAFT MINUTES

Present	Dr Alan Brook	(AB)	Chair
	David Longstaff	(DL)	Lay Member and Deputy Chair
	Dr Matt Walsh	(MW)	Chief Officer
	Lesley Stokey	(LS)	Interim Chief Finance Officer
	Jackie Bird	(JB)	Registered Nurse
	Rajesh Phatak	(RP)	Secondary Care Specialist
	Kate Smyth	(KS)	Lay Member (Patient and Public Involvement)
	Dr Steven Cleasby	(SC)	GP Member
	Dr Caroline Taylor	(CT)	GP Member
	Dr John Taylor	(JT)	GP Member
	Dr Nigel Taylor	(NT)	GP Member
	Dr Lubna Saghir	(LSa)	GP Member
Invitees	John Mallalieu	(JM)	Lay Advisor to the Governing Body
	Penny Woodhead	(PW)	Head of Quality
	Paul Butcher	(PB)	Director of Public Health, Calderdale Council
In attendance	Judith Salter	(JS)	Corporate and Governance Manager
	Debbie Graham	(DG)	Head of Service Improvement (for Agenda Items 4 & 10c)
	Jen Mulcahy	(JMu)	PMO Manager (Agenda Item 8)
	Thomas Britcliffe	(TB)	Property Strategy Manager, NHS Property Services Ltd (Agenda Item 9)
	Robert Gibson	(RG)	Risk, Health and Safety Manager (for Agenda Item 11)
	Neil Smurthwaite	(NS)	Chief Finance Officer from 1st September 2016
	Andrew O'Connor	(SH)	Corporate and Governance Officer (Minutes)
			Plus 6 members of the public.

78/16 APOLOGIES FOR ABSENCE

AB welcomed LSa to the Governing Body as the CCG's new GP Member. AB also welcomed NS who would be joining the CCG as Chief Finance Officer from the 1st September 2016.

Apologies were received from Dr Majid Azeb (GP Member) and Bev Maybury (Director of Adult Health and Social Care Services, Calderdale Council).

79/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

80/16 MINUTES OF THE PUBLIC SECTION OF THE MEETING HELD ON 9th JUNE 2016

DECISION:

The minutes of the public section of meeting held on the 9th June 2016 were received and adopted as a correct record.

81/16 ACTIONS

Min. 74/16: Review of Commissioning Engagement Scheme

MW reported that informal feedback from practices and clinical leads indicated a high level of engagement. A practice which had chosen not to sign up to the commissioning engagement scheme was said to still be engaged via discussions at both a practice and locality levels. The CCG's SMT had assessed the risk as low. A formal report evaluating the scheme would be received the Finance and Performance Committee at mid-year.

82/16 IMPROVING CARE FOR PATIENTS: TRANSFERS OF CARE:

DG introduced a video created by the Health Service Journal. The video used a patient's story to explore the impact that delays in transfer of care, particularly in hospitals, had on patients. DG noted that the patient's story provided a powerful reminder of the importance of this issue.

A video was played.

DG spoke to her report. A local transfer of care plan had been developed by the System Resilience Group. The plan was based on the eight evidence based high impact changes that had been developed nationally. The issue was noted to require a range and breadth of interventions to deliver improvements in patient care, services and value for money. The high levels of additional cost arising from care being delivered in the wrong setting were emphasised.

Under 3.5 in the report, attention was drawn to the results of a self-assessment that had been undertaken and targets for improvement.

Under 4.3, improvements in 2015/16 against formally reported Delayed Transfers of Care (DTOC) indicators were highlighted. The Governing Body was asked to note that, while there had been improvements for those patients formally recognised as delayed, this represented a small number in terms of the total number of service users known to be on a discharge pathway. DG advised that this larger cohort would be the focal point for improvement going forward. A trajectory for this larger group was being developed and a discharge pathway dashboard had been put in place enabling co-located Discharge Teams at Calderdale Royal Hospital and at Huddersfield Royal Infirmary to view and share real-time patient data.

Questions and comments were invited from the meeting.

SC commented positively on the reduction in the percentage of occupied beds due to delays. He then asked what outcomes could be expected from proposals, given that the CCG was already meeting national targets.

In response, DG explained that, whilst performance against the national DOTC performance indicators was positive, this represented a small percentage of the individuals known to be on a discharge pathway. 130-180 people were estimated to be on a discharge pathway at any one time. DG said the changes would reduce the length of time these patients spent in hospital by helping to reduce admissions, improving patient flow through hospitals and developing new models of care in a variety of settings.
PW asked how the Governing Body would be assured about the underlying changes

required to deliver the plan and improved outcomes for patients.

