Minutes of the Public Section of the Governing Body Meeting
held on Thursday 8 June 2017, 2pm
in Function Room 2 at the Shay Stadium, Halifax

DRAFT MINUTES

Present
Dr Alan Brook AB   Chair
David Longstaff DL   Deputy Chair and Lay Member (Audit and Conflicts of Interest)
Neil Smurthwaite NS  Chief Finance Officer and Deputy Chief Officer
Dr Steven Cleasby SC   GP Member and Assistant Clinical Chair
Dr Majid Azeb MA    GP Member
Jackie Bird JB    Registered Nurse
Dr Helen Davies HD    GP Member
Dr Farrukh Javid FJ   GP Member
John Mallalieu JM   Lay Member (Finance, Performance and External Relations)
Kate Smyth KS    Lay Member (Patient and Public Involvement)
Dr Caroline Taylor CT   GP Member
Dr Nigel Taylor NT   GP Member

Invitees
Penny Woodhead PW   Head of Quality
Stuart Smith SS    Stuart Smith (Director of Adult and Children’s Services, Calderdale Metropolitan Borough Council).

In attendance
Judith Salter JS    Corporate and Governance Manager
Andrew O’Connor AOC  Corporate and Governance Officer (Minutes)
Tim Shields TS    Performance Manager (item 7c, min no. 28/17)
Robert Gibson RG    Risk, Health and Safety Manager (item 8, min no. 29/17)

Plus 2 members of the public.

19/17 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from Matt Walsh (Chief Officer), Robert Atkinson (Secondary Care Specialist) and Paul Butcher (Director of Public Health, Calderdale Metropolitan Borough Council).

20/17 DECLARATIONS OF INTEREST

AB invited the Governing Body members to declare any interests relevant to items on the agenda.

KS declared an interest in relation to agenda item 7a, (minute no 26/17) - ‘Finance, Contracting and Recovery Report’ as a wheelchair service user. AB advised the meeting that this interest had been considered and it had been determined that it did not present a material conflict in the context of the meeting and no further action was required.

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.
DECISION:

The minutes of the public section of the Governing Body meeting were RECEIVED and ADOPTED as a correct record subject to the following amendment(s):

Present

‘Steven Cleasby” to read “Dr Steven Cleasby”.

ACTIONS AND MATTERS ARISING

Action 05/17 - Patient Story, ‘The Last 1000 days’

“The Last 1000 days” video had not been shared with the Calderdale and Huddersfield NHS Foundation Trust Partnership Board but would be considered for a future meeting. Whilst also not shown at the Quality Board, it had featured as part of a conversation concerning frailty. It was agreed that the action would be closed.

Action 05/17 - Patient Story, Time in Hospital Metric

The action was noted to be underway.

Action 16/17 - Key Messages for Member Practices, Recovery

Work was noted to be underway with further meetings planned. Recovery was also noted to feature at every Practice Commissioning Leads Meeting. It was agreed that the action would be closed.

QUESTIONS FROM THE PUBLIC

Seven questions had been received from Jenny Shepard.

Q1. Why is the Quality and Safety report being discussed in the private part of meeting where the public is excluded?

(PW responded)

A: It is being proposed that the Governing Body receive a quality and safety update on a particular item in the private section of the meeting today. Occasionally the Governing Body needs to discuss items confidentially. These can include items which if considered in public may have an unjustified adverse effect on an individual or group of individuals.

If the item is discussed in public the CCG would be at risk of breaching principle one of the Data Protection Act, which is there to protect the interests of individuals who would or might be identified, and who would reasonably expect information relating to them to be kept confidential.

We always carefully consider the need for confidentiality versus the importance of operating in an open and transparent way and the public interest in an item, before taking something in the private section.
Q2. In her question Jenny asserts that patients making appointments with Calderdale and Huddersfield Foundation Trust hospitals are reporting difficulties, and asked if the Quality and Safety Report referred to this.

(AB responded)

A: The item does not relate to this.

Q3. This question referred to Agenda Item 7a – The Finance, Contracting and Recovery report. Jenny referred specifically to section 5.1: Contracting Key Messages, in regards to Calderdale & Huddersfield NHS Foundation Trust, which states: The contract position as at the end of Month 12 is showing an over-trade of £7.7m against the plan, which is a further increase from an over-trade of £7.1m at Month 11. Performance in relation to Appointment Slot Issues has deteriorated to 27.5%. Jenny asked:

What does “Performance in relation to appointment slot issues has deteriorated to 27.5%” mean? Does this relate to the patient problems with getting appointments that I mentioned in question 2? What is the CCG doing to sort out the problem?

(AB responded)

A. In this instance the term ‘Appointment Slot Issues’ refers to those occasions where a first outpatient appointment slot is unavailable at the time of booking through the E-referral system in General Practice. These problems can be due to a number of factors, including interoperability between community and hospital based computer systems, as well as clinical capacity and we anticipate that it will improve as CHFT’s new Electronic Patient Record (EPR) system becomes embedded. The CCG monitors the position and performance is discussed at the monthly contract management meeting and escalated as required.

Q4. What is the publication date for the Right Care Time Right Place full business case?

(AB responded)

A. The capital Full Business Case is being developed by Calderdale and Huddersfield NHS Foundation Trust, not the CCGs. Therefore, your questions about the capital Full Business Case would be best directed to the Trust.

Q5. This question refers to Agenda Item 7a – The Finance, Contracting and Recovery report. Jenny refers specifically to point 2.1.3, within the Key Financial Messages section, which states: £6.8m of QIPP has been aligned against the Calderdale and Huddersfield Foundation Trust (CHFT) budget line. This means that the overall budget is £2.7m less than the contract value. The CCG will therefore have to under trade on this contract by at least £2.7m in order to deliver QIPP. Jenny put the following to the Governing Body: In other words the "efficiency savings" you have to make invalidate your contract with CHFT - so presumably CHFT will be desperately trying not to do work that they won't get paid for. Are the effects of this discussed in the secret Quality and Safety Report?

(NS responded)
A. The short answer to this question is no. The item in the private section does not relate to this.

However, it might be helpful to explain that the contract with CHFT is based on Payment by Results, and in such instances the provider is paid for the activity it does. The contract value referred to is the plan by which both CHFT and commissioners will monitor the trading position and how effective our jointly agreed cost reduction schemes are. The contract position is reported and discussed monthly at both the contract management meeting with CHFT and the CCG’s Finance & Performance Committee. Quality issues relating to the contract with CHFT are reported and discussed at the Clinical Quality Board with CHFT and the CCG’s Quality Committee.

Q6. What is “LCD capacity”, referred to in Contracts 5.8?

(AB responded)

A. The staff that provides the Out of Hours A&E Streaming Service are employed by Local Care Direct (LCD).

Q7. What is the CCG doing about Opcare’s contract breaches? The 3 year contract must be nearly ended now. Is the CCG going to extend it or not?

(NS responded)

A. The CCG continues to work with Opcare to ensure the performance of the contract is acceptable. Breaches of performance are monitored at regular contract management meetings, and appropriate action taken with the provider as required. The CCGs that commission this service are currently undertaking a review to determine whether the contract will be extended. This is in accordance with an option within the contract to extend by 1 or 2 years.

24/17 PATIENT STORY

PW in presenting the Patient Story explained that the meeting was going to view a performance portraying a conversation between a clinician and their patient. The piece was noted to have recently featured at a number of national patient engagement conferences.

Following the video comments and questions were invited.

In discussion, the following comments were made:

- communication, compassion and empathy were key in the provision of health care
- the key ideas and messages conveyed in the performance now featured as a standard part of mandatory General Practice training
- greater consistency in approach may be required at a secondary care level
- as part of cancer treatment, holistic needs assessments place the patient at the heart of the process
- clinician/patient interaction should be recognised as a two way dialogue
- careful thought needed to be given to how patients were equipped and supported in taking part in those conversations
- GPs play a significant role as intermediaries and advocates, explaining care and providing support to their patients
• interactions between those delivering and in receipt of social care should also be considered in the same context
• the increased specialisation in secondary care had prompted a focus on conditions creating a need for, for example, care coordinators or navigators to address patients’ holistic needs
• the CCG’s commitment to patient enablement required the development of behaviours and ways of working that support this agenda
• caution needed to be exercised when considering the need for new and/or additional roles and consideration should be given to what could be achieved through existing structures and provision
• consideration should be given to the influence that outcome measures have in driving and shaping behaviours and the potential that different measures, for example, “patient determined” measures might have in promoting change.

DECISION:

The Governing Body RECEIVED the Patient Story.

25/17 CHIEF OFFICER’S REPORT

NS in presenting the Chief Officer’s Report explained he would be updating the Governing Body on a number of important issues.

Right Care, Right Time, Right Place

CHFT was noted to be responsible for producing the Full Business Case (FBC). It was anticipated that FBC would be presented to its board for consideration during summer 2017. On the condition that it receives the support of the Trust’s Board, the Governing Body was advised that both Calderdale CCG and Greater Huddersfield CCG would consider the FBC in the context of three considerations as set out at 1.3 in the report.

The Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC) was reported to be meeting on the 21st July 2017 to determine whether their recommendations had been satisfactorily addressed and if they should refer the CCG’s proposals to the Secretary of State for Health.

Falls Prevention Through Early Identification

A CCG led multi-stakeholder project reviewing the approach to early identification and prevention of falls involving frail elderly people living in their own homes was reported to have been a success and was now been rolled out to all Fire and Rescue Service Teams across Calderdale. It was recognised to be in an excellent example of integrated working delivering positive outcomes for the residents of Calderdale and tribute was played to all involved.

Calderdale CCG Annual Report and Accounts 2016-17

Following approval under delegated authority by the Audit Committee at its meeting on the 18 May 2017, the CCG’s Annual Report and Accounts 2016-17 had been submitted to NHS England on the 26th May 2017 in line with the required deadline. It was noted that the both would be published week commencing 12 June 2017 and presented to the Governing Body at its Annual General Meeting on the 10 August 2017. The work across the organisation to produce the annual report and accounts was recognised.

DL added that KPMG (External Auditors) had made positive comment about the
CCG’s operations and also recognised the hard work across the organisation.

Sign Up to Safety

The CCG had agreed to support the “Sign up to Safety” national Patient Safety Campaign and had committed itself to the five campaign pledges, as set out at 4.1, and actions to strengthen patient safety, as set out at 4.2.

Comments and questions were invited.

PW reported that the Quality Committee would be receiving updates concerning how the CCG’s work and practices measured against the campaign commitments. “National Kitchen Table Week”, which the CCG had run earlier in the year, was noted to be part of the “Sign up to Safety” campaign.

Nationwide NHS Cyber-Attack: 12 May 2017

Calderdale had been minimally affected by the nationwide cyber-attack. The ongoing work of The Health Informatics Service (THIS) in assessing and managing IT security risks and the CCG’s recent Business Continuity Exercise were both noted to have played a key part in preparing the CCG for management of this incident. The work of the on-call Manager, Lesley Stokey, during the incident was recognised.

Comments and questions were invited.

DECISION:

The Governing Body RECEIVED and NOTED the Chief Officer’s Report.

FINANCE, CONTRACTING AND RECOVERY REPORT

NS in presenting the report explained that the CCG was required to budget for a 1% contribution to a national pool. As such, whilst the CCG would be reporting a £2.7m surplus nationally, locally it would be reporting a £0.4m deficit in-year. He confirmed that this would be made clear in future reports. He then highlighted the following:

- The CCG’s Quality, Innovation, Productivity and Prevention (QIPP) target of £11.5m was extremely challenging.
- £8m of QIPP savings had been allocated to individual budgets with further work taking place to identify remaining QIPP opportunities.
- £6.8m of QIPP had been allocated to the main acute provider budget line with the overall budget highlighted to be £2.7m less than the contract value. NS explained that this would require the CCG to under trade on the contract by at least £2.7m to deliver QIPP. Activity under the contract was noted to be “payment by results” and, as such, QIPP initiatives in place offered the possibility to reduce the cost to the CCG.
- The CCG was intending to fully utilise its running costs budget (£4.6m in 2017/18) in-year and was not using the funds to supplement programme expenditure as in other CCG areas.
- The delegated primary medical services budget in 2017/18 was £26.8m including an uplift of £0.8m (2.98%). The uplift reflected the outcomes of the national primary care contract negotiations. A detailed report concerning this matter had been received at meeting of Commissioning Primary Medical Services Committee on the 1 June 2017.
- Contracts information was highlighted as set out at 5.
Comments and questions were invited.

NS confirmed that the variation relating to the payment of non-NHS invoices involved Local Authority and GP Practice payments. This should improve in month two of the financial year and was not usual for the time of year.

DECISION:

The Governing Body NOTED the contents of the report.

27/17 QUALITY AND SAFETY REPORT AND QUALITY DASHBOARD

PW in presenting the report highlighted the following:

- The Learning Disabilities Mortality Review Programme (LeDeR) was now mandatory across England requiring that all deaths are both notified and reviewed. Responsibility for this process was being transferred from NHS England (NHSE) to CCGs but no additional resource would be provided. The CCG would have to identify staff from the system to train as reviewers by attending a training course commissioned by NHSE. The CCG would also have to establish Local Area Contacts who would be responsible for review coordination and sign-off prior to submission to the national team. Work was taking place with Calderdale and Kirklees Councils and with providers to identify reviewers. Three Local Area Contacts had been identified across the two areas to date. Any learning resulting from reviews would be received by the Transforming Care Partnership Board covering Calderdale, Kirklees, Wakefield and Barnsley area. Communications concerning the programme would feature in the next General Practice bulletin. The programme had been added to the CCG’s Corporate Risk Register due to its potential impact on organisational capacity and resource. Work was taking place to manage the potential for concurrent statutory reviews such as Safeguarding Adults/Children’s reviews.

SS advised the Governing Body that he anticipated in the future some Safeguarding Board duties being dealt with on a regional level and that the changed arrangement might include this area.

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) had again experienced challenges in meeting the 60 day timescale relating to serious incidents. However, the quality of the reports were much improved. The trade-off between meeting timescales and receiving a high quality report that did not require any further actions was noted. Discussions concerning how the timescales could be met were taking place with the Trust.

- South West Yorkshire Partnership Foundation Trust (SWYPFT) had introduced learning events for commissioners where learning from investigations could be disseminated. The CCG was encouraging other providers to learn from SWYPFT’s methodology.

- The Maternity Assurance Task and Finish Group had been concluded and the CCG had returned to routine surveillance in this area.

- The Quality Committee had addressed those areas identified as under “enhanced surveillance” on the dashboard.

Comments and questions were invited:

- CT noted the significant reduction in serious incidents in-year
- PW responded that there was a need to remain vigilant.
DECISION:

The Governing Body RECEIVED the updates and NOTED any actions being undertaken in the dashboard.

28/17 PERFORMANCE REPORT

TS reported that the CCG’s progress against the majority of the NHS Constitutional Standards was good. The following issues were highlighted:

- Accident & Emergency (A&E) Performance had deteriorated in May and June to-date. This had been attributed to the introduction of the Electronic Patient Record (EPR) system at Calderdale and Huddersfield NHS Foundation Trust (CHFT). The issue had been raised at A&E Delivery Board and while no specific trajectory for improvement had been set, CHFT had provided assurance that the position would be recovered during June.
- There had been a number of breaches during March associated with access to MRI scans and non-obstetric ultrasound. Both were the result of an increase in referrals as well as a reduction in capacity following the removal of agency staff. The issue had been notified to NHS Improvement (NHSI) and a recovery trajectory had been introduced. Indicative data received for June was positive to date.

Comments and questions were invited:

- With regard to the 4 hour target and the potential harm or adverse outcomes for patients, PW commented that she would be looking closely at the “Friends and Family Test” reports for the period in question. Furthermore, she would be seeking assurances at the next A&E Delivery Board.
- PW confirmed that there was a requirement to report serious incidents within 48 hours of identification. A full report would be received by the CCG within 60 days thereafter dependent on the extent of the event.
- PW confirmed that Datix was being used to report any incidents relating to EPR and that the CCG received a six monthly report from the National Learning System that benchmarked CHFT’s position against other providers. The EPR Board was explained to be addressing the incidents at its weekly meeting and a discussion was scheduled for Clinical Quality Board with CHFT in July.

DECISION:

The Governing Body NOTED the progress being made with the delivery of the constitutional standards.

29/17 RISK MANAGEMENT

RB in presenting the report highlighted that the risk register at the end of risk cycle 1 featured:

- three critical risks carried over from risk cycle 6
- three serious risks compared to four at the end of the last risk cycle

Critical risk updates had been provided as appendices to the report.

Comments and questions were invited.

SC sought assurance concerning efforts to reduce delays in transfers of care as he was conscious that the Governing Body were not necessarily seeing the
impacts of the sustained efforts in this area.

MA responded that delays in transfers of care were regularly reported on at A&E Delivery Board and that the Board was seeing evidence of significant improvements.

PW added that the CCG’s Head of Service Improvement, was reviewing the Delays in Transfers of Care Plan, for consideration, in the first instance, by the relevant CCG’s committees.

SS advised the Governing Body that were six performance indicators relating to delays in transfers of care (four relating to the NHS and two to Local Authorities). He suggested the Governing Body may wish to explore these to understand the issue more fully.

NS concluded that there remained work to be done with both Calderdale and Huddersfield Foundation Trust and Calderdale Metropolitan Borough Council concerning the indicators.

**DECISION:**


**COMMITTEE TERMS OF REFERENCE**

JS in presenting the report explained that three sets of committee terms of reference were being submitted to the Governing Body for approval.

**a) Finance and Performance Committee Terms of Reference**

The following amendments, in addition to those outlined in the report and appendices, were proposed:

- At 2.1, that JM’s role be amended to read “Lay Member”
- At 2.1, following names listed under “in attendance”, to add “Or nominated deputy can attend”.
- At 2.2 insert a new statement: “The Chair of the CCG Governing Body is also invited to attend the meetings of the Finance and Performance Committee” adjusting the numbering of those points that follow accordingly.

It was agreed that PW and JS would review the Quality Committee Terms of Reference to ensure consistency between the committees’ Terms of Reference.

**b) Audit Committee**

The proposed changes were noted to be set out in the draft terms of reference provided.
DL proposed to the meeting that at 3.1, “Lay Advisor” read “Lay Member” reflecting JM becoming a full member of the committee.

c) Remuneration Committee

The draft terms of reference submitted was noted to contain a significant change that would delegate decision making authority from the Governing Body to the committee concerning terms and conditions, allowances, travel and other allowances for Governing Body Members and effected staff. It was explained that the committee had previously had the authority to recommend proposals to the Governing Body. Furthermore, that the change would streamline the decision making and conflicts of interest management process. NHS England (NHSE) was recognised to have approved the change to the CCG’s Constitution which included the Scheme of Reservation and Delegation allowing this change to be proposed.

Under 2.0, it was proposed that “Lay Advisor” be changed to read “Lay Member” reflecting JM becoming a full member of the committee.

In response to a query regarding the potential for the committee to be quorate if both Lay Members were unable to attend, it was agreed that an amendment be made reflecting that quoracy could only be achieved when at least one Lay Member was in attendance who would also act as the committee’s Deputy Chair.

At 3.11, it was explained that, following the decision to only meet biannually, committee minutes would be approved electronically in order that they could be submitted to the Governing Body in good time.

Other proposed changes were noted to be set out in the draft terms of reference provided.

DECISION:

The Governing Body APPROVED the amendments to the committee of terms of reference.

31/17 COMMITTEE MINUTES

a) The Minutes of the Audit Committee held on 19 January 2017 and 11 May 2017

DECISION:

The Governing Body RECEIVED the minutes of the Audit Committee.

b) The Minutes of the Finance and Performance Committee held on 23 February 2017 and 30 March 2017

DECISION:

The Governing Body RECEIVED the minutes of the Finance and Performance Committee.
c) The Minutes of the Quality Committee held on 23 February 2017, 30 March 2017 and 27 April 2017

DECISION:

The Governing Body RECEIVED the minutes of the Quality Committee.

32/17 KEY MESSAGES FOR MEMBER PRACTICES

DECISION:

- Learning Disability Mortality programme (LeDeR)
- Link to Patient Story
- Falls Prevention Work
- Cyber-attack update and IT safety and security

33/17 DATE AND TIME OF THE NEXT MEETINGS OF THE GOVERNING BODY IN PUBLIC:

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

**CCG Governing Body Meeting and Annual General Meeting**
10th August 2017, 2pm
The Shay Stadium, Halifax

34/17 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 Thursday 8 June – Action Sheet

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
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<tbody>
<tr>
<td>Patient Story</td>
<td>05/17</td>
<td>Explore the potential development of a “currency” for the time that people spend in hospital to be included in the A&amp;E Delivery Board dashboard</td>
<td>MW</td>
<td>COMPLETE</td>
<td>10 August 2017</td>
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<td>Committee Terms of Reference</td>
<td>30/17</td>
<td>Review the Quality Committee Terms of Reference in light of the changes to Finance and Performance Committee to ensure consistency.</td>
<td>PW</td>
<td>Underway</td>
<td>10 August 2017</td>
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<tr>
<td>Key Messages for member practices</td>
<td>32/17</td>
<td>Information on the following topics to be communicated to the practices.</td>
<td>SR</td>
<td>COMPLETE</td>
<td>10 August 2017</td>
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<td>- Learning Disability Mortality programme (LeDeR)</td>
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Name of Meeting | Governing Body | Meeting Date | 10/08/2017
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Title of Report | Chief Officer’s Report | Agenda Item No. | 6
Report Author | Matt Walsh, Chief Officer | Public / Private Item | Public
GB / Clinical Lead | Matt Walsh, Chief Officer | Responsible Officer | Matt Walsh

**Executive Summary**

An update to the Governing Body on current pertinent issues.

**Recommendation(s)**

1) **RECEIVES** this report
2) **DELEGATES AUTHORITY** for the approval of the Better Care Fund Plan to a small group of Governing Body members consisting of the Chair, Lay Member (Finance and Performance), Chief Officer and the Chief Finance Officer/Deputy Chief Officer.

**Decision**

[X] | Assurance | Discussion | Other | For information

**Implications**

**Quality & Safety implications** (including Equality & Diversity considerations e.g. EqIA) | None Identified
---|---
**Public / Patient / Other Engagement** | None Identified
**Resources / Finance implications** (including Staffing/Workforce considerations) | None Identified
**Strategic Objectives** (which of the CCG objectives does this relate to – delete as applicable) | None identified
- Achieving the agreed strategic direction for Calderdale
- Improving quality
- Improving value
- Improving governance
**Risk** (include link to risks) | None identified
**Conflicts of Interest** (include detail of any identified/potential conflicts) | None identified

**Legal / CCG Constitution Implications** | As set out in the report.
1. **Right Care Right Time Right Place**

At its meeting on 21st July, 2017, the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC) met to determine whether their recommendations, in relation to the proposed future arrangements for hospital and community health services across Calderdale and Greater Huddersfield, had been satisfactorily addressed.

The Joint Committee has accepted that maintaining the status quo is not an option and understands the CCGs’ clinical and quality case for change. The Joint Committee also accepts that delivering services across two sites has contributed, in part, to the workforce challenges particularly in recruiting to key specialist areas at senior levels. It has expressed no view about the location of an “unplanned” hospital or a “planned” hospital. However, the Joint Committee has serious concerns about some of the consequences of reconfiguring hospital services in this way.

The Committee decided to exercise its right to refer the decision of the CCGs to the Secretary of State for Health on the grounds that:

- It is not satisfied with the adequacy of content of the consultation with the Joint Committee.
- The amended proposals presented to the Joint Committee are not consistent with the proposals originally consulted on by the CCGs in 2016.
- It considers that the proposal would not be in the interests of the people of Calderdale and Greater Huddersfield and hence not in the interests of the health service in the area.

We acknowledge and respect the Committee’s decision.

Calderdale and Huddersfield NHS Foundation Trust (CHFT) and the Clinical Commissioning Groups agree that change has to happen. The JHOSC also agrees that the status quo is not an option and equally wants to see improvements in the quality of hospital and community health services. Our proposals are based on our aim to meet the highest standards of safety and quality for patients and create a sustainable local NHS now and for future generations. We believe that our proposals are crucial to the long term sustainability of local services. We are confident that the changes which we have proposed are the best way to save more lives and improve outcomes for patients.