DG responded that the Finance and Performance Committee received the formally reportable DTOC figures and that it would receive figures for all patients on a discharge pathway in the future. In terms of the Governing Body being assured regarding progress against the set improvement targets, DG advised that movement between the levels of delivery were clearly defined and that arrangements could be put in place to submit reports to the Quality Committee. PW, in response, noted that delays in transfers of care appeared as a high level risk on the CCG's Risk Register. She suggested that it might be beneficial for this risk to be broken down, allowing it to be described and understood in greater depth by the Governing Body.

Having recognised the System Resilience Group's wider remit in terms of the plan, MW highlighted the importance of Calderdale CCG developing a clear understanding of how the issue impacted specifically on the Calderdale population.

JT welcomed the report. He and other Governing Body members had recently visited rehabilitation wards and commented on the impact of delays in the pathways. Some traditional procedural barriers would need to be addressed to reduce delays and this would require cooperation across the system.

KS asked whether the CCG had information concerning the proportion of those waiting for home care compared to those waiting for beds. DG responded that this information was available as part of the high level overview provided on the Discharge Pathways Dashboard. Furthermore, that staff at Calderdale and Huddersfield hospitals could see reasons for delays at a patient identifiable level.

In response to a further question from KS regarding the standard of advocacy services in Calderdale, DG responded that there were some third sector services working in the hospitals but that this element of service required improvement and, as such, was part of the overall plan.

Noting the importance of keeping patients active and mobile, MW suggested that conversations about this issue needed to be taking place with the hospitals. PB agreed, querying whether the importance of continued mobility was something understood by and highlighted to hospital staff. AB noted that stays in hospital needed to be minimised when it was in the best interest of the patient. PW, spoke of bringing the learning from the Royal College of Nursing programme into the work being undertaken on DTOC and the CCG's out of hospital care work. The need for a Clinical Development Forum discussion concerning this was noted.

SC queried whether the aspirations in the plan were high enough and whether some changes could be delivered sooner. DG replied that some of the changes were significant but that it might be possible for others to be moved forward at an accelerated pace. She added that a more sophisticated approach to targeting might be needed to reflect this.

AB noted that the Governing Body had recognised the importance of the issue and that the plan had significant aspirations for change and improvement across the system. He reminded the meeting that progress would be monitored via the CCG's Finance and Performance and Quality Committees. In terms of future updates to the Governing Body, it was agreed that information would be brought on a six monthly basis as part of the Performance Report.

DECISION:

The Governing Body **RECEIVED** the report on the development of a Systems Resilience Group (SRG) Transfer of Care Plan.

83/16 QUESTIONS FROM THE PUBLIC

The first question was noted to have been submitted by Jenny Shepard:

1) **What is the content of the discussions taking place with NHS England in relation to the impact of the Calderdale and Huddersfield NHS Foundation Trust's (CHFT) agreement with NHS Improvement (NHSI) which enables Calderdale and Huddersfield NHS Foundation Trust (CHFT) to access Sustainability and Transformation funding for 16-17?**

MW thanked Jenny for her question. With regard to the specifics of the conversations taking place between NHS Improvement, Calderdale and Huddersfield Foundation Trust and NHS England (NHSE), MW replied that these questions would be best directed to the organisations themselves.

With regard to NHS Calderdale CCG's position on the NHS constitutional standards, he said that the standards continued to be the CCG's constitutional commitment, as articulated in its own constitution. Furthermore, that the CCG, in its brief conversations with NHSE, had rearticulated this ongoing commitment and system wide expectation. MW added that he would comment further on related issues in his Chief Officer's report.

The second question was noted to be from Gordon Bache of Roche Products Limited.

2) **What are the current work streams under the healthy futures programme for cancer and what progress is currently being made in implementation of the independent cancer taskforce report recommendations, particularly in relation to the formation of a cancer alliance?"**

MW thanked Gordon for his question. In response he replied that it would be more appropriate for the questions to be dealt with directly by the Healthy Futures programme team and as such had been forwarded to the team for a written response. He added that West Yorkshire was in a strong position to act once NHSE provided greater clarity about its expectations in relation to the creation of cancer alliances. The content of the regional cancer workstream was said to cover prevention, early diagnosis, improving access to diagnostics, survivorship and end of life care.