We will continue to plan for change pending the Secretary of State’s decision,

2. **Better Care Fund**

The Integration and Better Care Fund (BCF) planning requirements for 2017-19 were published on the 5th of July 2017.

The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF).
The BCF planning requirements set out four national conditions:

- That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the Health and Wellbeing Board (HWB) and by the constituent Local Authorities and CCGs;
- A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
- That a specific proportion of the area’s allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
- All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

The IBCF planning guidance set out three aims of the additional funding:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

The timeline for agreement of plans is that plans are to be submitted from local Health and Wellbeing Board areas (agreed by CCGs and local authorities) by the 11th September 2017.

**Recommendation:**

Due to the deadline for final submission not aligning with the October meeting of the Governing Body, it is recommended that the Governing Body **DELEGATES AUTHORITY** for the approval of the Better Care Fund Plan to a small group of Governing Body members consisting of the Chair, Lay Member (Finance and Performance), Chief Officer and the Chief Finance Officer/Deputy Chief Officer.

**3. Healthier Calderdale after 10 year Smoking Ban**

Ten years after smoking was banned from public places there has been a significant drop in the number of smokers in Calderdale.

On 1 July 2007 it became illegal to smoke in restaurants, bars, clubs and other public places, protecting staff and guests from breathing second hand smoke.

New figures from Public Health England show that in 2012, five years after the introduction of the smoking ban, 21.6% of people in Calderdale smoked. By 2016 this figure had reduced to 18.7%.

There are many long-term medical conditions which are associated with smoking tobacco, such as heart disease and a range of respiratory conditions including lung cancer, bronchitis and emphysema. Since the smoking ban was introduced there has been a reduction in the number of deaths from these smoking related illnesses.
Between 2013 and 2015 there were approximately 19 fewer deaths per year from heart disease linked to smoking compared to 2007/09. There were also around 12 fewer deaths per year from strokes linked to smoking between 2013 and 2015, compared to 2007/09.

4. Quest for Quality in Care Homes - Assistive Technology – Sarah Garforth (Clinical Lead - Dr Steven Cleasby)

The following mobilisation has taken place in the Assistive Technology element of the Quest for Quality in Care Homes Service:

- Telehealth in community (the supply and installation of digital health solutions for people with long term conditions to help monitor their vital signs remotely from home - awarded to Baywater Healthcare):
  - COPD (Chronic Obstructive Pulmonary Disease) - all patients transferred from incumbent provider and accepting new referrals.
  - Virtual Ward - staff trained and to start accepting referrals in July.
  - Heart Failure - to commence once Virtual Ward embedded.

- Telehealth in Care Homes (the supply and installation of digital health solutions using applicable devices or technology to monitor/test vital signs for people residing in care homes in Calderdale - awarded to Baywater Healthcare):
  - Patients to be transferred in July from 5 care homes that were using it with the previous provider.

- Telecare (the supply and installation of Telecare equipment into all care homes in Calderdale - awarded to Tunstall Healthcare (UK) Ltd):
  - Already embedded as incumbent provider awarded contract.

- Out of Hours Telemonitoring (Call Centre/Monitoring Centre facilities for care homes out of hours – from 6.30 p.m. to 9.00 a.m. 7 days a week, 365 days a year - awarded to Local Care Direct):
  - Site surveys have commenced with care homes. This is a new element to the Quest service.

5. Bowel Cancer Screening- Helen Wraith(Clinical Lead: Nigel Taylor)

The CCG wrote to all practices in March 2017 to raise awareness of bowel cancer screening month in April that year. The letter included the offer of a practice visit from Cancer Research UK to visit the practice and discuss and advise on how they could increase screening uptake rates. Cancer Research UK has the screening rate uptake for Calderdale practices so can tailor the advice accordingly. The Better Living Service in Calderdale is continuing to promote bowel screening and support people to order kits. The newly established Cancer Network is finalising the Cancer Strategy which includes screening and
the opportunity to continue to focus on and improve uptake through application of best practice seen elsewhere.

6. Changes to Data Protection Law

A new data protection law will come into force on the 25th May 2018 which will replace the current UK Data Protection Act. The new General Data Protection Regulation is intended to strengthen privacy rights in relation to personal information.

In our current digital age the processing of personal information by private and public sector organisations takes place at an unprecedented level across the globe and our personal information is often easily accessible to many through the internet and social media, which can raise privacy concerns for individuals.

Working to put in place the highest standards of data protection is at the heart of how we operate as a CCG. Being able to trust the integrity, fairness and honesty of organisations such as the CCG is important to individuals who share their personal information. We have a responsibility to individuals to use their personal information appropriately and transparently.

In general the principles of data protection will remain similar to those of the current Data Protection Act; however the new law will be tougher on the collection of personal information by organisations and tougher on what constitutes valid consent for the use and sharing of personal information. Patients, staff and the general public will have more extensive rights in relation to how their information is used and there will be significant penalties for organisations that do not comply.

Within the NHS we are already on a journey towards compliance with the new law and many of the existing requirements within the IG Toolkit annual self-assessment will help to ensure we comply. We made excellent progress with the IG Toolkit in 2016/17 with an overall self-assessment score of 98%.

A detailed implementation plan to support the implementation of the new duties has been prepared by the CCG’s shared IG team and progress against the plan will be reported regularly through to the Senior Management Team (SMT) and the Audit Committee.

The IG team is working with colleagues across the four Calderdale, Kirklees and Wakefield CCGs to ensure implementation activities are adequately resourced. In recognition of the potential risk to the CCG, a risk has been added to the corporate risk register which captures the implications of failure to meet the implementation of statutory requirements by May 2018.

Further information about the new law can be found on the Information Commissioner's website: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/

7. Art Therapies

As the local commissioners of mental health services from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Calderdale Clinical Commissioning Group (CCG) has
been involved in recent discussions about concerns raised by members of the public that SWYPFT planned to stop providing Art Therapy.

Following concerns raised it was decided that a working party should be convened that involved local Councillors, CCG commissioners, SWYPT and service users. The working party agreed that an independent review of the service should be commissioned; and that this report would then be presented to Adult Health and Social Care (AHSC) Scrutiny Panel and CCG commissioners in order to inform next steps.

This review was undertaken by Mental Health Strategies and a report was presented to Adult Health and Social Care Scrutiny panel on 11th May 2017. The panel recommended several actions and letters have been forwarded from the CCG to SWYPFT to individual service users to advise them of the recommendations and the actions to be undertaken by the CCG and those that will be the direct responsibility of SWYPFT to action. The CCG will now carry out a wider review of psychology services and the views of art therapy service users will be taken into account as part of this review.
Executive Summary

Please include a brief summary of the purpose of the report

The purpose of the report is to provide an annual account of NHS Calderdale CCG’s engagement activity. The report sets out all engagement activity delivered during the period 1st April 2016 to 31st March 2017 and any planned activity for the year April 2017 onwards.

Recommendation (s)

It is recommended that the Governing Body:

APPROVES and SIGN OFF the annual statement of involvement as an accurate account of our activity during that period so the report can be published.

Decision ☒ Assurance ☒ Discussion ☑ Other 35T

Implications

Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)
The report references its link to equality and supporting Equality Impact Assessments (EQIA).

Public / Patient / Other Engagement
The paper sets out our annual activity for engaging public, patients, stakeholders, carers and staff.

Resources / Finance implications (including Staffing/Workforce considerations)
There are no resource or finance implications for this report.

Strategic Objectives (which of the CCG objectives does this relate to?)

Achieving the agreed strategic direction for Calderdale Improving Quality Improving Value

Risk (include risk number and a brief description of the risk)
None identified

Legal / CCG Constitutional Implications

Conflicts of Interest (include detail of any identified/potential conflicts)
None identified
1. **Introduction**

1.1 The purpose of the report is to provide an annual account of our engagement activity for the previous financial year 1st April 2016 – 31st March 2017.

1.2 The report includes all the engagement activity the CCG has delivered including what we did, the key messages and how the information was used.

1.3 The paper also includes wider engagement activity from other healthcare provider organisations including Locala, Calderdale and Huddersfield Foundation Trust (CHFT) and South West Yorkshire Partnership Foundation Trust (SWYPFT).

1.4 The paper also describes the engagement activity already planned for the forthcoming year April 2017 to March 2018.

2. **Detail**

2.1 NHS Calderdale CCG has a ‘Patient and Public Engagement and Experience Strategy’ which sets out our approach and process for engaging people and underpins our ‘whole system approach’ to supporting this work.

2.2 Our approach to public engagement and consultation is to make sure that we use a variety of different mechanisms, methods and approaches to engage with people. We need to ensure we can involve people, when they need to be engaged or indeed want to be engaged.

2.3 We want to make sure we hear from all the people and communities in Calderdale - everyone’s opinions matter. We understand that the way we ask for people to share their views can make a big difference to who responds. We also use equality monitoring to assess the representativeness of the views we have gathered.

2.4 The Annual Statement of Involvement is our opportunity to present the work we have done, catalogue our activities and present any changes as a result of this work. The report sets out the engagement activity which has taken place on the following areas:

- Right Care, Right Time, Right Place – Consultation on hospital and community services
- Right Care, Right Time, Right Place – Stakeholder event
- Calderdale Health Forum
- Learning Disability Transforming Care Programme (LDTCP)
- The Equality Delivery System (EDS2)
- An asset based approach – supporting people with a learning disability to have a voice:
- Stroke services – West Yorkshire and Harrogate Sustainability Transformation Partnership (STP):
- Provision of a Multi Faith Room at the Dales Unit – South West Yorkshire Partnership Foundation Trust (SWYPFT):
- Care Closer to Home (CC2H) Care Homes
- Primary Medical Services (PMS) funding review
- Vanguard – Locality model
- Mental Health Rehabilitation and Recovery
- Vanguard – Website Calderdale MBC
- Vanguard – Community Panel
- Working Voices
2.5 The report also describes how we have used the insight we have gathered from all engagement and consultation activity to support commission decisions, and how we plan to continue using this intelligence in 2017/18.

2.6 Subject to Governing Body approval and sign off, this report will be published on our website, circulated to our practices and key stakeholders.

3. **Next Steps**

3.1 The next steps will be:

- To publish the document
- To continue to deliver engagement on the projects identified in 2017/2018
- To identify the specific target audience we want to engage further and continue to develop our approach to engaging specific target audiences
- To generate the intelligence required to support equality impact assessments
- To continue to catalogue our activity and implement our Engagement and Patient Experience Action Plan for the period 2017/18

4. **Implications**

4.1 **Quality & Safety Implications**

The programmes of work set out in the report all support our equality duty by ensuring activities are monitored using an equality monitoring form. The information gathered also supports the completion of Equality Impact Assessments (EQIA). This process provides assurance that we are talking to the people who will be impacted by a proposal including our most protected groups.

4.2 **Public / Patient / Other Engagement**

The paper sets out our annual activity for engaging public, patients, stakeholders, carers and staff. The report provides assurance that the organisation considers the views of local people in commissioning decisions.

4.3 **Legal / CCG Constitutional Implications**

The CCG has to ensure that it delivers on the responsibilities set out under Section 242 Health and Social Care Act, The NHS Constitution and The Equality Act when delivering engagement and consultation activity.

5. **Recommendations**

5.1 It is recommended the Governing Body APPROVES and SIGN OFF the annual statement of involvement as an accurate account of our activity during that period so the report can be published

6. **Appendices**

Appendix 1 - Patient and Public Annual Statement of Involvement April 2016-March 2017
Patient and Public Engagement
Annual Statement of Involvement
1\textsuperscript{st} April 2016 – 31\textsuperscript{st} March 2017
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Acknowledgements

We would like to thank all of the individuals and organisations who have taken part in our consultation and engagement activities over the past year, and shared their experiences of using local services. Your contributions have helped to inform our commissioning decisions, ensuring your local NHS continues to provide quality and responsive services.

This report gives us the opportunity to tell you what consultation and engagement activities have happened over the last year, what you told us and what we have done with the comments you made.
1. Introduction

The CCG (Clinical Commissioning Group) was formally established in April 2013 and has the responsibility for ensuring that people living in Calderdale have access to high quality health services.

In 2006, Patient Involvement was strengthened by the NHS Act. Sections 242 and 244 of the Act place a duty on NHS organisations to involve and consult local people and stakeholders in the planning and development of services. Also included was a duty for Primary Care Trusts (PCTs) to report on this activity in an annual 'statement of involvement'.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how NHS commissioners will function. These amendments included two complementary duties for Clinical Commissioning Groups (CCGs) (as the organisations who replaced PCTs from 1 April 2013) with respect to patient and public participation and also a duty to promote the NHS Constitution which was refreshed in 2013. The legal duties in relation to Patient and Public Engagement are presented at Appendix 1.

This report provides an overview of the consultation and engagement activities that have taken place over the past year (from 1st April 2016 until 31st March 2017) and includes a summary of what people told us, what the outcome was and where you can find further information. It also includes details of any consultations/engagement activities that are currently planned for 2017/18.
2. About Us

NHS Calderdale Clinical Commissioning Group (CCG) is the CCG covering 26 General Practices and a registered population of more than 209,000 patients. CCGs are groups of GPs that are responsible for planning and designing local health services in England. We do this by ‘commissioning’ or buying health and care services including:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

Clinical Commissioning Groups work with patients and health and social care partners (e.g. local hospitals, local authorities, local community groups etc.) to ensure services meet local needs. CCG boards are made up of GPs from the local area and at least one registered nurse and one secondary care specialist doctor.

The CCG is made up of local clinicians who are working together to secure the best possible healthcare for local communities. Our aim is to improve the health and lives of local people by increasing life expectancy, making sure we commission and provide good quality services and to reduce health inequalities across the district.

Our vision and values

The CCG’s vision is:

To achieve the best health and wellbeing for the people of Calderdale within our available resources

Our values are:

- Preserve and uphold the values set out in the NHS constitution
- Treat each other with dignity and respect
- Encourage innovation to inspire people to do great things
- Be ambassadors for the people of Calderdale
- Work with our partners for the benefit of local people
- Value individuality and diversity and promote equity of access based on need
- Commission high quality services that are evidence based and make the most of available resources
- Encourage and enable the development of care closer to home

**Our priorities**

As an organisation we are working towards six key priorities. These are:

1. Preventing people from dying prematurely
2. Enhancing the quality of life for people with a long-term condition (including work on urgent care pathways)
3. Helping people to recover and maintain their independence (including work on intermediate tier)
4. Ensuring people have a positive experience of care (including those in care homes, and those accessing primary care)
5. Ensuring a safe environment and protecting people from harm
6. Reducing inequalities in Calderdale

**Our finances**

NHS Calderdale CCG is responsible for devolved healthcare budgets of approximately £300 million on behalf of our patients and people living across Calderdale.

We will make sure we use our available resources to deliver our priorities, fulfill our commissioning plans and improve outcomes for patients. We will regularly review our activities and where appropriate, take action to achieve financial balance in respect of provider costs, prescribing and management/running costs.
3. Our approach to engagement

Our approach to public engagement and consultation is to ensure that we use a variety of different mechanisms, methods and approaches to engage with people. We need to understand how we can best involve people, when they need to be engaged or indeed want to be engaged.

We have a ‘Patient and Public Engagement and Experience Strategy’ which sets out our plans for the next three years it is also in place to ensure that we adopt a whole system approach to supporting this work. To view the report: on this website: http://www.calderdaleccg.nhs.uk/wp-content/uploads/2013/03/Calderdale-CCG-PPEE-Strategy-final-version.pdf

Our strategy enables us to meet our responsibilities under the Health and Social Care Act 2012:

- putting patients at the heart of everything we do
- focusing on improving those things that really matter to our patients
- empowering and liberating clinicians to innovate, with the freedom to focus on improving healthcare services and,
- The recommendations of the Francis Report.

The strategy shows that we are committed to ensuring that we actively engage with patients, the public and other key stakeholders to ensure that the commissioning, design, development, delivery and monitoring of healthcare in Calderdale meets the needs of our population. By listening to patients, and learning from their experience of health care we can understand what really matters to people.

We want to make sure we hear from all the people and communities in Calderdale - everyone’s opinions matter. We understand that the way we ask for people to share their views can make a big difference to who responds so we ensure we design our patient experience and engagement processes with this in mind. We also use equality monitoring to assess the representativeness of the views we have gathered and where there are gaps or we identify trends in opinion these are looked into and plans made to address them.

Throughout the year we actively promote any activities for people to become involved and the Annual Report for Involvement is our opportunity to present the work undertaken, catalogue our activities and present any changes as a result of this work.

This report will be published on our website and circulated to our member practices and key stakeholders. We also have a number of other mechanisms in place to manage our engagement activities and gather your views, these are highlighted below.
Patient and Public Engagement and Experience (PPE&E) Steering Group
The purpose of the Patient Experience and Patient and Public Engagement Steering Group is to shape, steer and advise on any engagement and consultation activity.

New for 2016/17 Patient Experience Group (PEG)
The purpose of the Patient Experience Group is to help shape and improve patient experience. The group do this by:

- Networking – developing and sustaining positive relationships across the group membership.
- Collaborating - working together with providers to identify areas of good practice, areas of concern and actions for improvement.
- Learning – sharing good practice across local providers as well as being mindful of the ongoing work of the West Yorkshire and Harrogate STP as new plans are developed across the region.
- Shaping – Setting, monitoring and driving the delivery of the patient experience priorities.

Calderdale Health Forum
Calderdale Health Forum has been set up by the CCG as a forum to gather together representatives from each of the member practices’ patient reference groups (PRGs). Throughout the year we discuss engagement topics at the Health Forum meetings, this gives the group an opportunity to discuss in detail some of the main pieces of work and priorities of the CCG and provide feedback on these. The Network meets on a bi-monthly basis, but members are also informed of engagement opportunities on an on-going basis. We engage with the network as part of our decision making.

‘Engagement Champions’
Engagement Champions is an asset based approach to engagement and involves training members of the voluntary and community sector as engagement leads. The aim of the project is to support the third sector voice in commissioning and to use their communities to ensure we reach local people at a grass roots level.

Engagement Champions are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups.

New for 2016/17 Patient Stories
Patient stories help bring experiences to life and will encourage the CCGs to focus on the patient as a whole person rather than just a clinical condition or as an outcome. They have the potential to inspire us to make successful changes, educate the workforce, to support learning about what works well and to promote excellence. We now have a system in place to collect stories as part of the CCGs approach to involving people.
Calderdale CCG website (www.calderdaleccg.nhs.uk)
Calderdale CCG has a website which provides information to the public including a section called ‘Get Involved’. As a CCG we will fully use our website to inform of our plans to engage, raise awareness of any consultation activity and also provide opportunities to become involved. This website is updated on a regular basis so we can regularly report on the outcomes of all consultations and what we have done as a result of our engagement activity.

Patient Advice and Liaison Service (PALS)
PALS helps the NHS to improve services by listening to what matters to patients and their families and making changes when appropriate. PALS provide the following functions to the population of Calderdale:

- Providing the public with information about the NHS including complaints procedures, and helping with any other health-related enquiry
- Helping resolve concerns or problems and providing information for those using the NHS, and outside support groups and improving the NHS by listening to concerns, suggestions and experiences
- Providing an early warning system for NHS trusts and monitoring bodies by identifying problems or gaps in services and reporting them

Health Watch
Healthwatch is the consumer champion for both health and social care. It exists in two distinct forms – local Healthwatch and Healthwatch England. Local Healthwatch is an independent organisation and Calderdale CCG is working alongside the service to ensure that it forms part of our engagement of the local population. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Patient Opinion and NHS Choices
Patient Opinion is a feedback platform for the public so they can share their story or experience of healthcare services. Anyone can post an opinion on the website. NHS Choices also provides a similar facility. Calderdale CCG will search these facilities by provider to listen to what patients are saying about NHS services.

National and Local surveys
National and Local surveys take place throughout the year from various providers and local GP practices. Patients are encouraged to contribute to these surveys. The public can use surveys to have their say on current services and Calderdale CCG is able to use such surveys to understand the patient’s view of the service. In addition surveys can be used collectively to inform commissioning decisions.
Service redesign activities
Throughout the year we actively promote any activities for people to become involved. In addition we ask if people would like to have their name stored on a people bank so we can contact individuals directly about healthcare services.

Engagement as part of the development of our commissioning intentions will feed into the overall themes arising locally and support our decision making in respect of future actions. We will continuously cross reference the themes which arise from patient and public engagement to update and reflect on the intelligence we have to date.
4. Consultation and Engagement activities undertaken between April 1st 2016 and March 31st 2017

When there are decisions to be made which affect how local NHS services are commissioned, we make sure we talk to those patients who will be most affected and for those larger pieces of work we make sure the general public are made aware of any proposals so they too have the chance to have their say. We carry out one-off pieces of work as well as involving patients and the public on an on-going basis through the partnership arrangements we have in place with local patients and communities. For services planned to deliver engagement in 2016/17 that are not included in the report, other work has taken place. The service not included in this report is set out below with an update:

- **Long term conditions (All ages):** Whilst we have not completed any specific work with people who have a long term condition we continue through our equality monitoring to consider views. As part of our approach to engagement we routinely gather the views of those with a long term condition and report on specific experiences, the experiences of people with a long term condition are considered in all the CCGs activities.

The report includes all engagement and consultations that have been undertaken and completed during 2016/17, including any that started before 1 April 2016 or that started during the period of this report, but are not yet completed. It also includes details of the engagement and consultations planned for 2017/18. From all the work we have completed this year these are our **key emerging themes:**

- Services that are coordinated and wrap around all the persons needs
- Staff that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced and maintain quality
- More information available about health conditions and more communication about what is available
- Services that everyone can access including the buildings, appropriate information and staff that represent the community they serve.
- Any barriers to travel and transport addressed with a clear plan which takes account of diversity and locality
- Improved communication between all agencies involved in a person care and treatment
- Services that are responsive and flexible - particularly in an urgent care situation
- Reduce delays in getting the care and treatment required and improving waiting times
- As many services as possible should be close to home in local settings such as a GP practice

We will use these themes to continue to drive our work and have set out below the specific highlights of our engagement work from 2016/17 which have contributed to broader themes
and informed and supported specific pieces of work (activities are listed in alphabetical order).

Throughout the year we have actively promoted opportunities for people to become involved in the decision making process. During 2016, we had patient representatives taking part in a stakeholder event for hospital and care closer to home services as part of our deliberation of formal consultation.

5. Using Insight to support commissioning decisions

Every engagement and consultation delivered throughout the year provides more rich information and intelligence to support service development and design. Prior to embarking on a piece of work to gather views, the CCG gather any existing patient experience and engagement information.

By working through existing intelligence the CCG can identify key emerging themes and also identify where there are gaps. In addition we can also identify through the Equality Impact Assessment (EQIA) the communities we have already reached and need to reach in line with our equality duties. The information sources we use are:

- Patient Advice and Liaison (PALS) queries
- Reported Complaints
- Friends and family test
- Websites such as Patient Opinion and Patient Choices
- National and local surveys
- Findings from any engagement/consultation activity
- Calderdale Health Forum

The information we gather is saved in a format that allows for further interrogation. By looking at what we already know we can draw down information again and use it to support other service areas. The data we hold not only allows us to draw on a wealth of intelligence but further assures our local population that their views are an important source of business intelligence. The CCG also equality monitors all activity ensuring the insight we have can be used to represent the views of a range of protected groups.

From our vast data source we have been able to provide a number of composite reports which have underpinned our understanding of our local population. The first report of this kind was developed in February 2014 to support the programme Right Care, Right Time, Right Place. The four reports developed focussed on:

- Urgent care
- Planned Care
- Children and Young People
- Long term conditions
An additional report to support Right Care, Right Time, Right Place was written in July 2015 to support our understanding of hospital and community services programme. The report can be found on our website: http://www.calderdaleccg.nhs.uk/get-involved/

The style of report has been used by partners such as Kirklees Healthwatch to support the regional Vanguard and by the local West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP) to identify the key themes for the local area.

This approach has also resulted in the development of smaller insight reports which have been used to support service areas such as:

- Vanguard locality model and services as part of Care Closer to Home
- Calderdale and Huddersfield Foundation Trust (CHFT) Maternity and paediatric service review
- Travel and transport for Right Care, Right Time, Right place
- Primary Care developments including an enhanced service review

In 2017/18 we will be producing a similar report for Mental Health to support our understanding of current services, and inform the delivery of the Calderdale response to the five year forward view. In addition we will be drawing on existing data to support our plans for access to primary care services.
**Right Care, Right Time, Right Place – Consultation on hospital and community services:** The Right Care, Right Time, Right Place programme is the commissioners' response to the case for change that was developed as part of a services review undertaken in 2013. Following extensive engagement in 2015/16 a consultation on the proposals for service change took place in 2016/17.

The Right Care, Right Time, Right Place programme represents three interlinked pieces of work which are:

- Calderdale Care Closer to Home Programme;
- Greater Huddersfield Care Closer to Home Programme; and the
- Hospital Services Programme.

Collectively, these programmes developed proposals for what future community services in Calderdale and Greater Huddersfield and the future hospital services in Calderdale and Greater Huddersfield could look like.

**Who did we consult with and what did we ask?**

A full consultation document, survey and accompanying summary and easy read documents were produced to explain the proposals. A consultation ran for 14 weeks from 15 March to 21 June 2016 on the future of hospital and community services in Calderdale and Greater Huddersfield. The proposals were:

- To have two Urgent Care Centres, one at Calderdale Royal Hospital (CRH) and one at a new hospital on the Acre Mills site at Huddersfield
- To have one Emergency Centre at CRH
- To have a new Children’s Emergency Centre at CRH
- To build a new 120 bed planned care hospital on Acre Mills site at Huddersfield
- To continue with more maternity services in the community
- To have more health services out of hospital and in the community

The consultation was delivered through a range of communications, social media and website content as well as 3 public meetings, 17 information sessions and 16 roadshow activities. There were a total of 36 meetings with a range of stakeholders.

We also received feedback from the activities of a range of community groups who ran a variety of consultation activities on our behalf as part of the Community Voices programme. Most of the people our community voices reach are the most vulnerable people in our community, including those who represent protected groups. A range of questions were asked under each of the proposal headings which were:

- Urgent Care
- Emergency Care
- Planned Care
- Community Services
- Maternity and paediatric services
- Travel and transport
We also asked people to tell us anything else we may need to know under each of the headings.

**What did they tell us?**

We received 7,582 survey responses from local people which provided 40,000 comments to 11 questions. We also had in excess of 500 phone calls, letters, documents, texts and emails to read and 195 pages of transcripts from 3 public meetings and 8 petitions. In order to ensure the responses were fully considered, the CCG secured the services of an independent organisation Midland and Lancashire CSU (MLCSU) to analyse all the responses and produce a report of findings. The findings from the consultation are set out below.

**Feedback on all the proposed changes:** We asked people to tell us if the proposed changes would impact on them. 67% of all the people who answered the survey said they felt they would be negatively impacted by the proposed changes. When we looked at where people lived 80% of these people were from Greater Huddersfield. People told us their main concerns were:

- Travel times, the impact on other hospitals and the ambulance service. People also said that the proposed changes may not meet the need of local people.
- Some people did tell us that they thought the plans would deliver high quality care.

**Feedback on emergency care services (for life threatening and acute conditions):**

When asked what people disliked there were more concerned responses from people living in Huddersfield. When asked what people liked about the proposed changes from a list of options 61% of people from Greater Huddersfield said ‘none of these apply’. People from Calderdale ticked that they liked some of the proposed changes. People told us

- That ‘one emergency centre makes sense’ and that the best care should be in one place if resources are limited.
- The main concerns were about being seen and treated quickly, travel to services, keeping services as they are and putting lives at risk.

**Feedback on urgent care services (for non-life threatening conditions):**

When asked what people disliked about the proposed changes there were twice as many concerned responses from people living in Greater Huddersfield than Calderdale. People from Calderdale told us that they liked some of the proposed changes. The main comments were:

- How an Urgent Care Centre would work,
- What services it would provide and who the staff would be.
- Concerns about travel to receive treatment and access to the right care

**Feedback on planned care services (a procedure or treatment that is planned. You have to stay in hospital to recover):**

When people were asked what they disliked there were similar responses from people living in Calderdale and Huddersfield. Overall there were few concerns for planned care. People told us:

- The main concern was being seen and treated quickly.
• Longer waiting times for operations when one hospital has to provide more planned care for two towns.
• Travel time and access to services
• They wanted to know how a new hospital at Acre Mills would be funded.

Feedback on maternity services: The responses to what people liked and disliked about the proposed changes were similar for both Calderdale and Greater Huddersfield. There were fewer comments on maternity services with only 2,529 people answering the questions in this section. The main comments were:
  • People felt that Calderdale maternity services are understaffed.
  • Travel times for appointments and access are concerns.
  • Both towns need their own maternity services as there was not enough evidence that care closer to home is working.

Feedback on paediatric services: There were more responses about what people disliked about the proposed changes from people living in Greater Huddersfield. Most people stated:
  • They were not concerned about the quality of care or receiving the right treatment but more about how quickly they would receive care.
  • Over half of respondents said they did not like any of the proposed changes.
  • Concerns as to how quickly children would be seen and treated
  • Travel and transport to services particularly in an emergency.

Feedback on community services: People living in Greater Huddersfield told us they had more concerns for community services. The main comments were:
  • Concerns about the amount of trained staff in the community
  • How the proposals would be funded and delivered
  • More funding is needed for GP surgeries

From all the feedback received MLCSU told us there were six key areas that we needed to consider. The key areas for further work were:

1. Travel and transport: Impact of increased travel times, in particular for access to emergency treatment at Halifax. Travel between Huddersfield and Halifax on the Elland bypass. People also mentioned public transport, travel costs and lack of car parking at CRH and ambulance responses.

2. Clinical safety and capacity: People were concerned that lives could be put at risk from the need to travel further, the quality of care and the availability of treatment. How Urgent Care Centres would work with the Emergency Centre and the impact on GPs and the Ambulance Service.

3. The rationale for change: People stated that the proposals are to save money, instead of to improve results. They were worried that the Private Finance Initiative (PFI) agreement at CRH had influenced the proposals. People wanted to know if staff at the hospital and other services, such as the Ambulance Service, supported
4. **The consultation process**: People were worried how the consultation was done and how decisions would be made.

5. **Understanding the proposed model**: Some people did not understand the detail of the clinical model. People said there was not enough information on what it was and how it would work. People did not seem to understand the terms ‘emergency care’ and ‘urgent care’.

6. **The need for change**: Some people agreed that change is needed, even though there are concerns. Suggestions were made about alternative sites, different ways of arranging services and improvements to services.

**What did we do?**
The Governing Bodies of NHS Calderdale Clinical Commissioning Group (CCG) and NHS Greater Huddersfield CCG met in parallel in public on Thursday, 20 October 2016 to reach a decision on the outcome of the consultation and next steps on proposed changes to hospital and community health services in Calderdale and Greater Huddersfield. The findings from the consultation were deliberated by the CCGs and considered by the Governing Bodies at this meeting.

**Where can you find more information about this work?**
An independent report of findings was published by Midlands and Lancashire Commissioning Support Unit on the 25th August, 2016. You can find more information about this work and a copy of the consultation report on [www.rightcare.time.place.co.uk](http://www.rightcare.time.place.co.uk) website.
Right Care, Right Time, Right Place – Stakeholder event: Following the consultation a stakeholder event was arranged to support the CCG in deliberation of the consultation findings. A number of stakeholders had continued to work with us throughout the programme and we wanted to use the opportunity to engage them in the findings from consultation.

Who did we engage with and what did we ask?

The purpose of the stakeholder event was:

- To provide an overview of the consultation process – To describe the consultation activity and provide an overview of the activities which took place over the 14 week period.
- To describe the process of how the report of findings had been developed- to describe the methodology used and how consultees responses were analysed.
- To present the findings from the consultation process – To use the event to share the findings from the consultation process, in an accessible way, using the report of findings. This section would be presented by the independent provider.
- To provide the opportunity to identify the most important issues and make recommendations to address / mitigate the issues/ main themes
- To describe the next steps – To describe where we are in the process and the next steps.

There were a number of mechanisms for gathering views at the event. Following the presentation on the report of findings we asked participants as part of a table discussion to answer the following questions;

- Are you surprised by the findings, are they what you expected?
- From what you heard, what do you think the main issues are?
- From the main issues you have identified in activity 1- What are the potential solutions to address the main issues raised in the consultation?

Participants were asked to write comments on a post it note as part of a facilitated table discussion and place those comments on an opinion board. In addition to the table discussions each table was able to provide views or comments using:

- A comments clothes line for participants to peg up comments on flags of anything they wanted to say that may have not been captured adequately in the table discussions.
- An evaluation form gathered people’s views at the end of the event, and provided a final opportunity for participants to tell us anything they thought we should know

What did they tell us?
The findings from the stakeholder event are captured below. The findings include the key themes received from the table discussions. Key messages from each table were written on a ‘green flag’ and presented to the facilitator to read out at the end of the stakeholder event. The messages were;
• A&E versus urgent and emergency care – there needs to be a clear understanding of the differences. Communication and trust are needed and case studies and stories would help.
• Travel concerns – there needs to be some explanation of what A&E is and isn’t to help people understand.
• Need to communicate clearly and widely the model – the consultation suggests people still do not understand the urgent and emergency care model.
• Communicate how things will work in practice (the language we use is important) – help people to understand patient pathways, explain terminology, clarify things practically.
• Communication and culture shift – describe the bigger NHS picture and provide clear messages that hospitals are not always the answer. Make sure information is collaborative (everyone working together for both communities) and honest (including finance) to improve outcomes.
• Communicate the benefits and facts of the proposal - emphasise care closer to home.
• Need for change – clear understanding required, need to communicate.
• The rational for change needs a better explanation.
• Clinical case for change needs more describing - to help people understand how it affects ‘me’, this could include case studies.
• Clinical safety – emphasise the opportunity for new ways of working between hospital and GP practices and the use of new technology and better use of staff.
• The impact on GP services, including access – we need to start from the services closest to the individual and ensure community services are in place in order to design a secondary care system. This should be phased in and tested at each stage.
• Workforce planning – the system needs the right numbers of staff with the right breadth of competencies across a health and social care system. There needs to be the right balance between generalist and specialists and services need to be joined up.
• Recognition of the need for change and that all issues can be resolved – CCGs need to be sure that any issues identified can be achieved. The next stage is to win hearts and minds in order to progress further.
• 64% do not agree with the proposal – how will the CCG now flex the proposal and improve communication of any plans.
• We need to thank people for responding to the consultation – patients and public deserve a response.

What did we do?
The Governing Bodies of NHS Calderdale Clinical Commissioning Group (CCG) and NHS Greater Huddersfield CCG met in parallel in public on Thursday, 20 October 2016 to reach a decision on the outcome of the consultation and next steps on proposed changes to hospital and community health services in Calderdale and Greater Huddersfield. The findings from the stakeholder event and CCGs’ deliberation were considered by the Governing Bodies at this meeting.

Where can you find more information about this work?
A report of the findings from the stakeholder event was produced in October 2016. This report can be found on this website: www.rightcare.time.place.co.uk.
Calderdale Health Forum: The Calderdale Health Forum is a group of patient representatives from Calderdale GP practices that meet every quarter. The patient representatives come from the GP practice Patient Reference Groups.

What we do with the feedback
All the insight provided at each session is recorded and used to inform each programme of work. We do this by including the responses as part of a broader report of findings which we write for all engagement and consultation activity. Topics of conversation are fed into programme action plans which are often at the development stage. Members of the Forum are one of the first points of contact for service developments and represent one of our key stakeholder groups.

Recent topics covered by the Health Forum meetings include:

June 2016: Mental Health Services

What we asked:
The forum received a presentation on mental health services and the Calderdale ‘Mental Health Hub’. The hub has been set up to involve health, social care, voluntary sector, police and education to develop ideas for services/support for people with mental health. The NHS England ‘Five Year Forward View for Mental Health’ will drive these improvements in Calderdale. The key service areas for improvement are;
- High quality 7 day services for people in crisis
- Integration of physical and mental healthcare
- Prevention.
The group were asked to consider what could be done to stop people becoming mentally unwell, help people to recover or stabilise and help people to maintain good mental health.

What they told us:
Through a number of table discussions, the CCG received the following feedback:

- Community based support instead of going to GP for first contact
- Educating both public and people with mental health issues – ‘don’t fear asking for help’. Remove the stigma of mental health as a burden
- Peer support, simple conversations – ‘listening’. Take time out to understand people “Coffee and a chat”, asking about how people are. Idea of café to talk to others
- Exercise including yoga, Pilates, and any feel-good exercise
- People need to talk to someone – sometimes friends and family are not the right people. Friendships are important
- Not a quick fix – need long term support
- People with mental health problems still want privacy and dignity
- Maintain known networks e.g. Samaritans
- Know how to recognise the symptoms and what you can do – ‘quick list’. Not everyone recognises their own mental health problem. Getting a person
themselves to recognise the symptoms and accept they need help. Recognising at an early stage

- Information is needed for people supporting others with a mental health problem to give quick tips e.g. simple checklist. Help for partners, families, friends – place to go
- Workplace stress/anxiety – more work with employers on how to manage staff. Having volunteering opportunities i.e. help people back into a work environment
- Promote what’s in the community to help people. Knowing where to go to get help / supporting people to find that help. Arrange for people to visit people who are lonely – churches, Age UK
- Good neighbour/community spirit, talking to people
- Holistic approaches – not just about tablets
- Focus on people with more common conditions (impact on largest numbers)
- Need to be aware of modern life and the issues it brings
- Different attitudes these days in older people

September 2016: NHS Friends and Family Test (FFT)

What we asked:
FFT had been introduced in 2013 to help service providers and commissions gain views from their patients. The service was an anonymous way to give views by indicating whether they were likely to recommend services to friends and family. A presentation and short film about FFT, including the standard survey questions used to gather views were presented to the group. It was explained that a free text question in the survey could be changed locally to gather important local views.

Forum members were asked to consider the question on the free text response section of the survey which was currently set at ‘What is the main reason you feel this way?’ and consider how they would change the question.

What they told us:
Through a number of table discussions, the CCG received the following feedback:
- The current question is good and simple. The question at the moment fits well and gives opportunity for a broad range of answers and shows trends. Why do you feel this way?” – can be a positive or negative experience
- Specific questions about nurses/GPs/opening hours – are patients aware of what they are and when should hours be extended?
- Specific questions with multiple choice answers so its easy to report on the results
- Change the question regularly for a topic on if you have “X” medical condition, what support would you like to have? (“X” could be long term condition)
- “Why do you not get involved in the patient group?” – this could help to involve young people – can also ask the question whilst at the practice
- “Are you interested in joining a patient group?”
• “If you could change one thing for the better, what would it be?”
• “How could we help you when you need an urgent appointment?”
• “How could communication be improved in the practice?”
• “What would you suggest would improve how you feel about our service?”

Feedback on the approach to delivering FFT:
• Put some key messages on Friends & Family Test about the cost of missed appointments
• The text messaging with F&FT questions is a good service
• Some patient groups aren’t having meetings and/or discussing F&FT
• Need professional displays of the comments
• Put the comments on the TV screens
• Every 2 months, our practice asks a further 4 questions – the patient group analyse and feedback the findings to the patients attending the practice
• Our practice has a comments satisfaction book and the practice manager answers every question
• Should think about the representative cover across the practice population and how to capture this

September 2016: Patient On-line

What we asked:
NHS England have a national programme to encourage an increase in the use of online GP services. CCG’s have been asked to improve the use of these services with practices in their local area. Attendees were asked for views on the proposed campaign plan and key messages.

What they told us:
Through a number of table discussions, the CCG received the following feedback:
• Posters need to be in different fonts larger and highlighted – fewer pictures more text.
• Promotion materials need to be all over e.g. NHS, social care, libraries, and bus stations. Promotion via digital TV screens needs to have audio too
• Older people don’t go online – need to consider this. Need to promote computer literacy altogether. Need to be aware that not everyone will want to use online services
• Launch week should include a media launch
• Conflict of messages from NHS as GPs will not send information online unless the line is encrypted. NHS England promoting access to patient records online.
• Can the Icon to book an appointment online be easily found on all practice websites? ‘Create information for Practice websites’: Need to be simple/obvious access.
Could promote in the practice – PRG Group to spend a couple of hours helping people to navigate the website. Video demonstration on how to book an online appointment – on digital TV screens
Also consider those with hearing/sight issues – How do we target this group of people and LD groups
Not all patients always attend the surgery, not always time to look at information in the surgery. Register online without having to go into the surgery
‘Use of Social Media’: Useful for some groups of people – young people
‘Work with local voluntary and community groups to promote online’: Show people how to use online services

Following the meeting in September 2016 we surveyed all our members to identify how well the forum was working. Members told us that they wanted more time to discuss the topics of their choice, and be informed about future engagement activity to respond outside the meeting. ‘Your Space’ sessions were set up to allow for members to bring topics of importance which they wanted to:
  - share information on
  - have a conversation about
  - gather other people’s views on
  - test out an idea

The following meetings reflect the topics raised and chaired by members and the findings from these discussions.

**December 2016: Your space topic: Diabetes Support Group**

**Members asked:**
The context of the conversation was about setting up a diabetes support group. What did others think? And were groups useful?

**What they told us:**
Through a number of table discussions, the CCG received the following feedback:
  - Support groups for diabetes were very helpful.
  - Groups good for getting information out to friends and family.
  - Groups can be more than just diabetes support: friendship and general life advice too.
  - Diabetes treatment is more than medication but also food and a healthy diet, e.g. GI (slow release) foods.
  - Food for diabetes – small breakfast, big lunch and small dinner.

Concerns were expressed during the feedback that the membership of some support groups was getting older and there wasn’t anyone to take over and continue with this valuable work. There were existing groups that would not continue for these reasons.
September 2016: Reception Areas Surgeries – Message Boards

Members asked:
The context of the conversation was to identify how others provide information and communication in waiting room settings, and to learn from any good practice.

What they told us:
Through a number of table discussions, the CCG received the following feedback:

- Too many notices confuse patients as to which is most important to read.
- Need a clear message board to enable patients to focus on the key notices/messages.
- Possible solution would be to partition the message board to have specific topical health issues in one section, surgery information in another section and another section relating to Calderdale health issues, eg Health Forum information.
- Have a TV screen to display messages.
- Need to have up-to-date information on message boards.
- Newsletter (monthly): put on website and in the surgery, eg practice news, appointment times, topical health issues, etc. Clear simple notes and information.
- Have a nominated/designated person at each surgery responsible for maintaining/updating message boards/the website.

September 2016: NHS criteria for receiving services and patient responsibility for their own health / illness

Members asked:
The context of the conversation was to debate whether people who smoke or who are overweight receive the same services, or should a set of criteria be out in place as some areas are starting to do.

What they told us:
Through a number of table discussions, the CCG received the following feedback:

- If people’s lifestyle is affecting their health should the NHS pick up the tab?
- Lifestyle could be the cause of the illness but have no effect on treatment i.e. footballer and a broken leg.
- Some illnesses may stop people from exercise so it’s not the persons fault if they can’t exercise and put on weight – they shouldn’t be penalised.
- Poor decisions in the past may lead people to needing treatment now – there wasn’t the education about the dangers
- People should be encouraged to stop smoking or lose weight and not be penalised for it – people should at least try themselves first before treatment.
- Treatment should be based on a clinical need not a lifestyle need.
- GPs are overworked so don’t always have the time to listen to people.
• Should a GP be able to say I don’t like the way you live your lifestyle? It can also be down to the person who is talking to the patient. It takes a certain kind of person to help and encourage.
• There should be centres for people to go to

Attendees felt this was very subjective and that the dilemma would be where to draw the line. It was considered that educating people should be a better way forward.

March 2017: Are we duplicating Patient Reference Groups/Communications

**Members asked:**
The context of this conversation was around the potential/perceived duplication of work carried out by the different groups.

**What they told us:**
Through a number of table discussions, the CCG received the following feedback:
• Practice Champions – who are they and how are they funded?
• It is recommended to have a Patient Reference Group. Is it contracted and who does this?
• What is the relationship between this group and the local patient forum.
• Patient Reference Groups minutes need to be disseminated promptly so we can take to our local meetings
• Communication via Patient Reference Groups depends on the Practice Manager.

March 2017: Return of Appliances

**Members asked:**
The context for this discussion was the waste/cost to the NHS and Social Services of the non-return of equipment

**What they told us:**
Through a number of table discussions, the CCG received the following feedback:
• Equipment such as zimmer frames and crutches are not routinely returned
• NHS could tackle this to reduce overspend
• Cleaning of equipment versus wasted equipment in skips needs to be worked out
• Social Services and NHS hospitals to track equipment that is given out
• Can CCG influence social services to get equipment back?
• Does everybody know where to take equipment back
• No incentive to give equipment back – need a deposit system.

March 2017: Car Parking and Facilities for Patients with Severe Disabilities

**Members asked:**
The context for this discussion was the difficulties experienced with car parking at Calderdale Royal Hospital. Other members were asked if they had solutions.
What they told us:
Through a number of table discussions, the CCG received the following feedback:

- Different types of systems are needed at different entrances.
- Notices don’t tell you that the first 30 minutes are free.
- Cost of pre-paying means you may need to over pay.
- Not a very good public transport system: difficult to cross the main road.
- Is the shuttle bus between the two hospitals available for patients?
- When will new car park be started? Before or after the new hospital is built?
The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and autism.

The transformation plan is framed around ‘Building the Right Support’ and the ‘National Service Model’ October 2015 for transforming services. The service areas requiring transformation include:

- Mental health services
- Services that support specific neurodevelopmental syndrome
- The criminal justice system
- Lower level health or social care services
- Inpatient care

Each local area (CKWB) within the partnership had an initial programme of work to help transform services. The aim of the partnership was to share knowledge of each local plan and work towards developing a joint plan for the whole area.

**Who did we engage with and what did we ask?**

An event was arranged on 25th May 2016 by NHS Greater Huddersfield CCG on behalf of the CCG partners to support engagement with key stakeholders on the ‘Transforming Community Partnership Plan’ for people with a learning disability across Barnsley, Calderdale, Greater Huddersfield and Wakefield. The purpose of the event was to engage service users, carers, organisations and other key stakeholders on the ‘Transforming Care Partnership Plan’ and the strategy for engagement and communications. The event objectives were:

- To provide those attending with an overview of current Learning Disability services
- To engage people on Learning Disability services
- To use the findings from the engagement to help shape the ‘Transforming Care partnership Plan’
- To identify the best approach for communications and engagement
- To engage people in a fun day so they will continue to involve themselves further

The engagement part of the event was based on the draft ‘Transforming Care partnership Plan’. The plan already set out a number of areas of transformation. Each of these areas required further engagement with key stakeholders. The areas for engagement were:

- Crisis response/safe place accommodation
- Respite care/short breaks
- Response to challenging behaviour
- Homes in the community
- Supported living services
- Personalisation
- Transition
- Finance – including how money should be spent on services.
Engagement, Equality and communication strategy – which will gather views on our approach to engagement and communication and what we need to consider for equality.

What did they tell us?
Overall findings from this event are as follows. Key themes:

• Keeping active
  o Through exercise (especially group/team sports)
  o Through arts/community activities
  o Through socialising and relationship building

• Keeping healthy
  o Through self-management (with help where necessary)
  o Through working with staff (clinical and non-clinical)

• Being happy
  o Staying happy is easier when you try to keep active and healthy
  o Relationships are very important in keeping happy, especially parents, siblings, friends and staff.

• When asking for advice from attendees on how best to communicate, we heard:
  o Attendees enjoy receiving information in a written format such as a letter or newsletter.
  o Attendees also like taking part in group meetings and events like the ‘My Health Day.’