84/16 PETITIONS

a) Petitions received by Calderdale CCG

AB reported that on the 20th June 2016, the CCG received 4 petitions, submitted by Calderdale 38 Degrees NHS Campaign Group. AB announced the petitions received as follows:

PETITION ONE:

1) "Say no to downgrading of A&E: We the undersigned demand that there is no downgrading to Calderdale or Huddersfield Accident & Emergency Department and instead call for a huge investment in services to provide safe and decent staffing levels."**: 2639 signatures (hard copy) and 2348 (electronic/online petition)**

PETITION TWO:

2) "Our NHS is precious, and we're relying on you to protect it. Please do all you can to stop local health services being broken up or taken over by private healthcare companies. Listen to the real experts – doctors, nurses and patients – when they give warnings about these plans.

    a. Protect patient care – don't cut beds, wards, doctors or nurses.

b. Protect local NHS services and consult patients properly before making changes.
c. Spend money wisely and adopt policies and a constitution which reflect these values." **(241 signatures)**

PETITION THREE:

3) "The Emergency Care Intensive Support Team has just reported positively on Calderdale and Huddersfield A&E departments. Calderdale A&E is doing a good job for its patients. We the undersigned are opposed to all cuts to emergency services in Calderdale and Huddersfield." **(78 signatures)**

PETITION FOUR: organised by the Labour Party and submitted by Calderdale 38 Degrees NHS Campaign Group

4) "Save Calderdale Accident and Emergency Unit." **(13 Signatures)**

b) Petitions received by Greater Huddersfield CCG

AB advised the meeting that the following petitions had been received by Greater Huddersfield CCG and formally received by its Governing Body at its meeting in July 2016.

PETITION ONE:

1) On the 20th June, Greater Huddersfield CCG received a petition organised by Huddersfield Keep Our NHS Public stating:

"We the undersigned say no to any cuts to NHS Accident and Emergency Services in Huddersfield and Halifax."

The organisers had advised that the petition contained 10,286 signatures.

PETITION TWO:

2) On 21 June, the CCG received a petition organised by the #HandsoffHRI campaign group stating:

"Prevent the closure of Huddersfield A&E department. Please sign to show your support against the closure of Huddersfield A&E department."

The organisers had advised that the petition contained 70,000 signatures.

c) Petitions receives by the RCRTRP Programme Officer

AB reported that On the 21st June, the RCRTRP Programme Office received a petition organised by John Garside, addressed to the Trust and Jeremy Hunt and states:

"We the undersigned residents of Kirklees demand that the accident and emergency department continue at Lindley HRI hospital for many decades to come. It is ideally located to serve 250,000 population of Kirklees and beyond. It has good road communications and a well laid out hospital in case of a serious accident on the M62. Parts have been refurbished in recent years to a high standard. We demand that residents of Kirklees have full NHS hospital services based on the existing Lindley hospital, including A&E, intensive care, maternity, stroke, heart, cancer, colon and all the backup services e.g. X-ray, scan, blood testing etc."

The organisers had advised that the petition contained 190 signatures.

d) Petitions received by Independent Company (NHS Midlands and Lancashire Commissioning Support Unit)

AB reported that the independent company analysing the consultation responses (NHS Midlands and Lancashire Commissioning Support Unit) had advised that they were in receipt of an additional petition organised by Save our Hospital #HandsOffHRI stating:

Question

"Health bosses plan to close Huddersfield A&E and move all emergency services to Calderdale Hospital in Halifax. This will put Huddersfield lives at risk plus overload the A&E at Halifax with long waiting times. Please sign this petition to try and save hospital A&E."

This petition was noted to be signed by 29 people.

AB advised the meeting that all petitions would form part of the consultation response, and had been forwarded to NHS Midlands and Lancashire CSU who were collating the findings of the consultation.

DECISION:

The Governing **RECEIVED** the petitions submitted to the CCG and **NOTED** those received by Greater Huddersfield CCG, the RCRTRP programme office and NHS Lancashire Commissioning Support Unit.

85/16 CHIEF OFFICERS REPORT

MW presented his Chief Officer's report.

a) Financial Position

MW spoke about *Strengthening Financial Performance and Accountability 2016-17*, published by NHS England (NHSE) and NHS Improvement (NHSI) in July 2016 (also known as "the financial reset").

A number of the headline agreements reached between NHSE, NHSI and, principally, the provider sector had been set out in in the report followed by a description of their impact on the CCG's financial position in 2016/17.

The published document was said to clearly communicate NHSE's significant concerns regarding the financial position of the NHS for the current year and, should it fail to achieve a balanced position in 2016/17, during the rest of the parliament. A great deal of work was reported to have been undertaken to commit different parts of the system to the operation of financial controls. Agreements had also been secured regarding deployment of resources in key performance areas and between some Trusts and NHSI regarding a number of performance trajectories and NHS improvement targets,

With regard to the implications for Calderdale CCG, a known deterioration in the CCG's anticipated financial position during the first quarter was addressed. The role of national agreements regarding tariff settlement and changes to the allocation formula were cited as contributory factors. There was a need for the CCG to carefully challenge activity data in order to ensure patients were receiving the correct services at the appropriate levels of cost. A significant amount of work was reported as being undertaken by the contracts management team to provide this assurance.

It was noted that other, more financially challenged systems across Yorkshire and Humber were actively considering a range of options. MW advised the Governing Body that the CCG should not delay in undertaking the required conversations necessary to secure the CCG's financial positon for the current year.