• When asking for advice from attendees on how best to listen, we heard:
  o Attendees enjoy taking part in group meetings and sharing their stories with others.
  o They also see the benefits of doing surveys.

• When asking for advice from attendees on how best to involve everyone, we heard:
  o In order to involve everyone, more easy read materials need to be available (especially online).
  o Attending more group meetings.

What did we do?
The findings for the event will be used to support the development of the Transforming Care Partnership Plan. The Transforming Care Programme Board has received the findings and identified actions from improvements using the feedback provided.

In addition, the findings from each of the service areas have been used to further inform developments. A number of workshops held in winter 2016 used the findings from the engagement to ensure they were considered as part of future proposals.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in July 2016. This report can be found on this website: http://www.calderdaleccg.nhs.uk/get-involved/
The Equality Delivery System (EDS2): The Equality Delivery System (EDS2) is a tool designed to help NHS organisations review and improve their performance for local people protected by the Equality Act 2010. The tool identifies what needs to be done to ensure the organisation is meeting the Public Sector Equality Duty (PSED). The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Without engagement with local people and communities, it would not be possible to deliver EDS2 effectively. This year Calderdale CCG worked in partnership with several large healthcare providers including the Mid Yorkshire Hospitals NHS Trust, Calderdale & Huddersfield Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and the Yorkshire Ambulance Service to deliver a joint approach to engaging with local communities and delivering the EDS2.

Who did we consult with and what did we ask?
An assessment panel was assembled with membership drawn from voluntary and community sector organisations representing a range of protected characteristics. The panel members were recruited from the Engagement Champions programme. The assessment process was split into three stages:

1. A Briefing — which consisted of a workshop which explained how the EDS2 works and how the CCG and partner organisations could get involved.
2. EDS2 Panel — An event where panel members could assess local health organisations. The two areas assessed for Calderdale CCG were Right Care, Right Time, Right place and Learning Disability Transforming Care Partnership.
3. EDS2 Grading Panel — A further meeting of the panel where members could reflect on the information they had received and assess health organisations.

Panel members were asked to consider if organisations had met two out of four possible goals. The EDS2 4 goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

Panel members were then asked to grade the organisation as ‘Undeveloped’, ‘Developing’, ‘Achieving’ or ‘Excelling’

What did they tell us?
Panel members graded each programme and gave an assessment of the grading. Calderdale CCG received the following feedback:
Right Care, Right Time, Right Place: Graded as ‘developing’

- Presentation could have been improved as it was difficult to determine what protected characteristics had been reached
- Some panel members felt that traditional consultation methods had been used but more could have been done to reach some groups
- Some participants of the panel had no experience of the programme and felt it was easier to grade projects that had some relevance/local context
- No panel members felt it was achieving
- Panel members felt there were gaps in engagement and underrepresentation
- The materials used for engagement were not great for people with communication or accessibility needs

Learning Disability Transforming Care Partnership: Graded as ‘developing’

- The programme did not provide enough evidence of engaging with protected groups
- There is a gap in services for people from Black Minority Ethnic (BME) community with learning disabilities
- The service needs to be more consistency with regard to support and services across the Kirklees patch
- Carers services and voluntary and community sector should be involved
- Would be useful to have some self-care days in practices
- Need to raise GP awareness including cultural competence training and disability awareness

What did we do?
The services presented for grading by the CCG were given recommendations for improvement by panel members. The services were asked to develop an action plan based on recommendations.

An action plan for each service area has been developed and managers will go back to the panel in 12 months’ time to report on the delivery of the actions agreed. The process will be ongoing throughout 2017.

In addition the comments and recommendations made by the grading panel will be used to inform a new set of Equality Objectives and actions for the CCG in 2017.

Where can you find more information about this work?
A report of the findings from the engagement process will be developed and published on the CCG website in July 2017. The report once published can be found on this website: http://www.calderdaleccg.nhs.uk/get-involved/
An asset based approach – supporting people with a learning disability to have a voice: VAC, a Calderdale based organisation that specialise in community and voluntary sector support and advice, developed a programme to help give a voice to people with learning disabilities. This programme was used to support a 6 month pilot for the Learning Disability Transforming Care Partnership across Kirklees, Wakefield, Calderdale and Barnsley. The purpose of the pilot was to create a mechanism where participants could gain the confidence to respond to any planned engagement and consultation activity.

The programme aim is to give local people a say in the delivery of health and social care services. The ‘voice’ is facilitated through training sessions which build participants confidence. The programme builds on the CCGs engagement approach ‘Engagement Champions,’ which is in place to ensure local people have a say in healthcare services. The training programme covered the following areas:

- Why engage? (Explaining why the NHS needs your views)
- Engagement Skills (The various methods and ways you can have your say on health)

During the sessions participants were encouraged to tell us how they wanted to be involved and if the pilot could support them to give their views.

Who did we engage with and what did we do?
The pilot was led by VAC and managed by Greater Huddersfield CCG on behalf of the partnership. People with a learning disability in Calderdale were recruited through voluntary and community organisations. The project aims were to:

- Develop capacity for people with a learning disability to engage in co-production conversations
- Create a network of service users who could work with commissioners and providers in developing learning disability services
- Identify opportunities for future events to be service user led and include the voice through patient stories

The programme recruited 20 participants to take part in two programmes of training (10 participants at each session). Calderdale now have 40 ‘Engagement Champions’ who are adults with learning disabilities as a result of this pilot.

What did the pilot tell us?
The learning from the pilot is as follows:

- It was clear early on that the current training approach needed to be adapted to work with a wide range of abilities and needs. The initial model developed in Calderdale was not as relevant and so the format and content had to be adapted to those with more complex needs
• The facilitators and trainers also needed to be flexible and adaptable in their approach to delivering the training to meet people’s needs

• The ‘Engagement Champions’ model, of training people to engage and consult with others was not appropriate for this group of people. Individuals needed more support to represent their own views

• Training had to focus on raising awareness of the importance of engagement

• A group of 10 adults with learning disabilities requires considerable resource. Much of the support required was on a one to one basis. Because of the individual support required, delivery of the sessions required two facilitators/trainers rather than the one per session which had originally been proposed

• The positive response to this training from voluntary and community groups indicates there is a desire amongst groups to have the views of their service users represented

• Voluntary and community groups appear to be willing to be involved

• It is important to develop a partnership approach with the CCGs and local authorities in each area

**What did we do?**

The pilot helped to determine the process required to involve people with a learning disability in engagement and consultation. As the pilot was well received there is more work planned with organisations and adults with learning disabilities as part of the ongoing ‘Engagement Champions’, programme.

The CCG will also be working with organisations who support adults with learning disability to ensure there are trained organisations registered to be ‘Engagement Champions’ programme.

**Where can you find more information about this work?**

For more information about this work and our programme ‘Engagement Champions’ go the CCG website: [http://www.calderdaleccg.nhs.uk/get-involved/](http://www.calderdaleccg.nhs.uk/get-involved/)
Stroke services – West Yorkshire and Harrogate Sustainability Transformation Partnership (STP): West Yorkshire and Harrogate is one of 44 footprints across the country working to address the three gaps set out in the NHS Five Year Forward View. ‘The Five Year Forward’ view is the NHS England transformation plan for the next five years and sets out three areas for improvement; Health and wellbeing, care and quality, finance and efficiency.

The West Yorkshire footprint is made up of six local areas, all of which are developing individual plans to respond to the ‘Five Year Forward View’. The plans are known as sustainability and transformation plans (STPs).

West Yorkshire and Harrogate, health and social care services, including the NHS, are working together to look at better ways of delivering care for people who have a stroke. Before any decisions are made on the future of stroke services in West Yorkshire and Harrogate the STP wanted to find out what people think about the services currently provided. An engagement phase took place from Wednesday 1 February until Wednesday 15 March 2017 to gather views.

Who did we engage with and what did we ask?
The engagement work was led by Healthwatch and focussed on the quality of stroke services in place across all health, social care and voluntary sectors. The engagement was aimed at the public, including voluntary and community organisations, patients, carers and staff. People were asked:

- Where they lived and there experience of a stroke
- Which hospital did you / or the person you care for initially attend when you had a suspected stroke and which was this the closest hospital
- How would you describe your experience of care when you had a stroke and what would have improved that experience?
- How important do you think the following are when accessing care in the first few hours after a stroke? (response options included: fast ambulance response times, being treated at a hospital close to home)
- How important do you think the following are when accessing after care for people who have had a stroke? (response options included: Being treated by highly trained specialists, be involved in decisions about my care)
- Suggestions on how social care and the voluntary and community sector could support patients and their families / carers following a stroke.
- Questions on prevention and preventing a stroke.

What did they tell us?
Over 1500 people gave their views via an online survey, outreach sessions with voluntary and community groups, and interviews with people in GP practices, rehabilitation units, stroke wards, and libraries. Stroke consultants also took part in sessions so that people
could hear first-hand about the care and support available from health professionals. Some of the key themes from the engagement are:

- Many people said that they would travel further if it meant they were able to receive the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home.
- Those who had experienced a stroke described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout.
- It was also felt that there should not be a difference in care during the week and at the weekend.
- Many described how stroke can be a life changing event which can be difficult for the patient and their families to deal with without the appropriate levels of emotional support and advice.
- The valuable role of voluntary and community organisations specialising in stroke support, particular on hospital wards, was recognised.
- Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke.

What did we do?
The findings from this engagement will be fed into a programme for Stroke services. This programme is part of the West Yorkshire and Harrogate STP. Following consideration of the findings the next steps for stroke services will be considered and any further work to improve services will form part of a programme of work.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in May 2017. This report is published and also available on the CCG website. Go to http://www.calderdaleccg.nhs.uk/get-involved/
Provision of a Multi Faith Room at the Dales Unit – South West Yorkshire Partnership Foundation Trust (SWYPFT): The provision of a multi faith room at the Dales unit to meet the religious and spiritual needs of patients, carers, visitors and staff were reviewed, as there is increasing evidence that by accommodating these needs, this leads to improved patient and carers experience and better outcomes for all - including staff.

Who did we consult with and what did we ask?
We held a number of separate meetings with patients, carers and staff. We consulted with over 60 people. At the meetings we the asked the following questions:

- What could be improved to meet the spiritual needs of all at the Dales unit?
- If a space was available where should it be located?
- What would we need to include in terms of artefacts and other provisions?
- Could the room be used by people who had no faith?
- Is there anything else you would like to tell us about your experience of using the Pastoral care service at the Dales?
- Thinking about the future what would a good Pastoral care service look like?

What did they tell us?
Emerging themes from this engagement;

- The support from the Pastoral care team is really valued by patients, carers and staff. However, this is only available to those who been refereed by a staff member.
- Most people were not aware of the service offered by the Pastoral care team and this included carers and staff.
  - The provision of a room to be made available for the spiritual needs at the Dales was welcomed by all.
  - Access to support and advice from fully skilled and trained multi faith pastoral care team was acknowledged as an area that was currently underutilised.
  - Issues around accessing the room “out of hours” was discussed and how staff would be able to support individual requests in supportive/timely manner.

What did we do?
A new Multi faith room provision is now available for use by all at the Dales. From the findings from the engagement activity the feedback from this will include:

- Sharing the findings from the engagement with other in patient units in the Trust.
- Use the findings to inform the future service specification for services.(new builds both inpatient/community)
- Provide feedback to patients, carers and staff on the outcome of the engagement activity and the next steps.

Where can you find more information about this work?
To find out more about this work you can contact the Team Manager at ‘The Dales’ Occupational Therapy Department via SWYPFT website. Go to [www.southwestyorkshire.nhs.uk](http://www.southwestyorkshire.nhs.uk)
Care Closer to Home (CC2H) Care Homes: The aim of the project is to support people to live in their own home for as long as possible and if this is no longer possible, to ensure that the best possible care is provided to those people who live in residential settings.

NHS Calderdale CCG and Calderdale Council arranged a number of engagement activities and events on the future provision of care homes in Calderdale. The aim of the project is to create a vision for Calderdale and understand what’s important to people of Calderdale as they get older.

Who did we engage and what did we ask?

An event in January 2017 to launch the engagement was set up to:

- Provide an update on the background so far for future provision of care homes in Calderdale
- Gather experiences, views and ideas from stakeholders
- Give people the tools to help people carry on the conversation with their communities
- Explain the next steps including a provider event in March
- Use the findings to inform conversations with providers and other stakeholders and any additional engagement

The event was an essential part of our engagement process and included a range of local stakeholders including:

- Health forum members
- Healthwatch
- Third sector organisations
- Patient and carer representatives

Those attending were asked if they would support an engagement approach using a survey which would ask local people:

- What makes a good care home?
- What was important to people as they grow older
- One thing that would make Calderdale a great place to grow old

We also circulated postcards which asked:

- Tell us ‘one thing that would make Calderdale a great place to grow old’

What did they tell us?

People told us what a good care home looks like:

- People want the right staff who are skilled, trained and supported. Staff who are caring and compassionate and understand cultural needs and beliefs. They also want to see good management and homes that are staffed at all times.
- Quality of care was a significant factor to respondents. They want to see continuity of care with good quality standards and choice and be involved in their care and...
planning. Care that meet the needs of physical, social and mental health requirements.

- People said their environment was important to them with clean, well decorated, modern and good facilities. They want to feel safe, looked after in a warm friendly and loving environment that feels like their own home.
- Being in heart of the community was also important to people. To be near family and friends and local amenities.

People told us what is important to them as they get older:

- Staying fit, active and healthy for as long as possible is extremely important to people. They want to be able to continue with their hobbies such as playing sport (snooker, badminton) and to continue to enjoy themselves, by having trips out and meeting people, trying new activities, going for a walk, charity work. Being able to participate in activities within a care home and in the local community.
- People want to remain as independent as possible for as long possible but knowing there is help and support out there should they need it. They want the freedom to come and go as they please and be able to make their own decisions and be involved in their own care and planning.
- Family and friends are exceptionally important to people and being able to see them regularly.
- Being part of the local community is also vital to people so not to feel isolated or lonely.
- People also want to see good and wide range of services with their local communities that are easily accessible
- Respondents also said they want to be happy and enjoy life

People told us via the survey and postcards ‘one thing that would make Calderdale a great place to grow old’:

- People want to receive a good standard of care that’s appropriately funded and accommodates the needs of the older generation, different cultures and where people feel safe
- More activities and day care services for the elderly and disabled such as luncheon clubs that have an understanding of different need and cultures
- Well trained staff that recognise people have different needs and abilities and an understanding of the different values and cultures.
- More opportunities for older people to share their knowledge and experience with young people and volunteering opportunities within care homes
- People also said that they like Calderdale the way it is and wouldn’t change a thing

A community group produced a film on ‘The care needs of the south Asian communities’ which included the findings of an additional 100 members of the South Asian community in Calderdale. The themes from the film are below:

- **Independence** – people fear that dependence on professional care providers mean loss of independence, Asian women feel that they have no voice
- **Family links** – family ties and support are important to the community and must not be disrupted by professional care arrangements, people can feel isolated, being part of the community is important
- **Keeping active** – Body and mind need to be stimulated, people need to keep their independence, take part in activities and learn new hobbies
• **Staffing** – the community need to be assured that appropriately skilled and sensitive staff will be in place, staff need to be caring and compassionate, and have understanding of different cultures

• **Culture & Religion** – Being able to practice and maintain our culture & religion are paramount, cultural appropriate care and food i.e. Halal and being able to pray are important.

**What did we do?**
The findings form all the engagement activity has been shared with all stakeholders at two events which took place in March. Throughout spring and summer 2017 there will be more work with providers on care home provision. The information gathered will be used to inform this work and the conversations will continue.

**Where can you find more information about this work?**
A report of the findings from the engagement process and the films created will be available on this website: [http://www.calderdaleccg.nhs.uk/get-involved/](http://www.calderdaleccg.nhs.uk/get-involved/)
Primary Medical Services (PMS) funding review: Calderdale CCG has 26 practices providing Primary Medical Services across the district, each holding an individual contract. There are 3 main contracts in use:

a) General Medical Services (GMS) – 19 practices in Calderdale - a nationally negotiated contract which can only be held by a Doctor (GP)
b) Personal Medical Services (PMS) – 5 practices in Calderdale - similar to GMS but has local variations commissioned
c) Alternative Provider Medical Services (APMS) – 2 in Calderdale - a time limited contract determined locally and built on national standards

The engagement relates to a review of those practices under the PMS contract.

Nationally we were asked to undertake a review of local PMS contracts. The aim of the review was to ensure that any additional services funded in the five practices were equitable across Calderdale.

Who did we consult with and what did we ask?

The PMS services under review were:

- Dermatology (including Eczema and Dermascope)
- Diabetes – Level 3 and above
- Electrocardiogram - ECG
- Ambulatory Blood pressure monitoring

The review of each of these services required the primary care team to gather service user feedback. The two main services where patients would be directly impacted were dermatology and diabetes.

One practice had already gathered information on dermatology by asking:

- ‘We currently provide a GP specialist service for in dermatology’ and asked ‘how would you feel if you lose this service?’

A further dermatology survey was circulated to patients in the five practices. The engagement activity was to engage with patients who use the current service to:

- Understand what people thought of the current service
- Understand how local people want future services to be delivered

In addition the CCG used existing engagement intelligence for dermatology services.

To understand the services provided for people with diabetes, the CCG used existing engagement information only to understand the needs of patients.

What did they tell us?

The engagement activity with patients accessing services funded through PMS i.e. Dermatology and Diabetes were reviewed. The findings highlight a high degree of satisfaction with current services; however it is acknowledged that this is only for a small proportion of the population. Patients told us:

Dermatology: We received 50 responses to the engagement and used existing feedback from previous engagement activity. The general feedback from patients was that the...
service was highly valued and that patients felt they were seen quickly, in a convenient location and by a specialist.

- They would prefer to visit the GP practice and not the hospital
- This service could put pressure on the hospital
- Patients would not like to lose the service, they would be unhappy or upset if they did
- That services should remain closer to home
- It could have an impact on those who need it, particularly children and those who are vulnerable
- A GP specialist is a welcome addition to practice services
- Patients highly valued the service and the clinicians

The practice provided information gathered on dermatology services as part of their friends and family test. Patients told them:

- They would prefer to visit the GP practice and not the hospital
- This service could put pressure on the hospital
- Patients would not like to lose the service, they would be unhappy or upset if they did
- That services should remain closer to home
- It could have an impact on those who need it, particularly children and those who are vulnerable
- A GP specialist is a welcome addition to practice services
- Patients highly valued the service and the clinicians

The information provided has given an overview of what people think of the current service and how we could design a service that would meet local needs.

**Diabetes:** Patients told us that GP practices need to be central to the delivery of ‘Care Closer Home’. Patients want to see more hospital services closer to home and in a GP practice setting. People want more diabetes services and told us:

- Not enough done on the preventative agenda and we needed to stop people becoming unwell.
- More frequent checks for people who may be subject to conditions such as diabetes
- More help for people with mental health issues.
- Local support for people with diabetes, groups that can advise on diet. Lifestyle help people go the gym and back to work

**What did we do?**
The findings from engagement were used to understand in the variations in the delivery of contracts. The public engagement activity in relation to the PMS premium, needed to be considered with the wider engagement work as part of Right Care, Right Time, Right Place.

**Where can you find more information about this work?**
A report of the findings for diabetes can be found under existing engagement activity. The report for dermatology can be found on this website: [http://www.calderdaleccg.nhs.uk/get-involved/](http://www.calderdaleccg.nhs.uk/get-involved/)
**Vanguard – Locality model:** Community services in Calderdale are being revolutionised through a new approach to front line staff working together. In May 2016 Pennine GP Alliance and Calderdale and Huddersfield NHS Foundation Trust brought together representatives of frontline clinical staff from primary and secondary care to introduce a way of working across five localities.

The locality model is based on five local areas of Calderdale which are Upper Valley, Lower Valley, South Halifax, North Halifax and Central Halifax. The local areas have been created using patient list size, geography and likely travel routes. The event in May raised a number of issues particularly relating to nursing. The aim of the locality model was to identify what could be done differently to overcome any issues and what was needed to improve services.

**Who did we engage with and what did we ask?**

In order to support the locality model discussions we used existing information to create a data set of engagement intelligence for each local area. The purpose of the data was to understand what was important to people in each locality if we were to redesign or organise services.

Once the data had been separated it was easy to identify if there were any common themes for each local area or any specific themes that may require further consideration. The data reviewed included:

- **2012** - Engagement activities on unplanned, long term care & children’s services.
- **2013** - NHS national ‘Call to Action’ engagement were we received views of 487 people.
- **2014** – Engagement with a further **2500 people** on the providers’ Strategic Outline Case and CCG commissioning intentions
- **2015** - Composite report combining all other engagement activity delivered from March 2013 to August 2015
- **2016** – Hospital and Community Services consultation on the future of hospital and community services of **7,582 views**.

A separate report for each locality was presented at a number of events to support locality conversations and to ensure the voice of local people remained in the room at all times.

**What did the information tell us?**

There were a number of common themes across the five local areas, the common themes for providing services are set out below:

- Care closer to home would support older people and people with dementia better
- Care closer to home needs to be in places where they feel comfortable such as places of worship and community venues as well as GP practices that are easily accessible
- Local services are needed as specialist services move further away
- People like the idea of longer opening hours in particular weekends and evenings
• More walk in / drop in sessions and flexible appointment times, reduce waiting times – including services such as GP and community based services
• Patient information shared between hospitals and GPs needed to be handled more effectively
• GPs need to get their own services working effectively so they can be a hub for others in particular work with voluntary and community groups - self-help / support groups, information, help and advice
• More investment in preventative medicine particularly, massage, physiotherapists, therapies, support groups and physical and mental health issues
• More information and involvement for families and carers if a patient has a sensory disability so they can support communication and care of the patient
• Early detection of mental health and better care and treatment such as therapies, non-medical intervention and emotional support with out of hours services and drop in clinics
• More support for carers and families
• There is a need for more flexible appointment systems, GP communication, information and technology systems need to be improved
• Services need to be staffed appropriately and with the right trained staffed who are patient and understanding, a good mix of male and female GPs and staff speaking different languages

**What did we do?**

This information was shared at two stakeholder events held in Calderdale. The first event was for primary care staff and took place in September 2016. The second event was a larger stakeholder event involving professionals, staff and community representatives in December 2016.

Event attendees were asked to consider the findings from engagement to help shape local models of care. These models would help to understand how local services could be provided in the future.

**Where can you find more information about this work?**

An update report from the stakeholder events can be found under Vanguard on the CCG website: [http://www.calderdaleccg.nhs.uk/get-involved/](http://www.calderdaleccg.nhs.uk/get-involved/)
A clinical model is in development and the design includes the views of service users and staff from previous engagement activity. Further pre-consultation engagement is required to directly understand the views of those who would be directly impacted by any decision to change services. This additional engagement is required to further design a model which would be subject to formal consultation. The service that would be directly impacted is the Lyndhurst provision in Calderdale. VAC delivered the engagement on our behalf.

Who did we engage with and what did we ask?
VAC liaised with Calderdale CCG to draw up questionnaires aimed at gathering the views of service users, advocates, carers, family members and Staff. VAC contacted Lyndhurst so that meetings could be arranged to speak with people at the service.

Three separate surveys were designed for service users, carers and staff, all three surveys had 6 similar questions that could be mapped across. All questions were focused on what a good recovery and support service would look like. The questions we asked service users were:

- Thinking about your situation, what brought you to Lyndhurst, where you clear why you came here?
- Thinking about how staff supported your recovery so you can live back in the community, please answer the following: what has worked well? what could be improved?
- As part of your recovery a plan will have been put into place, did the plan: Provide clear goals for you to work towards? Provide the right support for you to achieve your goals?
- On your journey towards recovery please tell us: Who you think could help you and why? The key skills the person would have?
- What would good recovery and support services look like?

What did they tell us?
All those interviewed felt that services like Lyndhurst are a necessary part of the recovery pathway. Service users are aware they have a Recovery Plan at Lyndhurst that gives their lives structure and focus and that staff play a positive role in helping and supporting them as they progress through their recovery pathway.