Other important messages in S*trengthening Financial Performance and Accountability 2016/17* were noted to be those relating to the repercussions for failing systems and organisations. The interventions that NHSE and NHSI would undertake if CCG's failed to deliver on their statutory obligations were highlighted. Governing Body members were advised that the document was required reading. MW emphasised that Governing Body members needed to understand the environment being created for the remainder of the financial year.

MW advised that the CCG needed to produce a financial recovery plan as a response to the deteriorating financial position and which we could use as a response to this document, and recommended that the Finance and Performance Committee be asked to have responsibility for the oversight of the response document. He said that a headline report would be submitted to the committee at the end of August. A more detailed report would also be presented to the Governing Body at its next meeting.

b) Update from the Corporate Services Team (QIPP)

MW spoke positively about the work being undertaken by the Corporate Services Team with regard to QIPP savings. Changes to business practices were being identified and developed to deliver significant savings. MW noted it was important that the organisation applied the QIPP process of self-examination to itself as well as in the context of service provision.

c) Description and new Deb Animation

A further animation relating to mental health had been developed and launched as part of the Care Closer to Home (CC2H) Integrated Community Model. Governing Body members were encouraged to view the animation.

d) Quest for Quality in Care Homes

Information updating the Governing Body on Care Closer to Home initiatives was highlighted. Quest for Quality was noted as a particularly strong example. The rollout of the Quest service to other care homes was welcomed, particularly in the context of the video case study played earlier in the meeting.

Questions and comments were invited.

In response to a question concerning the uptake of the Quest for Quality in Care Homes pilot by remaining care homes, DG confirmed that the uptake had been very good and she believed that all 17 remaining care homes had signed up.

MW was thanked for his report.

86/16 RIGHT CARE, RIGHT TIME AND RIGHT PLACE: CONSULTATION DELIBERATION UPDATE

JMu presented the Right Care, Right Time and Right Place update.

The key decisions, deadline and activities relating to the consultation were revisited.

The CCG was reported to be in a post-consultation deliberation period during which an understanding of the consultation outcomes would be developed for consideration. JMu

advised that, in addition to the report setting out the consultation findings, which was expected in the near future, the process would also include the completion of an Equality and Health Inequality Impact Assessment. In addition, the Joint Health Scrutiny Committee would provide a formal response on the 3rd October 2016. Health Watch would also submit a response as part of the scrutiny process. The deadlines relating to receipt of the responses and planned activities up until the Governing Body Meeting in parallel on the 20th October 2016 were shared.

The contribution of temporary members of CCG staff was highlighted to the Governing. AB noted the positive work of communications staff.

In response to a question from MW concerning the Joint Scrutiny Committee meeting on the 7th September 2016, JMu confirmed that the purpose of the meeting would be to consider the consultation findings and that the committee papers would be published on the 20th August 2016. The CCG anticipated receipt of the consultation findings on the 19th August 2016 and intended to publish these on the 23rd August 2016.

In response to a question from DL, the number of survey returns received was reported to be 7,582. A 1% response was noted to be the level organisations undertaking a public consultation could typically anticipate receiving. The response rate was noted to exceed that in other systems. In this context, DL noted that it was a good response level for the purposes of the deliberations.

JMu advised the Governing Body that a stakeholder event would be taking pace on the 13th September 2016 to share the findings and receive feedback for the advisement of the CCG's and Governing Bodies. Along with the stakeholders who had been involved throughout the process, representatives of campaign groups had also been invited to participate. PW encouraged Governing Body members to attend.

In response to a question from JB concerning the planned publication date of the Equality and Health Inequalities Impact Assessment, JMu confirmed that this would not be published at the same time as the consultation findings.

DECISION:

The Governing Body:

1. **NOTED** that the public consultation on proposed future arrangements for hospital and community health services closed on 21st June.
2. **NOTED** the work required to undertake post-consultation deliberation together with the other known key dates and events within the same timescale.
3. **AGREED** that the Governing Body should write and thank the temporary members of staff who assisted during the public consultation.

87/16 NHS CALDEREDALE CCG DRAFT STRATEGIC ESTATES PLAN – JULY 2016

LS presented the report on the draft NHS Calderdale CCG Strategic Estates Plan.

The Governing Body were advised that NHSE required all CCGs to adopt a Strategic Estates Plan (SEP) to support the emerging vision for clinical services over the long term and to provide a framework for the prioritisation of resources within communities. The CCG's SEP would be its first estates plan. It was described as a vital step in transforming the delivery of care and as essential to the provision of safe, secure, high quality buildings capable of supporting current and future service needs. It was noted to be a working document that would evolve to meet the needs of the CCG's transformation plans as well as being an enabler firmly located in the context of Care Closer to Home and other care strategies.

Set against a backdrop of significant challenge, radical steps were reported to be required to ensure the sustainability and resilience of the system. LS set out the range of factors that would need to be taken into consideration, the key drivers of the of the CCG's SEP and the principal components of the CCG's place-based vision, based on a locality hub model.

LS explained that the CCG's intended commissioning of a community model would determine the type and amount of space required in different areas.

Next steps in the development of SEP were reported to be:

- Taking the work forward through a single working partnership group, developing an integrated approach to estates across the health, social care and the third sector
- Working through the scope of what is needed in each locality including a refresh of the 6 facet survey
- Mapping the opportunities available for the CCG and partners
- Development of a delivery plan
- Working through whether the proposed solutions support the aspiration of reducing the need for hospital investment

TB reported that he had been working with the CCG on its draft SEP for 18 months with the majority of work taking place since summer 2015. The Governing Body were advised that one of the key issues relating to estates was cost. Estates were noted to be the third highest cost incurred after staff and medicines, and an area where savings could be made more easily.

In terms of the Calderdale area, the SEP was recognised as being central to the delivery of Care Closer to Home. The integration of health and social care agenda and the potential for investment in primary care were both noted to present opportunities for the CCG.

In order to deliver a successful SEP, TB advised that strong leadership was required along with the cooperation of partners. Going forward, a project group looking at the design of services in the five identified localities was recommended. Asset surveys of GP practices had been undertaken and the results were expected in the near future. TB emphasised that the CCG was entering an important phase in terms of its estate and transformation plans.

Questions and comments were invited from the Governing Body.

MW advised that the CCG was in a process of deliberation regarding a model of care for the Calderdale area and the CCG would be in a position to decide on its final estates strategy when that process had been concluded. He said that the estates strategy needed to be an enabler for the model of care and not a driver. MW went on to identify an opportunity, leading from the creation of the Sustainability and Transformation Plan (STP), regarding the response to 'One Public Estate'. Whilst reinforcing the need to understand the different conversations taking place in both the CCG and the Local Authority systems, MW suggested that there was a need to create a better integrated, place based approach to public estates encompassing facilities available across the sector.

PW commented that she was pleased that the input and feedback of patients could be seen as influencing the development of the SEP. She highlighted the importance of inviting patient input again later in the process. Work undertaken by the Local Authority engaging communities regarding its estate was noted to have taken place along with the need to bring CCG and Local Authority conversations together. At a locality level, Health Forums and Patient Representatives were suggested as potential consultees.

CT declared an interest as a GP partner. She advised the Governing Body that providers and services were already seeking accommodation at practices and elsewhere and that consideration needed to be given with regard to how the owners of premises were engaged.

NS agreed that CT's comments highlighted existing issues within the system. He was conscious that partners would also have estates strategies and that they would be seeking to make use of the available facilities. He suggested that the CCG's role should be to facilitate discussions so that they took place in a planned and fair way. He recognised that this would require a significant mapping exercise and that the draft SEP provided a good first step. The need to understand acute and mental health service plans was also highlighted along with the need for this to be achieved quickly.

AB expressed a concern at the grouping of services at GP practices, saying that this worked against the CCG's ambition to distribute care and services across communities. JM responded that the draft SEP provided a set of principles and that the practical design of services would take place as part of the next steps. MW emphasised that the hub model was not about locating all services together at a single point.

In response to a question from NT concerning which committee would have responsibility for the SEP, MW replied that TB had recommended the creation of a specific working group. NS suggested that these arrangements be built into the Care Closer to Home programme. He said this would provide the focus and the strong leadership identified as being essential to successful delivery. There was a consensus on this point.

DECISION:

The Governing Body **APPROVED** the draft Estates Strategic Plan.

88/16 FINANCE, CONTRACTING AND QIPP REPORT

LS presented the Finance, Contracting and QIPP Report.

The CCG was forecasting to deliver a surplus of £6.4m, but this was noted to be reliant on the delivery of a number of mitigating actions to cover the risk presented by cost pressures. Estimated cost pressures of £7.9m above budget were forecast in 2016/17, including the QIPP gap, £7.3m of which were attributed to acute services. The CCG had a £1.4m contingency and £4.6m in additional mitigating actions in place which had been agreed by the Finance and Performance Committee. However, there was a residual risk of £1.8m for which further mitigating actions needed to be identified for 2016/17. In terms of the CCG's performance against financial duties and targets, the delivery of QIPP targets and the required surplus for 2016/17 was rated as amber.

Total cost pressures of £7.9m were reported to be mainly recurrent. These included acute cost pressures of £6m; £5.7m of which were associated with the CHFT contract. £6m of mitigating actions had been identified; however, £3.8m of that sum were against non-recurrent actions. Consequently, the measures only helped to mitigate the cost pressures in the current financial year. As such, in addition to £1.8m of further mitigating actions the CCG was already required to identify for the current financial year, there would be a recurrent cost pressure of £5.6m in 2016/17. LS concluded that the CCG needed to begin to identify the actions and measures to recover the financial position in 2016/17 but also in subsequent financial years.