It is recognised in by all surveyed that having compassion, understanding, a caring, empathetic nature, patience and being a good listener are the overriding skills that a person needs to work in Mental Health. It is clear, certainly amongst the staff we spoke with, that if
it is to happen, ‘Care in the Community’ in this field should include the service user having 24/7 access to Mental Health Services. Key themes are below:

- Staff at this point do not believe the service provided at Lyndhurst can be provided in a community setting
- Service users are aware they are at Lyndhurst for rehabilitation, to improve their Independent Living Skills and progress towards moving back into the community
- Service users feel that staff play a significant role in supporting them and helping them develop their skills through setting goals in their Recovery Plan
- Although some people are aware of the need for professional qualifications, staff, service users and family members believe the key attributes a person must have to work in Mental Health Services are: Compassion, be caring, understanding, empathetic, patient and a good listener
- Care in the community should involve having a Mental Health Recovery Hub that affords 24/7 access to service users who need it.
- Family members feel there is a communication problem with doctors at Lyndhurst in that they are not given updates on their loved ones progress. However, it is acknowledged that this may be the result of requests by service users to not have information divulged, thereby showing that doctors and staff are following confidentiality policy and procedure.
- Family members feel that a further communication issue is not being made aware of their loved ones Recovery Plan.

What did we do?
The findings from engagement were presented at a Rehabilitation and Recovery Programme Board. It was agreed at the board that a workshop should be set up to ensure the findings were considered as part of the proposed clinical model. A workshop took place in May 2017. In addition Lyndhurst received a full copy of the report findings to share with participants.

The proposed clinical model will be subject to formal consultation in Summer 2017.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in March 2016.

This report can be found on the website: http://www.calderdaleccg.nhs.uk/get-involved/
‘Your Child and You’ resource for website and APP: Calderdale MBC

led on this partnership project which was funded through the Vanguard programme. Vanguard was a national scheme designed to accelerate system change. Calderdale CCG used the funding to support work on Care Closer to Home. Vanguard was a large programme with seven local partners including Calderdale MBC.

The Healthy Early Years ‘Your Child and You’ website and APP is a newly developed range of online resources to ensure that parents and carers of children aged under five in Calderdale; and professionals in frontline services can access reliable, locally focussed information.

**Who did we consult with and what did we ask?**

In order to develop the website and APP Public Health based in Calderdale Council used national and local research. In addition they spoke to local parents and staff working in services.

They asked parents and staff how they would like to access information and what information they would want to have if a service was developed.

**What did they tell us?**

The findings were that in the under 5 age group the use of hospital and GP services was very high. When speaking with parents they told us:

- That they are bombarded with advice, which is often well-meaning but at the same time it can be baffling
- During pregnancy and in the first few days of looking after a new born information was needed and,
- Parents want to know how they prepare their child for nursery and school

Parents and frontline professionals told us:

- They want easy access to advice and guidance
- The advice and guidance has to come from a trustworthy source
- The source needs to be available to all

**What did we do?**

The Vanguard programme offered Calderdale Council and NHS Calderdale Clinical Commissioning Group the opportunity to create a suite of resources to provide information and guidance on over 30 health topics to reassure parents and carers.

Since its launch in November 2016, the Healthy Early Years website has been a great success. A major marketing campaign took place during November and December; reaching thousands of people across Calderdale, professionals in 26 GP practices, 21 children’s centres, all health visitors, midwives and private, voluntary and independent childcare providers to raise awareness of the website.
This has resulted in over 2800 people visiting the website with almost 100 downloads of the free mobile app in the first three months of its launch. People who use the site are spending around 5 minutes per visit to explore advice on services, school readiness and how to deal with childhood illnesses.

To complement the website a free mobile app for IPhone and Android has been created and is available to download. Together, they offer a trusted local resource packed with top tips to support little ones from birth to five to grow.

*Where can you find more information about this work?*

The website and app are available by using the following link: [www.healthyearlyyears.co.uk](http://www.healthyearlyyears.co.uk)

You can download the app for your Android or IPhone by searching 'Healthy Early Years'.
Community Panel, Vanguard: Calderdale received funding through a national vanguard to further support the CCG plans for Care Closer to Home. A community panel was set up to support this programme of work. Their remit was to act as a reference group for the programme work streams and board.

Who did we consult with and what did we ask?
The Community Panel is a group of local people who live in Calderdale who have a keen interest in their local health care community. The panel is made up of 34 individuals some of which represent 18 VCS organisations. The panel ensures that patient and carers voices are heard when developing new model of care and to ensure that those models meet the needs of local people. Over the year various consultations have taken place:

- Participated in working groups and attended development events of the Vanguard.
- General Practice – consultation regarding a uniform approach to directing patients to appropriate NHS services, avoiding unnecessary GP/nurse/Advanced Nurse Practitioner appointments across all surgeries.
- Attendance at training regarding the role of purpose of the community panel.
- Developing the logo and branding for the Calderdale Vanguard Programme
- Supported the CCG with procurement exercises

What did they tell us?
- Frailty Pathway - feedback advised to amend the proposed model.
- Advised changes to process and content of information given by surgery staff when calling a GP surgery. Advised increase access to resources for surgery staff to signpost patients to alternative services where appropriate.
- Feedback regarding service offer and design for patients with certain conditions and additionally: single point of contact, walk in centre and care homes.

What did we do?
- Frailty Pathway was adapted to ensure the patient was at the start of the process.
- Feedback incorporated in to system change and service offer where appropriate.
- Vanguard logo and branding implemented.

Where can you find more information about this work?
Jo Bolland, Co Chief Executive Officer, VAC jo.bolland@cvac.org.uk
Working Voices – Pilot Project: Working Voices is a project approach to involving the workforce in engagement and consultation. The project aims to create opportunities for workplace engagement on NHS services using existing channels of communication and involvement.

Who did we consult with and what did we ask?
Voluntary Action Calderdale (VAC) in partnership with NHS Calderdale CCG set up a pilot project in Calderdale. The aim of the project was to test out the model for Working Voices developed by NHS England. The pilot was aimed at employers and employees. Two very different employers took part in the project and a variety of methods were used to engage with employees in order to ascertain the likelihood of both employers and employees wishing to be engaged/consulted on health services in the workplace.

Specifically employees were asked about their awareness of the National Agenda; Satisfaction with health Services; their demographic profile and these were supplemented by questions from the employers about wider health and social issues and perceptions.

Employers were asked about their willingness to allow the workplace to be used for health engagement with employees.

What did they tell us?
Employees revealed a lack of knowledge about how health services are planned, and some limited awareness of screening programmes. They expressed a willingness to engage in consultation about health services in the workplace. Many respondents wrote positively about their experience of health services once they had accessed them, but many struggled to access services as they often run during working hours.

Employers were positive about the pilot but need to be confident that there are benefits to them from any further engagement/consultation on health services. The need for senior management buy in to progress any planned work was clear as was the identification of a dedicated contact and support.

What did we do?
The findings strongly suggest that the approach taken fits very well into the community asset model but adequate resources to deliver this are a key issue. Specific actions for both employers were agreed as part of the pilot to assist in taking the learning forward. Further discussions are taking place with the larger private sector employer involved to ascertain how the approach can be rolled out.

Where can you find more information about this work?
A presentation on the findings of the report can be requested from Jo Bolland Co-Chief Executive Officer, VAC. jo.bolland@cvac.org.uk
Voluntary and Community Sector (VCS) - Capacity Building

‘VCS Alliance’: Voluntary Action Calderdale (VAC) has spent over 5 years working with NHS Calderdale CCG to support the local voluntary and community sector. In the past few years this has developed into a full capacity and capability building programme for the sector.

Who did we consult with and what did we ask?
A natural development within the VCS to respond to the changes within the CCG (namely Care Closer to Home and New Care Models including new commissioning models) was to develop a VCS Alliance that could participate within a local Lead Provider Alliance Model.

In order to develop this VAC held a number of information and development sessions with a diverse range of VCS organisations across Calderdale. Continued networking and liaison has taken place culminating in an agreed shared vision for a new organisation to be formed. The new organisation is in development and will be called Calipso. Terms of membership, membership criteria and an ethical walls policy have been co-developed and agreed with core members. At the time of writing core membership consists of 17 organisations.

What did they tell us?
VCS groups understand the need to form new ways of working together in order to maximise benefit for our local communities.

Calipso membership should be inclusive and open to organisations who can meet the eligibility criteria.

What did we do?
We have listened to the VCS and are now working on the formation of the new organisation. Membership is being promoted across the VCS sector.

Where can you find more information about this work?
Neil Bolton-Heaton, Co Chief Executive Officer, VAC neil.bolton-heaton@cvac.org.uk
Voluntary Community Sector Networks: The CCG want to ensure that the voice of the local community is at the heart of everything it does. The CCG use a number of approaches to reach all our protected groups. The networks are groups the CCG want to engage with but require that require additional support to have a voice. VAC have been funded by the CCG to capacity build and sustain these networks.

Who did we consult with and what did we ask?
Over the year we have supported a wide range of networks that are in place to represent a number of diverse views to support our equality duty to engage groups with particular protected characteristics. The existing networks include:

- Black Minority Ethnic (BME) Health Forum
- Lesbian Gay Bisexual Transgender (LGBT) Health Forum
- Your Maternity Service Liaison Committee (MSLC)
- Forum 50+
- Disability Partnership Calderdale

The overall purpose of the engagement activity is to ensure seldom heard communities have a platform to share their views and experiences of health services and have an opportunity to become up-to-date with policy, with time and space to share experience and knowledge. Topics for the network meetings were varied and chosen by the members of the networks themselves.

Specific examples include LGBT Health Forum having a discussion about the SWYFHT Transgender Policy. The BME Health Forum considered the issue of Multiple and Complex Needs: Improving engagement and Access to services for BME communities. Representatives from the Disability Partnership, Forum 50+, the BME Health Forum and the LGBT Health Forum participated in the EDS 2 Grading Panel and Health Equality Panel.

What did they tell us?
The networks continually seek to raise awareness of issues affecting their communities to ask that any development plans and commissioning take into account the need to address health inequality and inequality in service provision.

What did we do?
It was realised that although there is dialogue individually between networks and CCG staff, there is no adequate route to raise issues or seek action within the CCG. Due to financial changes it was decided not to provide funding for the networks beyond 31st March 2017 and, as a consequence, VAC withdrew its support.

Where can you find more information about this work?
Please speak to Alan Duncan, Engagement Lead. alan.duncan@cvac.org.uk
Healthwatch Calderdale gathers and represents the views of adults, young people and children living or using services in Calderdale. Below is a list of work done by Healthwatch Calderdale (part of Healthwatch Kirklees) during April 2016 and March 2017:

- **Independent Health Complaints Advocacy Service**: The service helps anyone who wants to make a complaint about any NHS service; that includes hospitals, GPs, mental health services, dentists, community health services and many more. Across 2016/17, we supported people to make 78 complaints about the NHS in Calderdale.

- **Autism Spectrum Conditions (ASC)**: Healthwatch Calderdale investigated issues being raised by a number of people in Calderdale with diagnosed or undiagnosed Autism Spectrum Conditions (ASC), regarding the services they were being offered. We met with four ASC peer support groups, and received 22 completed surveys from adults with ASC based in Calderdale, and 12 from the parents, partners or carers of adults with ASC.

- **Art Therapy**: Service users contacted us for support on a plan to close the Art Psychotherapy Service; they had not been asked for their views to inform that decision, and they fundamentally disagreed with the decision.

- **Migrant Health**: Since January 2017, we have attended various meetings concerning migrants as well as visiting charities and organisations that provide help or advice.

- **Wheelchair Services**: In October 2016, Healthwatch was approached by organisations working with parents and carers of children with disabilities who wanted their service users to have opportunity to give feedback on OpCare.

- **Maternity Services**: Calderdale and Huddersfield NHS Foundation Trust (CHFT) asked Healthwatch in Kirklees and Calderdale to support them to embed patient feedback in their maternity journey.

- **Right Care, Right Time, Right Place**: Due to the significant potential impact of these proposals on the delivery of health services in these districts, Healthwatch Kirklees invested resource to gather the opinions of local people.

Where can you find more information about this work? Reports from the engagement are available and this can be found at [http://www.healthwatchcalderdale.co.uk/our-work-4/archive/](http://www.healthwatchcalderdale.co.uk/our-work-4/archive/)
6. Projects planned for 2017 – 2018

- **West Yorkshire and Harrogate Sustainability and Transformation Programme (STP):** There will be further engagement and possible formal consultation on Stroke services and engagement on cancer services as part of the STP. This work will be led by the STP and delivered locally by each CCG.

- **Right Care, Right Time, Right Place:** A Travel and Transport Working Group and Reference Group have been set up following the findings from the consultation which took place in 2016. Further engagement will take place throughout the year on specific service areas.

- **Rehabilitation and Recovery Mental Health services consultation:** A transformation of local rehabilitation and recovery mental services will involve consultation with the public in Summer 2017.

- **Primary Care Strategy:** We will be looking at improving access to primary care for both routine and urgent care appointments.

- **It's everyone’s NHS – and we’re not going to waste it:** Calderdale CCG has an overall budget allocation of £312million to “commission” or buy, health and care services such as:
  - Planned hospital and urgent and emergency care,
  - Rehabilitation care and community health services
  - Mental health and learning disability services
A growing demand for health and care services, inflation and the costs of new drugs and treatments mean we need to look at how we spend our budget to get maximum benefit for everyone. We will focus our conversations in 2017/18 on how we spend our budget and how we can make the savings required.

- **MSK musculoskeletal services:** We will be looking at how we can manage services such as pain management to patients with MSK conditions. A survey will capture the views of patients.

- **Care Closer to Home:** We will continue to engage on the specific requirements of some services that are closer to home.
7. Calderdale CCG Contact Details

NHS Calderdale CCG Contact Details
If you are interested in finding out more about getting involved in the work of NHS Calderdale CCG or would like to share your views on local health services, please contact us via the following contact details;

Address:
NHS Calderdale Clinical Commissioning Group
5th floor
F Mill
Dean Clough
Halifax
HX3 5AX

Tel: 01422 281300
Email: CCG.FEEDBACK@calderdale.nhs.uk

Please note that this email address should NOT be used if your message contains patient/personal information.
Facebook: NHS Calderdale CCG

Twitter: @calderdaleccg

Website: www.calderdaleccg.nhs.uk

Patient Opinion
Patient Opinion is an independent website about your experiences of UK health services, good or bad. They pass your stories to the right people to make a difference.

You can share your views and experiences of the healthcare you have received locally by visiting www.patientopinion.org.uk
Appendix 1

Legal duties in relation to Patient and Public Engagement

Section 14P - Duty to promote NHS Constitution
(1) Each clinical commissioning group must, in the exercise of its functions—
(a) Act with a view to securing that health services are provided in a way which promotes the NHS Constitution

Section 14U - Duty to promote involvement of each patient
(1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to—
(a) The prevention or diagnosis of illness in the patients, or
(b) Their care or treatment.

Section 14Z2 - Public involvement and consultation by clinical commissioning groups
(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).
(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
(a) In the planning of the commissioning arrangements by the group,
(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

NHS Constitution (Refreshed March 2013)
The NHS Constitution produced by the Department of Health establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.
A copy of the refreshed NHS Constitution and supporting handbook can be accessed via the following link;


Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. Principle Four focuses around patient engagement and involvement and is emphasised through the Patient’s Rights Section.

**Principle Four**
The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services

**Patient Rights - Involvement in your healthcare and in the NHS:**
You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.
The NHS also commits:
• To provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
• To work in partnership with you, your family, carers and representatives (pledge);
• To involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
• To encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).
### Executive Summary

The purpose of this report is to:

- Provide the Governing Body with the recommendation in respect of the provider for the Medicines Optimisation Service.
- Provide assurance for the Governing Body in respect of the robust tender process, evaluation and recommendation outcome for the appointment of the provider of the Medicines Optimisation Service.
- To enable the Governing Body to consider the recommendations and approve the contract award to the identified bidder for the service.
- To provide details of the next steps in terms of contract award and mobilisation of the service.

### Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Quality Committee</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMT</td>
<td>20/03/2017</td>
<td></td>
</tr>
</tbody>
</table>

### Recommendation (s)

It is recommended that the Governing Body:

- **NOTES** the process undertaken and confirms their confidence that a robust process has been followed for selecting the Medicines Optimisation Service which is in line with the CCG’s normal procurement rules.
- **APPROVES** the recommendation on the selection for the preferred bidder for appointment.

### Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)

EQIA updated May 2017

### Resources / Finance implications (including Staffing/Workforce considerations)

The CCG will commission and ensure the provision of sustainable services within the resources it has available.

### Strategic Objectives

- Achieving the agreed strategic direction for Calderdale
- Improving quality
- Improving value

### Risk (include risk number and a brief description of the risk)

None identified
| Legal / CCG Constitutional Implications | The CCG will apply appropriate governance, follow procurement policy and ensure sound financial management in doing so. | **Conflicts of Interest**  
(include detail of any identified/potential conflicts) | Any interests will be managed in line with the CCG’s policy for managing Conflicts of Interest.  
Evaluator conflicts of interest were declared and managed during the evaluation process. |
1. Introduction

1.1 The ambition for NHS Calderdale CCG is to improve the cost effectiveness and quality of prescribing in Calderdale through the commissioning of medicines optimisation in the community.

1.2 The overarching outcomes for this procurement are:

- To achieve value for money from the primary care prescribing budget whilst optimising outcomes for patients
- To deliver (Quality, Innovation, Productivity and Prevention) QIPP savings from the prescribing budget
- To contain cost growth in the prescribing budget in line with comparator CCGs
- To reduce avoidable hospital admissions due to adverse reactions from prescribed medicines
- To implement local and national medicines guidance to establish best practice in prescribing and monitoring of prescribing
- To support general practice in implementing effective medicines optimisation for Calderdale patients by providing additional clinical capacity and skills from a pharmacy workforce.

2. Detail

Process

2.1 Following approval to proceed to procurement, a competitive tender process was conducted. The financial envelope was confirmed as £125,000 per annum with a contract length of 3 years, plus an option to extend at the CCG’s discretion for a further 2 years (1+1).

2.2 The procurement was managed using the CCG’s normal procurement resource and procedures i.e. NHSSourcing (Bravo) e-tendering system and AWARD e-evaluation system. The procurement timetable as agreed is provided below:

<table>
<thead>
<tr>
<th>Procurement stage</th>
<th>Key dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Information Notice published</td>
<td>Week Commencing 2 May 2017</td>
</tr>
<tr>
<td>ITT submission dates</td>
<td>29 May – 10 July 2017</td>
</tr>
<tr>
<td>ITT Evaluation</td>
<td>12 July – 30 July 2017</td>
</tr>
<tr>
<td>Bidder Presentation Day (For Information Only)</td>
<td>Week Commencing 31 July 2017</td>
</tr>
<tr>
<td>Recommendation agreed / consensus meeting</td>
<td>Week Commencing 31 July 2017</td>
</tr>
<tr>
<td>CCG Approval route</td>
<td>10 August 2017 (Governing Body)</td>
</tr>
<tr>
<td>Notify Providers of Outcome</td>
<td>11 August 2017</td>
</tr>
<tr>
<td><strong>Contract Award</strong> (End of 10 Day stand still)</td>
<td>22 August 2017</td>
</tr>
<tr>
<td>Mobilisation period (inc TUPE resolution if applicable)</td>
<td>23 August – 30 October 2017</td>
</tr>
<tr>
<td><strong>Suggested Service Commencence</strong></td>
<td>1 November 2017</td>
</tr>
</tbody>
</table>

2.3 In accordance with an ‘open’ procedure where an Invitation to Tender (ITT) document is issued to all organisations expressing an interest. Seven suppliers registered such an interest. The Invitation to Tender was issued in accordance with the timetable and the project plan.
2.4 Six suppliers submitted the completed ITT documentation by the deadline date. These responses were then subject to evaluation. Details of the service specific questions are attached as Appendix 1.

**Evaluation**

2.5 In accordance with the CCG’s procedures, the evaluations were undertaken by a suitably qualified and experienced panel comprising of a CCG Service Lead, Clinical Lead, Quality Officer, Contract Officer, Finance Lead, Project Officer, Practice Manager and GP. The responses were evaluated in accordance with the pre-determined percentage weighted criteria.

2.6 Scoring rationale used for this procurement was:

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent Response</td>
<td>Bidder demonstrates a clear approach and addresses ALL of the required aspects of the question and provides practical examples</td>
<td>100</td>
</tr>
<tr>
<td>Very Good Response</td>
<td>Bidder demonstrates understanding and a clear approach and the answer addresses ALL the required aspects of the question</td>
<td>90</td>
</tr>
<tr>
<td>Good Response</td>
<td>Bidder demonstrates understanding and a clear approach and the answer addresses the majority of the required aspects of the question</td>
<td>70</td>
</tr>
<tr>
<td>Minor Concerns</td>
<td>Incomplete answer; fails to address some of the required aspects of the question</td>
<td>30</td>
</tr>
<tr>
<td>Moderate Concerns</td>
<td>Incomplete answer; fails to address all the required aspects of the question. Demonstrates a lack of understanding</td>
<td>10</td>
</tr>
<tr>
<td>Major Concerns</td>
<td>Inadequate answer</td>
<td>0</td>
</tr>
</tbody>
</table>

2.7 In accordance with CCG’s procurement process, the bidder having the highest aggregate score will be identified as the preferred bidder. This will then form the basis of the recommendation to award a contract. There was discretion to meet with the bidders prior to making a recommendation award, should this feel necessary, to seek further clarification on bidders’ responses. The meeting was arranged and included a presentation of the service model.

2.8 The AWARD e-evaluation system was used by evaluators to input their score and rationale/comments on the bids received to ensure a full audit trail and to aid feedback following the award of the contract.

2.9 The summary of the aggregate ‘raw’ (pre-moderation) scores and consensus (moderated) scores are detailed below. An example of a consensus extract from the AWARD e-evaluation system is attached as Appendix 2. The AWARD system provides a full audit trail to demonstrate the robustness of the process.
<table>
<thead>
<tr>
<th>Bidder 1</th>
<th>Pre-moderation Score (%)</th>
<th>Moderated (Final) Score (%)</th>
<th>Contract value (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bidder 2</td>
<td>53</td>
<td>48</td>
<td>627,123</td>
</tr>
<tr>
<td>Bidder 3</td>
<td>67</td>
<td>71</td>
<td>674,790</td>
</tr>
<tr>
<td>Bidder 4</td>
<td>66</td>
<td>60</td>
<td>619,316</td>
</tr>
<tr>
<td>Bidder 5</td>
<td>24</td>
<td>Excluded, below 50% benchmark</td>
<td>675,000</td>
</tr>
<tr>
<td>Bidder 6</td>
<td>62</td>
<td>60</td>
<td>673,704</td>
</tr>
</tbody>
</table>

2.10 On the basis of this evaluation, Bidder 3 scored the highest overall raw and moderated score, and is the preferred bidder for recommendation to the Governing Body for approval to award.

3. **Next Steps**

3.1 The Governing Body to consider the process undertaken to procure the services for the Medicines Optimisation Service and confirm both the robustness and compliance of the process and their confidence in the outcome of the evaluation.

3.2 Following Governing Body approval to award the contract to the identified bidder, the Procurement Team will proceed to award the contract and provide debriefing reports to the unsuccessful bidders with further feedback provided if requested.

3.3 Service commencement 1 November 2017

4. **Recommendations**

4.1 It is recommended that the Governing Body:

1. **NOTES** the process undertaken and confirms their confidence that a robust process has been followed for selecting the Medicines Optimisation Service provider, which are in line with the CCG’s normal procurement rules.

2. **APPROVES** the recommendation on the selection of the preferred bidder for appointment.

5. **Appendices**

Appendix 1 – Service specific questions
Appendix 2 – Submission scores
## Service Delivery and Mobilisation

### 2.1.1 Please provide details of your proposed service delivery model. Describe, with practical examples, how you will ensure the outcomes outlined in the service specification will be captured, recorded and used on a day to day basis?