Questions and comments were invited.

In response to a question from JT querying how much of the additional CHFT cost pressure was associated with an increase in activity as opposed to the effects of tariff, LS responded that, as the overtrading was both significant and consistent over the first quarter, a piece of work was being undertaken across Calderdale and Greater Huddersfield CCG's to identify why this was the case. Sixteen hypotheses were being explored in areas experiencing an adverse variation from the plan. Six key themes were emerging from this exercise including: demand, coding, patient flow, service effectiveness, staffing issues impacting on

admissions rates and the impact of the regulation regime. The key indicators with regard to the latter were the A&E and 18 weeks targets. Once the piece of work was complete, formal discussions would take place with CHFT. LS concluded that the CCG's response would demand an understanding of the contracting issues, demand and the associated trends.

NS advised the Governing Body of discussions at Finance and Performance Committee on the apparent 10% increase in GP referrals compared to the previous year. Further action would include challenging the activity data from CHFT and gaining a better understanding of the demand profile.

LS reported on the contracts position. An early review of the month 3 position indicated overtrading of £1.5m at CHFT. This exceeded the total CCG contingency for 2016/17. Attention was also drawn to the expansion of services for Quest Quality in Care Homes which had been discussed earlier in the meeting.

Questions and Comments were invited.

In response to a question from JT concerning Quest for Quality and how many members of staff taking up posts were from the existing CHFT workforce, LS responded that she could find out this number. She went on to comment that the funding for the posts was new and she expected that, if staff had moved, CHFT would be trying to recruit to the vacant posts.

In response to a question from NT, LS said that her understanding was that Bradford and Wakefield CCGs were also experiencing acute contract pressures. NS added that the picture was not consistent nationally and that different systems experienced issues at different points dependent on a range of factors.

SC commented that that the Practice Leads and Locality Commissioning Team meetings could be used to further explore the increase in GP referrals. Some of the locality commissioning teams had also requested the roll out of the GP dashboard.

In response to question from DL regarding whether there was any historical evidence that might indicate a dip in activity later in the year, LS responded that the financial plan had been set against activity levels in previous years.

DL asked about timescales. LS advised that the CCG needed to be making its decisions as soon as possible.

AB noted that the work already underway indicated that the CCG was aware of the seriousness of the situation and was taking the required step. Furthermore, he noted that planned discussions with Practice Leads would help to ensure there was an increasing awareness of the issues faced by the CCG across its members.

Referring to the finance report to Finance and Performance Committee in August, JM suggested that a more detailed report should come to Finance and Performance Committee in September, followed by a further update to the Governing Body meeting in October MW advised Governing Body members that they were welcome to attend the Finance and Performance Committee to take part in discussions.

DECISION:

The Governing Body **NOTED** the contents of the Finance, Contracting and QIPP report.

89/16 QUALITY & SAFETY REPORT/QUALITY DASHBOARD

PW presented the Quality & Safety Report and Quality Dashboard report and drew attention to three items

a) Care Quality Commissioning (CQC) Inspection Reports and Inspections

South West Yorkshire Partnership Foundation Trust (SWYPFT)

The SWYPFT inspection report had been published on the 24th June 2016. 70% of individual ratings had been assessed as "good". Effectiveness of end of life care and the caring nature of community services for children, young people and their families had been assessed as "outstanding". There were no scores of "inadequate". Due to the CQC's methodology, the overall outcome of the inspection was "requires improvement". Additional information relating to the inspection was offered to Governing Body members at their request. As per the requirements of the CQC, SWYPFT were developing an action plan. The CCG was already in receipt of a draft which would be discussed at the Quality Board. The frequency of monitoring and arrangements for feeding back to the CCG's Quality Committee were to be agreed.

Ambulance Service

The Ambulance Service would receive its follow-up inspection in early September 2016. Information had been submitted to Wakefield CCG as the coordinating commissioner.

NHS 111

The NHS 111 Service would be inspected in October 2016. Quality leads had met with the CQC to share information ahead of the inspection.

Spire Elland and Locala

Spire Elland would be inspected in the near future. Information had been collated by the CCG's Contacting Team and submitted by the deadline.

Locala would be inspected in October 2016. The CCG was in the process of collating the required information for submission.

b) Calderdale and Huddersfield NHS Foundation Trust (CHFT) – Quality Risk Profile (QRP) update

Discussions regarding the dashboard had already taken place with the Governing Body and the Quality Committee. A number of scores were static while some were deteriorating. Discussions addressing individual lines had taken place with CHFT. Change was not anticipated against some of the metrics until other changes, grounded in a quality and safety case for change, were delivered.