**Maximum word count: 1000 words (Weighting 10%)**

You are expected to provide details of your proposed service delivery model against the requirements of the service specification.

In addition your response should include but not be limited to:

- A description of the model of delivery, identifying the key aspects of the model.
- The role of the service manager as the key point of communication for the provider team and Commissioner
- How you will monitor performance and quality.
- How you will record progress against outcomes.
- How you will review the model to identify opportunities for improvements to service delivery.
- How you will effectively deploy staff and use skill mix

Please illustrate your answers with any relevant past experiences where appropriate.

### 2.1.2 Please provide details of how you will work with the Commissioner to review processes and procedures to continually improve your service delivery model

**Maximum word count: 1000 words (Weighting 5%)**

You are expected to provide details on how you intend to:

- Develop effective reporting mechanisms in line with the Commissioners requirements
- Carry out the review of your policies and procedures, providing any timelines where appropriate.
- Implement a model to ensure regular effective two-way communication with the Commissioner regarding service and improvement.
- Discuss with and report to Commissioners your internal developments and improvements to the service.
- Provide details of any future developments planned or otherwise.

Please illustrate your answers with relevant past experiences where appropriate.

### 2.1.3 Please provide a detailed plan of how you will mobilise the service, your plan must describe the key tasks and milestones and their completion dates, as well as the key roles of those responsible and accountable within the implementation team. The plan must also detail where key tasks are critical and dependent on others and how these will be mitigated, as well as how you will interface with existing providers?

**Maximum word count: 1000 words (Weighting 5%)**

You are expected to provide a detailed plan including:
• How you will mobilise the service.
• Key tasks and milestones.
• Dates and timescales.
• Key contacts and details of accountability including the role of the service manager.
• Risks and mitigation.
• How you will interface with other relevant providers.
• Prospective and current locations for service delivery.

Please illustrate your answers with relevant past experiences where appropriate.

Care Pathway

2.2.1 Please describe how you intend to deliver patient centred and responsive care in line with the practices current protocols and systems.

Maximum word count: 1000 words (Weighting 5%)

You are expected to provide practical examples of:

• How you will engage with the patient population including those with diverse needs
• How you will capture patient experience and ensure the patients’ voice is considered in the delivery of your service model.
• How you will ensure any feedback is incorporated into the care pathway and how this is adapted to the patients’ needs.
• How you will adapt your service to fit individual practice needs.

Please illustrate your answers with relevant past experiences where appropriate.

Local Agreements and Partnerships

2.3.1 If you are intending to sub-contract any element of the service, please provide details of how you will manage the sub-contracting arrangements to ensure the delivery against the service specification and adherence to the desired governance model?

Maximum word count: 1000 words (Weighting 5%)

You are expected to provide details of:

• How you will ensure sub-contractors are fully compliant with the service model and associated quality and safety requirements.
• How you will maintain management and contractual responsibility of the sub-contractors.
• How you will ensure any sub-contractors deliver and report on the identified service outcomes.

Please illustrate your answers with relevant past experiences where appropriate.

Clinical Governance

2.4.1 Describe how this service links to your organisation’s governance arrangements?

Maximum word count: 1000 words (Weighting 2%)
You are expected to provide details of your governance arrangements clearly outlining how these will link to your service. Your response should include but not be limited to:

- Governance organisational structures.
- Implementation of risk assessment processes and on-going management of risks.
- How any incidents are captured and changes incorporated into the service delivery.
- Process for staff recruitment.
- How you would deal with/record with unforeseen circumstances, emergency or serious incidents

Please illustrate your answers with relevant past experiences where appropriate.

### 2.4.2 Please provide evidence of your leadership, team work and accountability for clinical governance. How is this supported by organisational culture?

**Maximum word count: 1000 words (Weighting 3%)**

You are expected to provide details of your clinical governance, leadership, team work and accountability. Your answer should include but not be limited to:

- Director / Management Support.
- Staff induction, and on-going training needs analysis
- Staff appraisal
- Staff training/support
- Reporting Structures
- Standard Operating Procedures
- Operational Plans

Please illustrate your answers with relevant past experiences where appropriate.

## Staff

### 2.5.1 For the staff involved in the delivery of the service, please describe how you will ensure new and current staff achieve and maintain appropriate levels of competence and continuous development.

**Maximum word count 1000 words (Weighting 10%)**

You are expected to provide details of how you will ensure your staff are appropriately trained, registered and qualified over the period of the contract. Your answer should include but not be limited to:

- Use of supervision for new and existing staff
- Process for recruitment, induction of new staff including familiarity with clinical systems
- Process for monitoring training, identification of training needs and provision of continuous professional development.
- Process for ensuring the workforce maintains clinical knowledge and follow up-to-date local policies and guidelines, national standards and best practice guidelines.
- Training on client relationships
- How you maintain staff training records
- Working effectively within professional and personal scope of competence

If your service model is to use sub-contractors for any part; details of the above must be explicitly provided for all sub-contractors.
Please illustrate your answers with relevant past experiences where appropriate.

2.5.2 Please describe what training you provide to staff in relation to bespoke clinical interventions, record keeping and patient specific information

**Maximum word count 1000 words (Weighting 10%)**

You are expected to clearly provide details of:

- Use of SOPs and individualising actions to patient and practice needs
- Any training you have provided to staff.
- How the staff training will be delivered.
- How you maintain staff training records.
- Quality of record keeping within the clinical record

Please illustrate your answers with relevant past experiences where appropriate.

---

**Equity of Access**

2.6.1 How will you demonstrate compliance with the Equality Act 2010, including the public sector equality duty?

**Maximum word count 1000 words (Weighting 5%)**

Your response should include reference to the following key areas:

- Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advancing equality of opportunity between people who share a protected characteristic* and those who do not.
- Fostering good relations between people who share a protected characteristic* and those who do not.
- Please illustrate your answers with relevant past experiences and outcomes where appropriate.

* Explanation of protected characteristics can be located on the Home Office website - [http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty](http://www.homeoffice.gov.uk/equalities/equality-act/equality-duty)

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**Costing Matrix**

2.7.1 Please provide a copy of your costing matrix using the template found under the supplier attachment area.

*(Weighting 40%)*

Your response should include:

- Breakdown of costs for capacity required
- Breakdown of any equipment / requirements
- Identify any additional costs

Prices are to be submitted in Pounds Sterling and exclusive of VAT. It should be assumed that all the requirements under the specification should be included in the costing proposal.

**Please note:** No additional costs will be considered unless these are clearly stated in the pricing schedule response.
Results Report
Project: NHS Calderdale CCG - Medicines Optimisation Service
Exercise: Consensus
Submission: All
Measure: Score
Report Date: Aug/03/2017 15:40:40
Report Timezone: (GMT) Western Europe Time, London, Lisbon

Ranked Submissions

<table>
<thead>
<tr>
<th>Submission</th>
<th>Current Score %</th>
<th>Best Possible Score %</th>
<th>Progress (%Complete)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>71</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td>Bidder 1</td>
<td>65</td>
<td>65</td>
<td>100</td>
</tr>
<tr>
<td>Bidder 4</td>
<td>60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Bidder 6</td>
<td>60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Bidder 2</td>
<td>48</td>
<td>48</td>
<td>100</td>
</tr>
<tr>
<td>Bidder 5</td>
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<td>100</td>
<td>0</td>
</tr>
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</table>

Results Table

<table>
<thead>
<tr>
<th>Question</th>
<th>Submission</th>
<th>Weight</th>
<th>Best Possible Score %</th>
<th>Score Impact (%)</th>
<th>Current Result Impact (%)</th>
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<tbody>
<tr>
<td>Overall</td>
<td>Bidder 1</td>
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<td>100</td>
<td>65</td>
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<td>Overall</td>
<td>Bidder 2</td>
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<td>48</td>
<td>100</td>
<td>48</td>
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<tr>
<td>Overall</td>
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<td>Overall</td>
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<tr>
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AWARD® from Commerce Decisions
Name of Meeting | Governing Body | Meeting Date | 10/08/2017  
---|---|---|---  
Title of Report | Continuing Healthcare (CHC) Commissioning Principles Policy | Agenda Item No. | 9  
Report Author | Sarah Antemes | Public / Private Item | Public  
GB / Clinical Lead | Dr Steven Cleasby | Responsible Officer | Lesley Stokey  

Executive Summary

Please include a brief summary of the purpose of the report

The paper seeks approval of a proposed new Continuing Healthcare Commissioning Principles Policy for Calderdale CCG. The detail within this policy has been considered and reviewed by the Quality and Finance and Performance Committees and has been recommended for approval by the Governing Body.

This policy is consistent with the policy has been agreed and is in operation by Greater Huddersfield and North Kirklees CCGs.

Previous consideration

| Name of meeting | Quality Committee | Meeting Date | 27/07/2017  
---|---|---|---  
| Name of meeting | Finance and Performance Committee | Meeting Date | 27/07/2017  

Recommendation (s)

It is recommended that the Governing Body APPROVES the Continuing Healthcare Commissioning Principles Policy.

Decision

☒ Assurance ☐ Discussion ☐ Other 35T

Implications

| Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA) | The policy sets out how decisions about care packages for individuals take account of clinical need to ensure that they are effective, deliver agreed outcomes and provide value for money.  
|---|---  
| Public / Patient / Other Engagement | Engagement work was carried out by North Kirklees CCG when forming the original policy. This work has been approved by the Quality team in Calderdale CCG to ensure its validity for this document.  
| Resources / Finance implications (including Staffing/Workforce considerations) | This policy will ensure that the CCG achieves value for money in its purchasing of services for individuals eligible for NHS Continuing Healthcare and joint packages of care.  
| Strategic Objectives (which of the CCG objectives does this relate to? | • Achieving the agreed strategic direction for Calderdale • Improving quality • Improving value  
| Risk (include risk number and a brief description of the risk) | None identified  
| Legal / CCG Constitutional Implications | There may be legal challenge from individuals whose expectations of the service are not commissioned by the CCG in line with the principles in this policy  
| Conflicts of Interest (include detail of any identified/potential conflicts) | None identified  

Page 1 of 3
1. **Introduction**

1.1 The CCG does not currently have a Continuing Healthcare Commissioning (CHC) Principles Policy.

1.2 The CCG does not therefore have a clear agreement in place about resource allocation in relation to options of packages of care for individual patients. A policy is required in order to inform, guide and support CHC staff when in discussions and negotiations about options with families and individuals.

2. **Detail**

2.1 A Continuing Healthcare Commissioning Principles Policy would establish clear guidelines to ensure resource allocation is a consideration when deciding on a package of care and that the same principles are applied to decision making.

2.2 This policy will support the CHC team to have open and transparent conversations with individuals and/or their families and ensure consistency and fairness in decision making.

2.3 Many CCGs have established Continuing Healthcare Commissioning Principles Policies in place.

2.4 The proposal is to establish a Continuing Healthcare Commissioning Principles Policy for Calderdale CCG which is based upon that already agreed and in current use in Greater Huddersfield and North Kirklees CCGs.

3. **Next Steps**

3.1 It is proposed that the policy is established and used to guide decisions about any new home care packages for individuals.

3.2 It is also proposed that the policy is considered as part of the routine review of existing home care packages.

4. **Implications**

4.1 **Quality & Safety Implications**

4.1.1 Any decisions about care packages will be made with the agreement and understanding of the individual where possible and their family if appropriate. Decisions will be made in consideration of a number of key factors:

- Clinical need
- Individual safety
- Public safety
- Individual choice and preference
- Individual's rights to family life.
4.2 Public / Patient / Other Engagement

4.2.1 Engagement work was carried out by North Kirklees CCG when forming the original policy. This work has been approved by the Quality team in CCCG to ensure its validity for this document.

4.2.2 This policy will ensure that there is an objective assessment of the individual’s clinical needs, safety and best interests and will be applied on an individual basis.

4.2.3 This policy has had an Equality Impact Assessment and Quality Impact Assessment and has been fully reviewed by legal advisors on behalf of North Kirklees CCG.

4.3 Risk

There may be a risk that the expectations of individuals exceed the level of service which can be safely commissioned by the CCG in line with the principles in this policy.

5. Recommendations

5.1 It is recommended that Governing Body APPROVES the Continuing Healthcare Commissioning Principles Policy.

6. Appendices

6.1 Appendix 1: Continuing Healthcare Commissioning Principles Policy.
NHS Calderdale CCG

Continuing Healthcare Commissioning Principles Policy

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Policy Reference No: XX

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1. Introduction

1.1 ‘NHS continuing healthcare’ (NHS CHC) means a package of continuing care that is arranged and funded solely by the NHS. ‘Continuing care’ means care provided over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness.

1.2 This Policy has been developed to guide the care commissioning stage of the Continuing Healthcare pathway, to ensure that the principles of equity and fairness are upheld, and to maintain Calderdale Clinical Commissioning Group’s (CCG) responsibilities for financial governance.

1.3 The policy is reflective of the CCG’s visions and values and supports that individuals are at the heart of the commissioning process in regard to decision-making in the area of NHS Continuing healthcare. The policy demonstrates the requirement for the individual, and/or their representative to be at the centre of the care planning and outcomes process, and be fully involved in and informed of decisions made in relation to their care.

1.4 The policy is designed to demonstrate the requirement of the CCG to commission quality services that will improve the individual’s experiences of care and their health outcomes, balanced with the requirement to manage the substantial financial challenges against the backdrop of increasing need.

2. Purpose

2.1 The CCG is responsible for commissioning and procuring services for all individuals who qualify for NHS continuing healthcare and for the healthcare element of any joint care package funded by the Local Authority (LA) and the CCG (including situations where the individual may make a personal contribution via means testing by the LA). The purpose of this policy is to assist Calderdale CCG to ensure that the reasonable requirements of eligible individuals are met.

2.2 This policy applies once an individual has received a comprehensive, multidisciplinary assessment of their health and social care needs and the outcome identifies that they either have a primary health need and are determined to be eligible for NHS Continuing Healthcare (CHC) funding, or, are eligible for a joint package of care.

2.3 This policy has been developed to help provide a common and shared understanding of CCG commitments in relation to individual choice and resource allocation.

2.4 The benefits of this policy are to:

- Inform robust and consistent commissioning decisions for the CCG in the provision of CHC;
- Ensure that there is consistency in the local area about the quality of services that individuals are offered;
- Ensure there is an objective assessment of the individual's clinical needs, safety and best interests;
• Ensure the CCG achieves value for money in its purchasing of services for individuals eligible for NHS Continuing Healthcare and joint packages of care;
• Facilitate effective partnership working between health care providers, NHS bodies and the Local Authority in the area;
• Promote individual choice as far as reasonably possible;
• Ensure equity in the provision of care.

2.5 This policy details the legal requirements and CCG responsibilities in commissioning CHC which meets the individual’s assessed needs. This policy has been developed to assist the CCG to meet its responsibilities under the sources of guidance listed towards the end of this policy.

2.6 Whilst improving quality and consistency of care, this policy is intended to assist the CCG to make decisions about clinically appropriate care provision for individuals in a robust way which promotes efficient and effective use of NHS resources.

3. Definitions / Explanation of Terms
Refer to the glossary in Appendix A

4. Scope of the Policy

4.1 This policy applies to NHS Calderdale CCG and applies to all employees, members of the CCG, Associates and members of the Governing Body and its committees who must comply with the arrangements outlined in this policy.

4.2 This policy relates to patients eligible for NHS continuing healthcare, NHS funded nursing care, or a joint package of health and social care who are registered with a GP in Calderdale or where the CCG is responsible under the responsible commissioner guidance, Who Pays, NHS England 2013.

4.3 The NHS Continuing Healthcare and Funded Nursing Care Framework (revised 2012) is a legal framework that is used to identify whether patients are eligible for NHS continuing healthcare or funded nursing care. See link below:


5. Duties / Accountabilities and Responsibilities

The Head of Commissioning Continuing Care/mental health and learning disability services is the accountable officer with responsibility for this policy.

Day to day responsibility for the development and implementation of this policy sits with the Operations manager for Continuing Care, as well as responsibility for ensuring that this policy is reviewed and necessary training is facilitated.
5.1 NHS Calderdale CCG Employees

All staff involved in the assessment of eligibility for NHS CHC, decision making, or referral for consideration of a Personal Health Budget ("PHB") has a responsibility to work within this policy and should:

- Be aware of how to access it;
- Act in accordance with it;
- Attend any relevant training which is offered in relation to it;
- Report any issues affecting compliance with it to their line manager.

This also includes those contracted to deliver the CHC function on the CCG’s behalf.

5.2 Responsibilities for Approval

- NHS Calderdale CCG is responsible for the development of this policy.
- This policy is issued to support Calderdale CCG to meet its commitments under The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the Standing Rules") for continuing healthcare, in accordance with the National Framework. See link above.
- This policy will ensure that the CCG adheres to national and local requirements to safeguard adults and adhere to the principles identified within the Mental Capacity Act and its associated Code of Practice, including the Deprivation of Liberty Safeguards (2009).
- This policy will take effect once authorised by NHS Calderdale CCG Governing Body.

6.1 Policy Document Requirements Details

6.1.1 The policy is to be implemented at the point of new eligibility decisions in relation to NHS Continuing Healthcare and Funded Nursing Care, as well as at the point of any review of care needs and packages.

6.1.2 Where an individual qualifies for NHS continuing healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated social care needs.

6.1.3 The CCG will seek to accommodate the individual's wishes and preferences as to how and where their care is delivered as far as possible, although this must be balanced against the need for the efficient and effective use of NHS resources.

6.1.4 The CCG will seek to promote the individual’s independence subject to the factors set out in paragraph 6.1.6. The CCG aims to support individuals to take reasonable risks whilst ensuring that care provided is clinically safe, including through the use of a personal health budget, where requested and appropriate.

6.1.5 The CCG’s responsibility to commission, procure or provide continuing healthcare is not indefinite, as an individual's overall care needs may change. Regular reviews, after three months and then at least annually, are built into the process to ensure that the care provision continues to meet the individual's overall care needs and is funded appropriately.
**6.1.6** When commissioning services for individuals, the CCG will balance a range of factors including: (These lists are not exhaustive.)

**Safety, Governance & Assurance**

- Clinical need;
- Individual safety;
- Public safety;
- Individual choice and preference;
- Individual's rights to family life;
- Value for money; and
- The best use of resources for the population of Calderdale

**Personalisation, Choice & Diversity**

- Ensuring services meet the required quality standards;
- Ensuring services are culturally sensitive; and
- Ensuring services are personalised to meet individual need.

**6.1.7** Decisions made by the CCG under this policy will comply with the Human Rights Act 1998.

**6.2 Mental Capacity & Representation**

**6.2.1** Where there is reason to believe that an individual may lack capacity to make a decision regarding the provision of (or change to) their care or accommodation, a mental capacity assessment shall be undertaken. If the assessment confirms that the individual lacks capacity to make a decision or decisions about the provision of CHC then a best interests decision shall be undertaken by the CCG in accordance with the Mental Capacity Act 2005 and the Code of Practice. This includes a requirement to take into account the individual's past and present wishes and feelings and the views of those who are involved in caring for the individual and/or who are interested in their welfare (e.g. close family members or friends). The CCG will appoint an Independent Mental Capacity Advocate to support the individual and to report to the CCG before making a best interests decision where there is no-one to consult as above in accordance with the Act.

**6.2.2** Where there is reason to believe that an individual may lack capacity to participate in a CHC assessment, an initial mental capacity assessment shall be undertaken. If an individual is unable to consent to the assessment, then a best interests decision shall be undertaken to decide whether the CHC assessment is in the individual's best interests. This best interests decision shall be carried in in accordance with the principles set out in section 6.2.1 (above).

**6.2.3** In some circumstances, another person or the Court of Protection may have legal authority to make a decision on the incapacitated individual's behalf in their best interests. Where the CCG is made aware of this, and a best interest decision is required in respect of an offer of care, it will ask to see one of the following documents:

- A Lasting Power of Attorney (LPA) which has been registered with the Office of the Public Guardian. (This would need to be a Health and Personal Welfare LPA
because a Property and Financial Affairs LPA would not extend to personal welfare decisions such as whether to accept an offer of care provision);

- An order of the Court of Protection appointing them as Personal Welfare Deputy and the order enables them to decide on the care or accommodation of the individual, or;
- An order from the Court of Protection, in respect of the care or accommodation of the individual.

6.2.4 Any disputes about what is in the incapacitated person's best interests must be dealt with in accordance with the Mental Capacity Act and its Code of Practice which, in appropriate cases, could involve seeking involvement of the Court of Protection in resolving any dispute.

6.3 Identification of care provision

6.3.1 Where an individual is eligible for CHC funding, the CCG will commission care which meets the individual’s assessed care needs which will be set out in a care plan. The CCG will only fund services to meet the needs that are identified in the care plan, for which it has a statutory responsibility and that are needed to meet the individual’s reasonable requirements based on all relevant factors, including those in 6.1.6.

6.3.2 The individual’s care coordinator will discuss the proposed care provision with the individual and their representative(s) (where the individual gives consent for such a discussion or where the individual lacks capacity) including where the service may be provided. The care plan will identify the outcomes that the individual wishes to achieve. The care coordinator should identify different options for providing the care, indicating which of these is preferred by the individual.

6.3.3 The care coordinator will use the CCG’s care package documentation as appropriate to set out the requested care package and associated information. The pro-forma must be completed in full for every proposed care package before verification.

6.3.4 The CCG will seek to take into account any reasonable request from the individual and their representative(s) in making the decision about the care provision, subject to the factors set out in paragraph 6.1.6 above.

6.3.5 As stated in the CHC National Framework ('FAQs' section), CCGs can take into account comparative costs and value for money when determining the care provision offered. The cost comparison has to be on the basis of the genuine costs of alternative models of care provision, based on the actual costs that would be incurred in supporting a person with the same specific needs and not on an assumed standard care home cost. In some situations a model of support preferred by the individual will be more expensive than other options.

6.3.6 The CCG will endeavour to offer a reasonable choice of available contracted providers to the individual. Where the individual wishes to receive their care from an alternative provider the CCG will consider this subject to the CCG adhering to the following criteria:

- The individual’s preferred care setting is considered by the CCG to be suitable in relation to the individual’s care needs as assessed by the CCG;
• The cost of making arrangements for the individual at their preferred care setting would not require the CCG to pay more than they would usually expect to pay having regard to the individual’s assessed care needs.
• The individual’s preferred care setting is available;
• The provider in charge of the preferred care setting is willing and able to provide the required care to the individual subject to the CCG’s usual terms and conditions, having regard to the nature of the care setting.

6.3.7 Where the CCG deems that a provider is not providing care of an acceptable quality and standard, the CCG reserves the right to move the individual to an alternative provider.

6.4 Registered care settings

6.4.1 Where care is to be provided in a registered care setting (such as a care home or independent hospital), the CCG will only place individuals with providers which are:

• registered with the Care Quality Commission (or any successor) as providing care to meet the individual’s assessed care needs; and
• Not subject to an embargo by the CCG or Local Authority, including the host CCG or Local Authority if the provider is not located in Calderdale
• contracted to the CCG to provide nursing care at the standard rate; or
• Contracted to the CCG to provide care at an enhanced rate, where the CCG determines enhanced care is required.

6.4.2 Location requests will be accommodated as much as reasonably possible, and in accordance with this policy, for example, proximity to relatives will be taken into account. Location requests will be subject to fulfilment of the criteria described in section 6.4.1 of this policy.

6.4.3 If a care home that was not originally offered is requested by the individual, the CCG will accept the individual’s selection providing it complies with the criteria set out in section 6.4.1 of this policy.

6.4.4 The CCG understands that individuals may want to be located near specific places to stay in the local community and enable family and friends to visit easily. To accommodate this, where the CCG’s contracted available care homes are not within a reasonable travelling distance, the CCG may choose to make a specific purchase, entering into a contract where the provider can demonstrate compliance with section 6.4.1 for that individual to enable them to be accommodated in their preferred area where the anticipated cost to the CCG may be more than the available CCG contracted accommodation (based on CCG agreed standard rates for equivalent levels of need).

6.4.5 The CCG will consider requests on a case-by-case basis, guided by the factors set out in section 6.1.6 and using the two stage process for determining exceptional circumstances set out in 6.1.5 below (‘Exceptional Circumstances’) where necessary.

6.4.6 Reasonable travelling distance will be based on a case-by-case assessment of an individual’s circumstances, and will take into account factors such as ability of family and
friends to visit, which may include public transport links and mobility of the family and friends.

6.4.7 If an individual or their representative(s) exercise individual choice and select a care home in another area, the CCG will consider placing the individual there and, if they do place the individual, the responsibility for commissioning between different CCGs will be decided in accordance with NHS England's 'Who Pays?' guidance.

6.4.8 The CCG will consider providing a placement in a registered care setting not contracted to the CCG in exceptional circumstances. This will only be approved when the provider complies with paragraphs 6.4.1 point one and two above, and a contract will be implemented once this has been established, as long as the factors highlighted in 6.1.6 are addressed.

6.5 Home care

6.5.1 The CCG will take account of the wishes expressed by individuals and their families when making decisions as to the location or locations of care to be offered to individuals to satisfy the obligations of the CCG to provide CHC. The CCG acknowledges that an individual who is eligible for CHC may wish to remain in their own home with support provided wherever possible. Where an individual or their representative(s) express such a desire, the CCG will investigate whether a sustainable package of NHS CHC for an individual can be provided in their own home, having regard to the principles set out in this policy.

6.5.2 The willingness of family to supplement care and support should be taken into account, although no pressure should be put on them to offer such support. Whilst family members are under no legal obligation to offer care, the CCG will ask family members if they are prepared to do so and, if they agree, the CCG is entitled to assume that family members will provide any agreed level of support in designing any home care package.

6.5.3 The actual cost of care at home should not generally exceed the equivalent cost of a registered care setting capable of meeting the assessed needs of that individual at that time.

6.5.4 The CCG may be prepared to support a package of care which keeps an individual in their own home where the anticipated cost of the care to the CCG may be more than the most cost-effective care identified (based on CCG agreed standard rates for equivalent levels of need).

6.5.5 The CCG will consider requests under paragraph 6.5.4 above on a case-by-case basis guided by the factors set out in section 6.1.6 and using the two stage process for determining exceptional circumstances set out in Section 6.15 below ('Exceptional Circumstances').

6.5.6 Where the CCG decides to offer care at home to an individual, the individual’s home becomes a place of work for those employed to care for the individual at home. Employee safety is an important consideration in home care packages. The individual’s home must be a reasonably safe environment to work and deliver care to the individual. This includes
cleanliness of the environment, and interactions between the individual, family/carer and the employee.

6.5.7 Where home care is to be provided, the CCG will use domiciliary care agencies it has commissioned to provide such care, including agencies commissioned by the Local Authority on its behalf. Home care will be provided by agencies suitably qualified to deliver the care that meets an individual’s assessed care needs. The requirements for registration as identified above as also relevant. Individuals who have been in receipt of private funded care and requests for carers to remain once CHC has been determined can be considered if: 1) CQC registered, 2) VAT registered 3) provide evidence of DBS and mandatory training. If this cannot be provided alternate appropriate registered providers will be offered.

6.5.8 The cost of home care provision should not exceed the equivalent cost of care in a registered care setting capable of meeting the assessed needs of the individual. This is subject to the provisions of paragraphs 6.1.6 above.

6.5.9 If an individual with a package for domiciliary care is admitted to an acute care setting, the CCG will only pay for a carer to accompany the individual and ensure they are settled in the acute setting. The CCG will pay to the end of the particular shift.

6.6 Personal Health Budgets

6.6.1 Patients eligible for CHC have had the right to have a personal health budget since October 2014. The cost of a personal health budget should not exceed the equivalent cost of care in an alternative care setting capable of meeting the assessed needs of the individual. This is subject to the provisions of paragraph 6.6.4 and 6.6.5 below.

6.6.2 A personal health budget may be provided to an individual in a registered or a non-registered setting. It may cover all or part of the assessed care needed by the individual. It may only be used to pay for care agreed as part of a care package by the CCG.

6.6.3 Where the CCG offers an individual a personal health budget, it will benchmark the cost of such a package against alternative packages of care. The cost of a personal health budget will generally not exceed the equivalent cost of meeting the individual’s assessed care needs without a personal health budget (subject to the provisions of paragraphs 6.6.4 and 6.6.5 below). The cost of a personal health budget may include any directly incurred additional expenditure, as described within the Personal Health Budgets Policy.

6.6.4 The CCG may be prepared to support a package of care which keeps an individual in their own home where the anticipated cost of the care to the CCG may be more than the most cost-effective care identified (based on CCG agreed standard rates for equivalent levels of need).

6.6.5 CCG will consider requests under paragraph 6.6.4 on a case-by-case basis guided by the factors set out in section 6.1.6 and using the two stage process for determining exceptional circumstances set out in Section 6.1.5 (‘Exceptional Circumstances’).

6.6.6 Where the individual receives a personal health budget and they directly employ staff they assume responsibility for all of the obligations that apply to any employer. The CCG will not
accept any vicarious liability arising out of an individual's decisions to employ staff, funded by a personal health budget.

6.6.7 Due to the time it takes to arrange a personal health budget, this provision is generally not suitable for individuals for whom the CCG are providing care through the Fast Track pathway, however the CCG will take account of each request and circumstances, and where necessary, consider any 'Exceptional Circumstances'.

6.7 Choice of provider

6.7.1 To assist the CCG in achieving consistent, equitable care, the CCG will endeavour to offer and place individuals with providers with whom the CCG contracts ('contracted provider').

6.7.2 Where a contracted provider is not available to meet the individual’s assessed care needs, the CCG may make a specific purchase and place the individual with another care provider who does meet the individual's needs pending a contract agreement between the two parties. For example, if an individual has a specific care need which cannot be catered for in available contracted accommodation or service, the CCG will need to specifically commission accommodation or care for the individual, potentially through an individually negotiated agreement followed by implementation of a formal contract.

6.7.3 Though all reasonable requests from individuals and their families will be considered, and the CCG will, where possible, seek to place an individual in their preferred placement, the CCG is not obliged to accept requests from individuals for specific care providers.

6.7.4 Where the CCG deems that a provider is not providing care of an acceptable quality and standard, the CCG reserves the right to move the individual to an alternative suitable care provider. Where practicable, save in an emergency, the individual and their family will be consulted about any move in advance of such move and their preferences taken into account.

6.7.5 The CCG contracts with different providers to meet the needs of different service users. Where an individual's needs change, the CCG may offer the individual a package of care with a new care provider to meet the changed need.

6.8 Additional services

6.8.1 The individual or their representative(s) has the right to enter into discussions with any provider to supplement the care provision, over and above that required to meet the individual's assessed needs. Any such costs arising out of any such agreement must be funded by the individual or through third party funding. These costs may relate to:

- Additional non-healthcare services to the individual. For example hairdressing, provision of a larger room, en-suite, or enhanced TV packages.

- Additional healthcare services to the individual, outside of the services the CCG has agreed to provide within the CHC package. These types of services may include things
such as chiropractor appointments or additional physiotherapy sessions. The CCG will satisfy itself that these services do not constitute any part of the CHC identified need.

6.8.2 The decision to purchase additional services to supplement a CHC package must be entirely voluntary for the individual. The provision of the CHC package must not be contingent on or dependent on the individual or their representative(s) agreeing to fund any additional services. This means that the care home must be willing and able to deliver the assessed CHC needs to the individual, without the package being supplemented by other services as described in 6.8.1 of this policy.

6.8.3 Any funding provided by the individual for private services should not contribute towards costs of the assessed need that the CCG has agreed to fund. Similarly, CHC funding should not in any way subsidise any private service that an individual chooses outside of the identified care plan.

6.8.4 Where an individual is funding additional services, the associated costs to the individual must be explicitly stated and set out in a separate agreement with the provider. If the individual chooses to hold a contract for the provision of these services, it should be clear that the additional payments are not to cover any assessed care needs funded by the CCG.

6.8.5 In order to ensure that there is no confusion between the NHS and privately funded services, the CCG will enter into a legally binding contract with the selected provider which details the provision by the provider of a defined level of health and social care to the individual. This will expressly be independent of any arrangement between the care provider and the individual or their representative(s) and will be expressed to continue notwithstanding the termination of any arrangements made between the individual and the care provider. Any payments made by the individual under a contract with the care provider for additional services cannot be made under the CCG contract.

6.8.6 If the individual or their representative(s), for any reason, decides that they no longer wish to fund the additional services supplementing the care package, the CCG will not assume responsibility for funding those additional services.

6.8.7 Where the CCG is aware of additional services being provided to the individual privately, the CCG will satisfy itself that they do not constitute any part of the provision to meet assessed needs.

6.9 Availability

6.9.1 To enable individuals to receive the correct care promptly, individuals will be offered available care as soon as possible. If an individual's first choice from the CCG’s contracted provider range is not available, they will be offered another CCG contracted provider to ensure provision as soon as possible. The CCG will offer care from contracted providers before any other unless exceptional circumstances apply.

6.9.2 If the individual requests care which is currently unavailable, and is unwilling to accept the CCG’s offer of care, there are several options available.
6.9.3 Temporary placement of the individual with alternative care provision until the care from the CCG’s contracted care is available. For example, alternative home care provider, alternative care home, respite care or a community bed.

6.9.4 The individual may choose to go to their own or a relative’s home without the assessed care provision until the preferred care is available. The terms set out in Section 6.10 of this policy will apply. The individual will, however, retain the right subsequently to change their mind and elect to accept the care provision offered by the CCG. If the individual does not have mental capacity to make this decision, the CCG will exercise its duties under the Mental Capacity Act;

6.9.5 If it has been agreed with the individual that the assessed care needs can best be met through a care home placement, the CCG may choose to provide home care until the preferred care home is available, but cost implications to the CCG must be considered. This will be in accordance with section 6.5 of this policy.

6.9.6 If the individual’s representative(s) are delaying placement in a care home due to non-availability of a preferred home, and the individual does not have the mental capacity to make this decision themselves, the CCG will have recourse to the Safeguarding Adults Multi Agency Policy and Procedure for West Yorkshire and North Yorkshire (Published April 2015) and the Mental Capacity Act, as appropriate.

6.9.7 If the individual is in hospital, the individual should move to the most appropriate care setting as soon as they are medically fit for discharge from hospital, even if their first choice of care provision is not available. The individual’s preference will be considered in line with Section 6.3 of this policy, when the CCG is deciding which package of care to offer to them. Where the individual’s preferred choice is not available, but alternative provision which will meet their assessed needs is available, they are required to move and cannot remain in an acute healthcare setting once they are fit for discharge.

6.9.8 If the CCG provides an individual with care that is more expensive than the standard cost due to, either availability in the market, or the ability of the CCG to commission at the standard cost, the additional cost will be funded by the CCG. Where such an arrangement has been agreed the CCG reserves the right to move the individual to a suitable contracted provider when available. The CCG will notify the individual and/or their representative(s) that they may be moved should a contracted provider subsequently have capacity. In such circumstances, the CCG will give a minimum of 7 days’ notice to the individual or their representative.

6.10 Right to refuse

6.10.1 An individual is not obliged to accept a CHC package. Once an individual is eligible and offered CHC, and they choose not to accept the CHC package, the CCG may, in appropriate cases, take reasonable steps to make the individual aware that the Local Authority may not assume responsibility to provide care to the individual because they have refused NHS care.
6.10.2 The CCG will work with the individual to help them understand their available options and facilitate access to appropriate advocacy support. As appropriate, the CCG will have recourse to and the Mental Capacity Act 2005. Appropriate Section of the Safeguarding Adults Multi Agency Policy and Procedure for West Yorkshire and North Yorkshire.

6.10.3 The CCG discharges its duty to individuals by making an offer of a suitable CHC care package whether or not they choose to accept the offer. For example, the CCG may discharge its duty by offering to provide a package of services for an individual in one or more appropriate care settings, irrespective of whether this is the individual's preferred location, and that offer is rejected by the individual. Despite a refusal, the CCG will continue to offer the CHC care package for as long as the individual is eligible for CHC.

6.10.4 The CCG offers to discharge its duty to an individual who, to date, has had a package of services in their own home funded either by themselves or the Local Authority by moving the individual to one or more appropriate care homes (since the costs of providing such care may be significantly less than providing care for an isolated individual) but that offer of a care home is rejected by the individual.

6.10.5 If the CCG's offers of appropriate care packages are refused by someone with legal authority to act on behalf of an incapacitated individual, the CCG will have recourse to the Calderdale Multi-Agency Safeguarding Policies and Procedures and the Mental Capacity Act, as appropriate.

6.10.6 Where an individual exercises their right to refuse, the CCG will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of care provision.

6.11 Withdrawal

6.11.1 It may be appropriate for the CCG to withdraw CHC services where the situation presents a risk of danger, violence to or harassment of care staff who are delivering the care package. However, services will not be withdrawn without first exploring all reasonable alternative options to ensure the individual's assessed care needs are met without care staff being put at risk as described – e.g. by arranging an alternative care setting which is more appropriate to managing the identified risks.

6.11.2 The CCG may withdraw CHC-funded support where the clinical risks become too high. This can be identified through, or independently of, the review process. Where the clinical risk has become too high in a home care setting, for example, the CCG may choose to offer CHC in a care home setting or the individual may need to be assessed for possible inpatient hospital admission.

6.11.3 The CCG may consider the requirement to withdraw part of, or the entire care package where there is evidence of potential fraudulent activity. This may manifest itself with concerns that care which is paid for by the CCG is not provided, or individuals, carers or providers making a financial gain via the CHC system. Where this is identified, the CCG must take the appropriate actions.
6.12 Disputes

6.12.1 Where there are disputes between the CCG and the Local Authority over care provision in respect of a joint package of care, the CCG will follow the Dispute Resolution Policy agreed with the Local Authority.

6.13 Complaints

6.13.1 An individual may complain about any decision by the CCG as to the nature of a care package. Complaints will be dealt with through the CCG’s NHS complaints procedure.

6.13.2 If the complaint cannot be resolved locally the individual or their representative can be referred directly to the Health Service Ombudsman.

6.14 Continuing Healthcare Review

6.14.1 A case review of eligibility for CHC should be undertaken no later than three months after the initial eligibility decision, in order to reassess the individual’s care needs and ongoing eligibility for CHC, and to ensure that the individual’s assessed care needs are being met as well as assessing the effectiveness and appropriateness of the care/support arrangements. Reviews should thereafter take place annually, as a minimum, or when there is a substantial change in need. This policy is applicable at any point in the review process, even if the initial care package was implemented prior to this policy, or previous versions, were in place.

6.14.2 If the review demonstrates that the individual’s condition has improved to an extent that they no longer meet the eligibility criteria for CHC funded care provision, the CCG is obliged to cease funding (subject to the provisions of paragraph 6.14.3 and 6.14.4 below). This includes home care and care home provision. In these cases the CCG will carry out a joint review with the Local Authority.

6.14.3 At this point the Local Authority has 28 days to review the individual’s requirements and the individual will be notified they may no longer be eligible for CHC. CCG funding for an individual’s care may be continued for 28 days where a Local Authority is undertaking such a review or such longer period as seems reasonable in the circumstances.

6.14.4 Neither the NHS nor the Local Authority should unilaterally withdraw from an existing care arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change of arrangement. It is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding in order to ensure continuity of care.

6.14.5 The CHC review may identify an adjusted, decreased or increased care need:

- Where an individual is receiving home care, the CCG will consider the ability of the package to be delivered in the home environment, and also the cost effectiveness of this package in accordance with Section 6.3 of this Policy.
• Where the individual is accommodated in a care home, the CCG will ensure that the care home is able and suitable to deliver the change in needs.
• Where the care home is unable to meet this adjusted care need, the CCG will accommodate the individual in accordance with Sections 6.4 of this policy.
• Where there is a decreased need, the CCG will consider the cost effectiveness of the package to be delivered in the current care home, and may move the individual to a suitable alternative provider in accordance with Section 6.3 of this policy.

6.14.6 On review of the CHC the CCG may adjust the package even if the underlying needs of the individual have not changed, if it is possible to provide the care necessary to meet those needs in a more effective and efficient way.

6.15 Exceptional circumstances

6.15.1 In exceptional circumstances, the CCG may be prepared to consider funding provision of an individual CHC care package where the anticipated cost to the CCG is more than the cost of an equivalent care package under this policy.

6.15.2 In order to determine whether exceptional circumstances exist, a two-stage process will apply:

• Are the individual’s needs significantly different to other individuals with the same or similar conditions?
• Will the individual benefit significantly more from the additional or alternative services than other individuals with the same or similar conditions?

6.15.3 Exceptionality will be determined on a case-by-case basis and will require the agreement of the Head of Commissioning Continuing Care or nominated deputy.

6.16 Fast track

6.16.1 Care provision for individuals assessed on the fast track will be subject to the same principles as set out in the relevant sections in this policy dependant on needs. The eligibility criteria for a Fast Track application are defined within the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care.

7. Public Sector Equality Duty

7.1 NHS Calderdale CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage.

8. Consultation

8.1 Stakeholders:

Development of this policy was completed with consultation from a strategic steering group that consisted of members from Kirklees Local Authority, North Kirklees CCG, North
Kirklees Lay Member and North Kirklees CCG. Terms of Reference of this group gave members the responsibility of disseminating the draft policy for consultation within their organisation prior to approval.

8.2 Service Users:

Services commissioned to deliver continuing healthcare will be contracted to work with service users, which will be fed back to the CCG. This will include comments, compliments and complaints as well as regular service user feedback questionnaires being issued. The CCG will also monitor any direct comments, compliments and complaints.

Information will be reviewed and the policy will be amended accordingly.

9. Training

9.1 Training will be delivered according to stakeholder requirements and will therefore be by two separate approaches.

Level 1

Stakeholders who have day-to-day involvement with the context of this policy will require in depth training, namely:

- CCG Continuing Healthcare Staff
- Calderdale Local Authority Commissioners
- Social Work Teams
- Calderdale hospital discharge matron

Level 2

Stakeholders who need to have an understanding and be able to promote this policy will be:

- Primary and Secondary care providers

In addition to training on this policy, it is essential that those involved provide personalised care. To support this, all staff will require training in equality and diversity.

10. Monitoring Compliance with the Document

10.1 Calderdale CCG will develop an internal process to ensure compliance with this policy. The policy will be reviewed on an annual basis to ensure compliance with emerging case law.

10.2 The responsibilities of Calderdale CCG under this guidance may also be discharged on its behalf by any organisation commissioned to undertake commitments on its behalf.

10.3 Monitoring arrangements for compliance and effectiveness
Data will be collated for all new service users when the continuing healthcare nurse completes the initial assessment. All existing service users’ data will be collated at their next review.

The data will be recorded in a standard template on Broadcare and will include the following:

- Age
- Disability
- Gender/Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race, religion or belief
- Sex, sexual orientation

Responsibilities for conducting monitoring – Operations Manager for Continuing Care

Process for reviewing results of monitoring; identifying any learning and ensuring improvements in performance occur:

- Quarterly Continuing Care Report presented to Quality, Performance and Finance Committee
- Feedback at strategic steering group.

11. Arrangements for Review

11.1 This policy will be reviewed annually. It will be reviewed accordingly in line with any local or national framework changes. Any changes will be consulted on with Calderdale Local Authority. These changes will take effect once authorised by Calderdale CCG Governing Body.

12. Dissemination

This policy will be published on the Calderdale CCG Website.

The policy will be stored in the necessary policy folder on Calderdale CCG drive.

All stakeholders will be sent an electronic copy with a read receipt action and this will be recorded on a log held by Calderdale CCG.

Any revisions or amendments to previous documents will be recorded in the version control paragraph and the document will go through the above process.

13. Associated Documentation

- Calderdale CCG Equality and Diversity Policy
- Calderdale CCG Safeguarding Children and Adults at Risk Policy
- The West Yorkshire Multi-Agency Safeguarding Adults Policy
- CHC Personal Health Budgets Policy
• CHC Operational Protocol

14. References

• NHS Act 2006
• Health and Social Care Act 2012
• Care Act 2014
• The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 as amended
• The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (revised)
• NHSE: Personal health Budgets: link - http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Personal_health_budgets_right_to_have_guidance.pdf
• Mental Capacity Act 2005 and Code of Practice
• Human Rights Act 1998
• National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (as amended) (the CCG is not bound by the Choice Directions but will endeavour to comply with their spirit so far as possible in accordance with the provisions of this policy)
• Updated guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992: Consultation outcome (14 October 2004)
• National Health Service Income Generation - Best practice: Revised guidance on income generation in the NHS (1 February 2006)
• 'Who Pays? Determining Responsibility for Payments to Providers' (August 2013)
• Guidance on NHS patients who wish to pay for additional private care (May 2009)

Legal guidance relevant case law, notably:

• Gunter v South Western Staffordshire Primary Care Trust (2005)
• St Helens Borough Council v Manchester Primary Care Trust (2008)
• McDonald v Royal Borough of Kensington and Chelsea (2010)
### Glossary

<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Accommodation</strong></td>
<td>In the context of CHC, accommodation relates to an appropriately registered care setting or the individual's own home.</td>
</tr>
<tr>
<td><strong>Care coordinator</strong></td>
<td>Care coordinator refers to the person who coordinates the assessment and care planning process. Care coordinators are usually the central point of contact with the individual.</td>
</tr>
<tr>
<td><strong>Care provision</strong></td>
<td>Care provision takes two main forms:</td>
</tr>
<tr>
<td></td>
<td>• Care provided in an individual’s own home and referred to in this document as ‘home care’ or ‘domiciliary care’.</td>
</tr>
<tr>
<td></td>
<td>• Care provided in an appropriately registered care setting (such as a nursing home, a residential home or an independent hospital) and referred to in this document as ‘registered care setting’ or ‘care home’.</td>
</tr>
<tr>
<td><strong>Care Quality Commission (CQC)</strong></td>
<td>Independent regulator of all health and social care services in England.</td>
</tr>
<tr>
<td><strong>CCG</strong></td>
<td>CCG refers to NHS Calderdale Clinical Commissioning Group</td>
</tr>
<tr>
<td><strong>Joint Package of Care</strong></td>
<td>A joint package funded by the NHS and the local authority, where an individual is not eligible for continuing healthcare, but specific needs from the decision support tool are of a nature that the LA cannot solely meet or beyond their powers to meet.</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>In the context of this policy the individual is the service user that has been assessed for and offered continuing healthcare, often referred to as the individual. A person who has formally been appointed as an Attorney or Deputy has defined responsibilities for the individual. The extent of these responsibilities will vary according to the nature of their appointment.</td>
</tr>
<tr>
<td><strong>Local Authority</strong></td>
<td>Local Authority refers to Calderdale Council.</td>
</tr>
<tr>
<td><strong>Multidisciplinary Assessment (MDA)</strong></td>
<td>A holistic assessment with health and social care members to identify the needs of the individual.</td>
</tr>
<tr>
<td><strong>Preferred providers</strong></td>
<td>These providers have been assessed and accepted by the CCG as being able to fulfil the continuing healthcare requirements of defined categories of individuals at an agreed cost. These providers will be maintained within and “Approved List”.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Provider refers to organisation that provides NHS continuing healthcare on behalf of the CCG.</td>
</tr>
<tr>
<td><strong>Representative(s)</strong></td>
<td>Representative(s) refers to the people or person that liaises between individuals and the CCG. The individual receiving healthcare may elect to have representative(s) act with them or on their behalf, or there may be representative(s) where the individual does not have the mental capacity to make independent decisions. Representatives may be legal representatives, individual advocates, family, or other</td>
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people who are interested in the individual’s wellbeing. Where the individual has capacity, they must give consent for any representative to act on their behalf.
### Key Stakeholders Consulted/Involved in the Development of the Policy Document

<table>
<thead>
<tr>
<th>Stakeholders name and designation</th>
<th>Date Feedback requested</th>
<th>Detail of feedback received</th>
<th>Date Feedback received</th>
<th>Action taken</th>
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<td>Helen Severns – Head of Transformation (NK)</td>
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<td>Happy with contents</td>
<td>24/07/2015</td>
<td>Amendments made</td>
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<td>Helen Shallow – Head of Finance &amp; Contracting (NK)</td>
<td>08/07/2015</td>
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<tr>
<td>Dianne Green – Local Authority Representative</td>
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<td>Julie Elliott – Lay Member (NK)</td>
<td>08/07/2015</td>
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<tr>
<td>Clare Robinson – Designated Professional Safeguarding Adults</td>
<td>08/07/2015</td>
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<tr>
<td>Kiran Ball – Lay Member (NK)</td>
<td>08/07/2015</td>
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INTRODUCTION

This Equality Impact Assessment had been conducted to fulfil four objectives:

1. Ensure that the North Kirklees fully considers the needs of protected characteristic groups in the future commissioning of Continuing Health Care.