When it had protracted concerns about quality and safety, the CCG was reported as being required to look at every opportunity for improvement. As per the requirements of NHSE, the CCG had put a Quality Risk Profile in place addressing existing actions and exploring others that could be put in place. This piece of work was being undertaken in conjunction with CHFT and would be shared with them for agreement at the end of July 2016. The Quality Team would work with CHFT to link the QRP the process with the feedback from the recent CQC inspection. The draft CQC report was expected to be received in July or early August. Once this work was completed a further QRP report would be shared with the Quality Committee towards the end of the tear.

c) NHS England Safeguarding Assurance Visit

The visit had taken place in early July 2016. The experience was positive in terms of style and approach. Some minor points for improvement were noted, including ensuring reference to safeguarding in various CCG policies.

Questions and comments were invited.

DECISION:

The Governing Body **NOTED** the contents of the Quality & Safety report and Quality Dashboard Report.

90/16 PERFORMANCE REPORT

DG presented the Performance Report.

The CCG continued to maintain good progress with the delivery of the majority of constitutional standards. Sustaining the 4 hour target in Accident & Emergency (A&E) provided a challenge in 2015/16 and continued to do so 2016/17. An improvement in Quarter 1 of the current year, against a background of increased demand, was noted. However, the more challenging periods of the year were noted to have not yet been reached. A significant amount of ongoing improvement work in relation to delayed transfers of care, the Emergency Care Improvement Programme and in other areas was noted.

NHSE had produced a report which included a requirement to rename the Strategic Resilience Group (SRG) as an "A&E Delivery Board". DG, while recognising the importance of A&E, suggested it was only a single part of the whole system and one which was significantly impacted on by the other parts. DG advised the Governing Body that the SRG would continue to focus on the key priorities for the area.

In May 2016, 5 of 62 patients with breast cancer symptoms who had been urgently referred had waiting times that breached the constitutional standard. This was reported to be the second month when the standard had been breached. Clinical reviews of breaches were taking place with the outcomes being fed back at the CHFT contract meeting. Initial data for June indicated the standard had been met in that month.

With regard to the two month (62 day) wait from urgent GP referral to first definitive treatment for cancer, in May 2016, 6 of 35 patients had waiting times that breached the constitutional standard. 3 patient delays were linked to complex conditions. The remaining 3 patients required a transfer of care to another hospital which, in each instance, took place 38 days following referral. Breaches were being clinically reviewed and addressed at the CHFT contract meeting. The standard for June had been met.

Questions and comments were invited.

In response to a question from NT regarding changes to the SRG Board, DG responded that initial discussions locally indicated a desire to maintain a focus on what was most important to the Calderdale system. MW read the extract from the published guidance: "*All systems will reform their Systems Resilience Groups into local A&E Delivery Boards to focus only on emergency and urgent care, ensure that all statutory bodies are represented and that all attendees are executive level"*. MW advised the Governing Body that, regardless of local appetite, the CCG would need to meet this expectation. NT noted that such a change would impact on the reporting arrangements for the Elective Care Improvement Board. Further comments were made concerning the existing focus of the SRG Board, engagement levels and the impact of other parts of the system on A&E. MW concluded the discussion by repeating that the expectation set out in the guidance would need to be met.

DECISION:

The Governing Body **NOTED** the content of the Performance Report.

91/16 RISK REPORT AND HIGH LEVEL RISK LOG

RG presented the Risk Report and High Level Risk Log for Cycle 2.

The risk review period for cycle 2 commenced on the 31st May 2016 and concluded with a review at Senior Management Team (SMT) on the 20th June 2016. All risks had then been reported to the relevant committees. At the end of risk cycle 2, there were 38 risks on the Risk Register including 8 marked for closure leaving 30 open risks as compared to 32 open risks at end of cycle 1. There was one critical risk rated at 20 regarding delays in transfer of care. There were 7 serious risks rated at 15 or 16. There had been 6 critical risks at the end of cycle 1. Risks 829 and 826, relating to finance, were noted to be new risks. Risk 826 was a risk during the previous year (Risk 161) which been closed and re-opened with scoring increased from 12 to 16. The scoring for Risk 40, relating to the lack of availability for appointments at CHFT, had increased from 12 to 15. All other risks were static.

Questions and comments were invited.

DL asked whether serious consideration should be given to the financial challenge during the next cycle. JM responded that the review cycle process would address Risks 826 and 829 again. Furthermore, work presently being undertaken to address these risks was not reflected in the quarter 2 data.

AB welcomed the reintroduction of reporting on appointments.

JT queried whether there had been a recent audit of the advice facility available via the electronic booking process, noting it produced savings whilst delivering appropriate care. Figures were reported to be reviewed regularly and submitted to the Governing Body as part of the contract report. A discussion took place during which a range of options for improving the service were shared. The service was suggested for inclusion in the QIPP recovery plan.

NS addressed the financial risk rating of 16 for Risk 826. He advised the Governing Body that it might want to consider the rating going forward. He suggested reducing the likelihood to 2 or 3 initially, whilst still recognising the potential impact as 5. MW suggested that this be taken forward into discussions during the next review cycle.

DECISION:

The Governing Body **RECEIVED** the Risk Report, High Level Risk Log and CCG Risk Dashboard at the end of Risk Cycle 2 of 2016/2017.

92/16 APPOINTING EXTERNAL AUDITORS

JS provided an update regarding the CCG's appointment of an external auditor. A single procurement process would be undertaken led by the CCG's Contracting Team across Calderdale and Greater Huddersfield CCGs. The procurement would take the form of a mini-competition using the Crown Commercial Services (CCS) Consultancy 1 Framework. A three year contract with option to extend by a further two years would be offered. The intention regarding the procurement process was noted. The Auditor Panel had met in August to confirm arrangements for making the approach to market and to address the draft specification which was amended at that time. The evaluation criterion was also considered along with the proposed process and timeline. A detailed timeline was reported to be in place and work to proceed to procurement was being undertaken. A first review of responses would be undertaken by the Auditor Panel in early October 2016. JS provided

assurance that the CCG was progressing in line with guidance and would be in position to make a decision in November 2016 which would then be reported to the Governing Body for ratification in December 2016. The successful external auditor would then be in place from 1st April 2017.

The Auditor Panel had also addressed its Terms of Reference in line with the roles and responsibilities agreed by the Governing Body at its meeting on the 9th June 2016. In response to further guidance, the panel's membership had been enhanced in order to ensure quoracy.

Questions and comments were invited from the Governing Body.

DL noted that he had sought assurance that the CCG was on target and had been satisfied with the responses he had received from SMT members. He had responded to an email from NHSE as the Chair of the Audit Committee confirming the CCG's strong position. JM, as a member of the Auditor Panel, also confirmed that the Governing Body could be assured that the CCG was on target in terms of the procurement.

DECISION:

The Governing Body:

1) **NOTED** the update on the procurement process.
2) **APPROVED** the Terms of Reference for the Auditor Panel.

93/16 COMMITTEES

a) Audit Committee Annual Report 2015/16

DL presented the Audit Committee's Annual Report for 2015/16.

The Governing Body was advised that key issues over the next 12 months would include responding to revised guidance regarding conflicts of interest. A Governing Body development session was scheduled for early September.

DL offered to circulate to Governing Body members copies of KMPG's Technical Update for information. The document was explained to provide an overview of issues across the NHS.

Questions and comments were invited.

DECISION:

The Governing Body **RECEIVED** the Audit Committee Annual Report for 2016/17.

b) Minutes of the Audit Committee Meeting held on the 19th May 2016

DECISION:

The Governing Body **RECEIVED** the minutes of Audit Committee meeting.

c) Minutes of the Finance and Performance Committee meetings held on 26th May 2016 and 30th June 2016.

DECISION:

The Governing Body **RECEIVED** the minutes of the Finance and Performance Committee meetings.

d) Minutes of the Quality Committee meetings held on 26th May 2016 and 30th June 2016

DECISION:

The Governing Body **RECEIVED** the minutes of the Quality Committee meetings.

e) Minutes of the Commissioning Primary Medical Services Committee held on 21 April 2016.

JM reported that the committee had met again in early July. At that meeting, it had addressed the review of premium services and the principles for the investment for PMS funding. Further discussions concerning both matters would take place at the committee's next meeting in October.

DECISION:

The Governing Body **RECEIVED** the minutes of the Commissioning Primary Medical Services Committee.

AB noted that managing conflicts of interest presented challenges and that it was essential that CCG meet this duty whilst continuing to function as a clinically led organisation.

94/16 KEY MESSAGES FOR MEMBER PRACTICES

There were no key messages be sent out to member practices on this occasion.

95/16 DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

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

CCG Annual General Meeting
8th September 2016
6.30pm, Shay Stadium

96/16 EXCLUSION OF THE PUBLIC

DECISION:

That representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Governing Body Meeting 11 August 2016 – Action Sheet

Report name	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
QUESTIONS FROM THE PUBLIC	83/16	Healthy Futures Programmes Team to supply response to question from Gordon Bache.	Andrew O'Connor	Complete	13 October 2016
RCRTRP	86/16	Chair to write thanking to temporary CCG Communications staff for their contribution.	Alan Brook	Complete	13 October 2016
FINANCE, CONTRACTING AND QIPP REPORT	88/16	LS to confirm number of staff taking up Care for Quality in Care Home posts that might have been from the existing CHFT workforce.	Lesley Stokey	Due	13 October 2016