2. To ensure the strategic framework contained within the policy is compliant with the Public Sector Equality Duty (PSED); and particularly mitigates against, and enables a better understanding of the impact on protected characteristic groups;

3. Ensure that the development and detail therein the policy framework is both equalities tested, and designed to deliver better health outcomes to all diverse communities of North Kirklees

4. That the Equality Impact Assessment Action Plan covers:
   a) Implementing robust processes
   b) Collection, analysis and reporting of intelligent data
   c) To ensure sufficient training
   d) To consult and involve service users, their representatives, or their advocates on an annual basis, including professionals who undertake the assessments

This EQIA aims to embed within the Commissioning intentions and the potential impact and implications of Continuing Health Care for groups of people who are protected under the Equality Act (2010) in relation to:

- Age
- Disability – vision, hearing, LD, autism, carers by association & Physical impairment and Mental Health
- Gender reassignment
- Marriage & Civil partnership
- Pregnancy & Maternity
- Race, Nationality, Ethnicity
- Religious Belief
- Gender/Sex - Men & Women
- Sexual Orientation
AIM OF CHC POLICY FRAMEWORK:

This policy aims to assist North Kirklees CCG to ensure that reasonable requirements of eligible individuals are met following a comprehensive, multidisciplinary assessment of their health and social care needs. To qualify for support it must be clearly evident that ‘Continuing care’ is required over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness.

This is North Kirklees Clinical Commissioning Group’s (CCG) policy on the commissioning of care packages for patients eligible for an episode of continuing healthcare (CHC), funded by the National Health Service.

GOVERNANCE RESPONSIBILITY:

The North Kirklees Clinical Commissioning Group’s (CCG) has overall governance responsibilities for the fair and effective implementation of this policy. They are responsible for the commissioning of care packages for patients eligible for an episode of continuing healthcare (CHC). The CCG is responsible for commissioning and procuring services for all individuals who qualify for NHS continuing healthcare and for the healthcare element of a joint care package.

UNDERSTANDING IMPACT:

This policy is likely to have a positive impact on patients and carers in North Kirklees and North Kirklees. Any future procurement of provision may result in a service from a non-NHS provider and the potential impact of this will need to be factored in terms of impact on all equality groups, and fully considered; as articulated within the recommendations in this EQIA.

AGE:

A key feature of the policy is that both health and social care needs are personalised to the needs of individual, through the principles of co-production. Therefore, it is imperative that when jointly conducting an assessment, ‘the right to plan and choice’ are clearly communicated to the person or representative contributing to the assessment.

Generally, the approach articulated in this policy should have a positive impact on all age groups.

DISABILITY; LONG-TERM CONDITION: Eligible service users with a disability/injury requiring continuing health care are likely to either have an on-going long term physical or sensory impairment or a long term condition that requires regular monitoring or treatment, or they are likely to have had an incident or event which makes them temporarily physically impaired or requiring on-going support. The policy is specifically designed to support such groups and assessments will take place periodically at three month and annual intervals. However, it is critical to minimise impact, that information is conveyed between the carer providing the service, to their superiors in the 9 month period when there is not an assessment, so that any new emerging needs can be managed robustly and catered for.
This policy is judged to have a Positive Impact on disability groups, due to its personalised nature and commitment to co-produce care plans.

**GENDER REASSIGNMENT [TRANSGENDERED PEOPLE]**: Critical to the assessment tool, in terms of care planning, is to have clarity of the personal characteristics of the individual/s requiring support, not to make assumptions, and being clear about the specific needs of the individual ‘in terms of planning and choice’.

**RACE**: North Kirklees is rich in diversity and are fused with multi-culturalism. The assessment process will need to make allowances and provide support for those members of the community who do not have spoken English fluently. Furthermore, it is critical that cultural and religious needs are not lost in translation, and are considered as significant need factors in the assessed care package provision (if requested). Therefore, provision will need to be in place in the likelihood that a service user requires a (qualified) interpreter. However, it is probably likely that there may-be a family member or representative that may provide this service, as consented by the service user.

This policy is judged to have a Positive Impact on race groups.

**RELIGION OR BELIEF**: Generally communities with strong religious or beliefs, regard those elements as critical to their way of life and choices they make. Therefore, it is critical that religion and belief is regarded as a core part of the assessment process, including how this relates to specific gender needs. See recommendation’s specific to Race:

This aspect of the policy is judged likely to have a Positive Impact on religion and belief groups.

**GENDER [Male or Female]**: This aspect of the policy is judged likely to have a Positive Impact on Gender, given the commitment to co-produce the care package, and tailor to specific needs.

**SEXUAL ORIENTATION [Lesbian, Gay or Bisexual]**: This aspect of the policy is judged likely to have a Positive Impact on the LGBT group, given the commitment to co-produce the care package, and tailor to specific needs.

**PREGNANCY & MATERNITY**: This aspect of the policy is judged likely to have a Positive Impact on people who are pregnant or undertaking maternity, given the commitment to co-produce the care package, and tailor to specific needs.

**MARRIAGE & CIVIL PARTNERSHIP**: This aspect of the policy is judged likely to have a Positive Impact on people who are either married, in a civil relationship, given the commitment to co-produce the care package, and tailor to specific needs.

**CONSULTATION AND INVOLVEMENT**: The policy makes clear that ‘governance’ members have been involved and been consulted in its development. Crucial to the future success of this policy is that there needs to be a commitment to involve and consult the people that this policy is intended for, not only will this ensure efficiency, assurance; in fact it will increase satisfaction rates
and improve experience. The consultation and involvement of those people who are either affected/impacted:

Directly (the cared for)
Indirectly (the representatives)
By association (frontline, contractors)
And by seeking the views of those equality groups that may not be eligible, or have not been picked up due to lack of awareness of their rights or the initiative in general, or blockage in referral process.

It is a significant plus that the policy makes provision for service users, or their representatives to help co-produce specific personalised care packages; subject to them being clinically safe. This is a crucial feature and must be communicated and promoted as a choice to all perspective (eligible) service users. This in itself should pick up a range of equality and diversity issues, including those associated to religion and belief issues.

Given the recommendation? To develop an intelligence hub, that specifically collates care provision data in one place, this will also lend itself to inviting ‘the involvement’ of those specific people in further re-iteration of this policy framework

**STAFF AWARENESS AND TRAINING:**

This policy aims to provide a holistic ‘personalised’ package of support to those people that are eligible for continuing health care provision. Critical to the effective implementation of the policy and equality considerations will be the skills and awareness of staff at three tiers, those that are:

1. Undertaking the assessments;
2. Those people who make the decisions;
3. And those people who will hear appeals, following a decision of refusal.

**COMMUNICATIONS**

A further success determinant of this policy is how, and the format used to communicate its provisions to people, so that they are able to access opportunity, and claim their respective entitlement. Equally important is for staff conducting the assessments to be aware of both the information and communication needs of people, and have access to supplementary provision that will support them and the service user to meet mutually beneficial objectives, need and satisfaction.

**PERFORMANCE MANAGEMENT AND MONITORING**

Critical to the success of this policy, and future business planning, is the ability to monitor trends, identify specific themes and to be able to respond to them; particularly if there are gaps in the provider framework relative to specific equality needs. On-going monitoring will not only identify risks; in fact it should result in greater satisfaction rates, based on people’s experiences. More importantly, a robust performance framework has the capacity to ensure that resources are spent efficiently and in accordance with needs, and decisions are made based on intelligence. The ability to identify unique trends will
also support the CCG to potentially procure specific services and challenge providers to evolve their service provision model as part of on-going contract management negotiations and management.

To ensure the CCG embed equality considerations within the policy framework, so that outcomes reflect equalities, the CCG will actively implement the following recommendations:

RECOMMENDATION 1: To develop/or utilise an intelligence system to capture data to enable specific information to be monitored, reported and analysed relative to equality characteristic groups and their respective needs.

RECOMMENDATION 2: To ensure that within the assessment tool, specific equality characteristic questions are incorporated within.

RECOMMENDATION 3: To ensure the procurement of services with providers encompasses all aspects of equality and diversity.

RECOMMENDATION 4: When commissioning future service provision, equality characteristic groups should be involved in the design of the specification.

RECOMMENDATION 5: Ensure that individuals are listened to properly and treated with dignity, and this is specifically asked in on-going consultation and involvement exercises.

RECOMMENDATION 6: Advice and information needs to be provided in appropriate formats and languages and the service users understanding should be checked. It should be made clear (subject to eligibility) the care package that is being offered, explaining the role of the provider, capacity, location and hours of the services with examples of what to expect, relative to respective needs.

RECOMMENDATION 7: To fully consider cultural and religious needs as critical factors of on-going health care, particularly for those communities who request it; and that staff are trained with awareness to support this.

RECOMMENDATION 8: Identify any gaps in terms of equality characteristic groups, and make provision to seek the view of that group, in the context of: if they ever required continuing care, what are the key considerations that they would wish the assessment process to identify, specifically related to their characteristic?
Quality Impact Assessment Tool:

<table>
<thead>
<tr>
<th>Title of scheme: Continuing Healthcare Commissioning Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Kirklees CCG Lead Manager: Helen Severns/Toni Smith</td>
</tr>
<tr>
<td>GP Clinical Lead Signature: N/A Date: 08/07/2015</td>
</tr>
<tr>
<td>Head of Quality and Patient Safety (Chief Nurse) Signature: Deborah Turner Date: 08/07/2015</td>
</tr>
</tbody>
</table>

Brief description of scheme:

This assessment is being completed as part of a review and amendment of the Continuing Healthcare Commissioning Policy which was developed to support quality and effective commissioning. This document provides clarity and transparency to the public and stakeholders on the methodology and the decision making process pertaining to the commissioning of continuing healthcare within North Kirklees.
### A: Simple Quality Impact Assessment

<table>
<thead>
<tr>
<th>What is the impact on ....</th>
<th>Positive (Impact on strategy)</th>
<th>Negative (Impacts on equality)</th>
<th>Likelihood</th>
<th>Overall Score</th>
<th>Litigation strategy &amp; monitoring arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty to Commission Quality Services</td>
<td>Positive impact on strategic partnership between NKCCG, NKCCG and Local Authority.</td>
<td></td>
<td></td>
<td></td>
<td>Equality impact assessment is in place to monitor this policy.</td>
</tr>
<tr>
<td>Continuous improvement, high quality workplaces, strategic partnerships and shared risk, equality, clinical quality indicators, CCG’s strategic objectives and quality premium, duty to protect children, young people and vulnerable adults</td>
<td>Positive impact on CCG’s strategic objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Individual choice and preference is described, taking into account individuals right to family life.</td>
<td></td>
<td></td>
<td></td>
<td>Personal health budget service users will be monitored using service user and carers questionnaires.</td>
</tr>
<tr>
<td>Patient choice, access, reported patient experience, compassionate and personal care</td>
<td>Personalisation is central to the policy and this includes the offer of personalised health budgets.</td>
<td></td>
<td></td>
<td></td>
<td>Quarterly reporting includes: feedback regarding service quality, monitoring of complaints and compliments and appeals.</td>
</tr>
<tr>
<td></td>
<td>Whilst individual choice is an essential element, the importance of value for money and effective use of resources will need to be considered.</td>
<td></td>
<td></td>
<td></td>
<td>As above</td>
</tr>
</tbody>
</table>
Other elements that will be considered are clinical need, individual safety and public safety, this may mean that patient choice is not commissioned.

<table>
<thead>
<tr>
<th>Clinical Effectiveness</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of evidence based practice, clinical leadership, variations in care, data quality, pathways and clinical engagement</td>
<td></td>
</tr>
</tbody>
</table>

The policy states that any commissioned service provider must be registered with The Care Quality Commission (CQC) under Part II of the Health & Social Care Act 2008.

The policy states that individual safety and public safety are key areas for consideration when commissioners are making decisions.

Safeguarding - Detailed service requirements have been included in the policy following input from NKCCG/NKCCG’s Designated Professional for Safeguarding of Adults.

The policy highlights the importance of commissioned care meeting individuals needs, this should include all their

| Prevention | prevention of long term conditions, health inequalities | 3 | 3 | 9 |
| **Productivity and Innovation**  
*Delivery of care in most clinically effective setting, elimination of inefficiency and waste, the environment, service innovation, accelerating adoption and diffusion of innovation and care pathway improvement* | holistic needs including prevention. |  |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The policy underpins the principles of commissioning value for money, needs led quality provision.</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Personalised health budgets will support innovative care provision.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This policy will support the clinical and commissioning decisions made by the continuing healthcare team.</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
| **Workforce**  
*Staffing levels, morale, workload, sustainability of service due to workforce changes* |  |  |  |
|  | This policy may increase workload of the continuing healthcare team due to the additional administration work required to manage and monitor. | 4 | 2 | 8 |
|  | There has been a full restructure of the team, and following a 'fresh eyes review' completed Jan – April 2015, further changes have been made to the staffing structure to ensure this meets local need and provides sustainability. |  |  |  |
| **Resource impact**  
*Estates, IT resource, sustainability of service providers, equipment availability* |  |  |  |
|  | The policy demonstrates that North Kirklees will only commission with preferred providers, which will enable providers to do effective business planning, whilst ensuring the CCG is commissioning value for money care. | 3 | 4 | 12 |
|  | As part of the review in CHC, the market is being developed to give greater choice to service users. This will ensure the CCG can maintain the access to the appropriate provision in a timely manner. This is essential due to the rising number |  |  |  |
The development of integrated commissioning processes will further support this work.

| Reputation | The policy may not be perceived well by some members of the public due to the many factors being considered other than patient choice when decisions are made regarding the care provision. |
| 4 | 3 | 12 | The equality impact assessment identifies the required work to ensure engagement with all stakeholders and the monitoring of the policy. |

2 Children’s Act, 2004; Safeguarding Vulnerable Groups Act, 2006; Working Together to Safeguard Children, 2010; Better Care, Better Value.
3 Better Care, Better Value.
<table>
<thead>
<tr>
<th>Name of Meeting</th>
<th>Governing Body</th>
<th>Meeting Date</th>
<th>10/08/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Report</td>
<td>Finance, Contracting and Recovery Report</td>
<td>Agenda Item No.</td>
<td>10 a</td>
</tr>
<tr>
<td>Report Author</td>
<td>Neil Smurthwaite / Lesley Stokey</td>
<td>Public / Private Item</td>
<td>Public</td>
</tr>
<tr>
<td>GB / Clinical Lead</td>
<td>Dr Nigel Taylor</td>
<td>Responsible Officer</td>
<td>Neil Smurthwaite</td>
</tr>
</tbody>
</table>

### Executive Summary

Please include a brief summary of the purpose of the report

Key messages at month 3:

1. The CCG is planning to deliver an in year deficit of £3.13m however there is a £2.4m risk to achieving this.

2. The CCG has a Quality Innovation Productivity and Prevention (QIPP) plan of £11.5m but has a gap in of £2.4m which has yet to be allocated. Work is ongoing on stretch targets, so far identified £1.5m of part year affect. Stretch is a priority at both Recovery Operation Group (ROGr) and Senior Management Team Recovery (SMTR) to bridge gap and mitigate risks.

### Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Finance and Performance Committee</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of meeting</td>
<td></td>
<td>27/07/2017</td>
</tr>
</tbody>
</table>

### Recommendation(s)

It is recommended that the Governing Body NOTES the contents of this report.

### Decision

<table>
<thead>
<tr>
<th>Assurance</th>
<th>Discussion</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒</td>
<td></td>
<td>34T</td>
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</tbody>
</table>

### Implications

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>None identified</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Public / Patient / Other Engagement</th>
<th>None identified</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resources / Finance implications (including Staffing/Workforce considerations)</th>
<th>None identified</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Strategic Objectives (which of the CCG objectives does this relate to)</th>
<th>Risk (include link to risks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Achieving the agreed strategic direction for Calderdale</td>
<td>Risk 829 – delivery of planned surplus</td>
</tr>
<tr>
<td>▪ Improving quality</td>
<td>Risk 826 – appropriate QIPP schemes in place</td>
</tr>
<tr>
<td>▪ Improving value</td>
<td>Risk 849 – acute contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal / CCG Constitution Implications</th>
<th>Conflicts of Interest (include detail of any identified/potential conflicts)</th>
<th>Any interests will be managed in line with the CCG’s policy for managing Conflicts of Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>None identified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.0  **Key Messages**

1.1  This report updates the financial position as at Month 3. Key messages are as follows:

- The CCG is forecasting to meet its planned drawdown of £3.1m. However there is a significant risk to achieving this.

- In month 3 the CCG is showing an unmitigated risk of £2.4m to reflect the level of uncertainty in relation to Quality Innovation Productivity and Prevention (QIPP) delivery and potential contract overtrades. This is covered more in the risk section below.

- The CCG has fully utilised the £1.6m contingency budget to help mitigate financial risks.

- The CCG has a QIPP requirement of £11.5m.

- The CCG is in the process of allocating QIPP to individual budget lines. There is currently a balance of £2.4m which needs to be allocated to budgets. As a result of the allocation of QIPP to budget lines, the Calderdale and Huddersfield NHS Foundation Trust (CHFT) budget is currently £2.7m less than the contract value.

**STP Financial Strategy**

The West Yorkshire & Harrogate Sustainability and Transformation Partnership (WY&H STP) has commissioned the York Health Economics Consortium to undertake some modelling work to assist with the development of the STP Financial Strategy. This work is looking at place based (e.g. Calderdale) health and social care systems. However to ensure economies of scale and recognising that the acute hospital serves both Calderdale and Greater Huddersfield CCG, this work will be undertaken jointly with the two CCGs, both Councils and the acute hospital. This work is very time limited and outputs are due to be shared at a Healthy Future’s workshop in October.

**NHS England QIPP Support Phase 2**

The CCG has been successful in its bid to be provided with some additional support from the North of England Commissioning Support (NECS) in the delivery of its QIPP savings. There are two significant pieces of work which are being undertaken jointly between the CCG, Greater Huddersfield CCG and CHFT. The first area will look at how as a health system we can work more efficiently and effectively to deliver the financial challenges facing our health systems. This work is being led by two senior NHS officials, looking at leadership and ways of working, bringing in experience from other health systems that are experiences similar challenges. The second piece of work will focus on some dedicated programme management resource to assist with our work on outpatients. Outpatients have been highlighted as an area for savings by both the CCGs and Trust.

**System Risk Reserve**

Appendix E is a letter from Paul Baumann Director of Finance for NHS England (NHSE) which covers two key points. The first, which has the most impact, is the decision for NHSE to retain the impact of Category M generic drug price changes centrally. This will increase pressure on our prescribing costs as, whilst we hadn’t planned for the impact as part of our QIPP, it would have significantly helped our stretch QIPP targets. The Governing Body may have been aware that there was significant reduction in the price of Pregabalin which the CCG will not benefit from this year. The second relates to the requirement for acute trusts to retain part of their Commissioning for Quality and Innovation (CQUIN) payments to contribute to the national risk reserve. The CCG has
received some guidance from NHSE and is working with the trust to report an accurate position on this and we will report back through the finance and contracting reports compliance with this requirement.

2.0 Financial Performance 2017/18 – Delivery of Planned Surplus

2.1 Table 1 below shows a summary of the financial performance of the CCGs programme budgets. Key messages are shown below:

- **Acute** - CHFT at the end of month 2 is showing an under-trade of £0.03m. The main variances are Elective under-trade £0.1m, Non-Elective over-trade £0.1m, Outpatients under-trade £0.2m, Other NHS Non-Tariff activity over-trading by £0.2m which is attributed to the QIPP adjustment £0.6m and is offset by under-trades in Rehab Bed days £0.087m. The month 2 data contains some estimates due to the implementation of Electronic Patient Records (EPR). All other contracts are on track with the exception of Leeds Teaching Hospitals Trust which is under trading by £0.2m we have kept the forecast at the contract level until we get further into the year.

- **Prescribing** - The CCG has not received any prescribing forecast information relating to 2017/18 from the Prescription Prescribing Authority (PPA). It is expected that we will receive the first report soon. The CCG has received information for the first 2 months of the year which is lower than plan giving a year to date variance of £0.5m. This has not been reflected in the forecast. Once more information is available the forecast will be updated.

- **Contingency** - The contingency budget has been released to offset against acute budget pressures.

3.0 Delivery of QIPP

3.1 The CCG has a QIPP target of £11.5m is made up as follows:-

Table 1

<table>
<thead>
<tr>
<th>QIPP</th>
<th>Target £'m</th>
<th>Risk Adjustment %</th>
<th>Projected Delivery £'m</th>
<th>Risk £'m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute - CHFT</td>
<td>6.70</td>
<td>60%</td>
<td>4.00</td>
<td>2.70</td>
</tr>
<tr>
<td>Prescribing</td>
<td>0.75</td>
<td>100%</td>
<td>0.75</td>
<td>0.00</td>
</tr>
<tr>
<td>CHC</td>
<td>0.50</td>
<td>100%</td>
<td>0.50</td>
<td>0.00</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.00</td>
<td>0%</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Other</td>
<td>0.00</td>
<td>0%</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Gap</td>
<td>3.55</td>
<td>32%</td>
<td>1.15</td>
<td>2.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11.50</strong></td>
<td></td>
<td><strong>6.40</strong></td>
<td><strong>5.10</strong></td>
</tr>
</tbody>
</table>

4.0 QIPP Stretch

4.1 Due to the projected risk on delivery of £5.1m on QIPP schemes the CCG is seeking new schemes to fill the gap and has been reviewing all available data to help identify short and longer term opportunities.
4.2 **Health Optimisation** - The CCG has not yet considered applying any criteria for treatment in relation to smoking or obesity but is looking to understand how as a system, with the help of public health colleagues how health optimisation can be maximised for full health and social care benefit. The CCG has a clear vision for HO which is not predicated on purely smoking or obesity but a more holistic integrated prevention/proactive care of its population but all contact points for the patient not just on referral for treatment.

4.3 **Procedures of limited clinical value and clinical thresholds** - The CCG has a number of Procedures of Limited Clinical Value (PLCV) and thresholds as part of its QIPP agenda and is now looking for stretch on existing schemes, developing pathways and also identifying additional PLCV to target. Particular PLCV we are concentrating on are: carpal tunnel syndrome, Dupuytrens contracture, arthroscopies, arthroplasties (hip/knee) with a clinical summit due in late July to agree next steps.

4.4 **Menu Of Opportunities (MOO)** - The CCG has been working on Musculoskeletal (MSK) and Frailty chapters of the MOO. A new MSK service went live on 1 June. The management of people with frailty and respiratory conditions have been part of our QIPP and community model for past 18 months. Services are being reviewed to ensure they deliver the quality outcomes and savings expected. A number of areas in the MOO have been previously recognised by the CCG and a programme of reviews is underway to ensure delivery of the required impact.

4.5 **Accessing national QIPP support** - The QIPP support to date has helped identify some significant areas to target particularly around Continuing Health Care (CHC) and also around MSK pathways.

4.6 **Continuing Health Care (CHC)** - The CCG is in the process of reviewing the recommendations of the CHC pack and is confident that we will be able to make some inroads in relation to the CHC opportunities identified. The CCG is planning to implement a new policy (over next 2 months) to establish some thresholds for homecare. The CCG is also reviewing its fast track procedures as part of a local End of Life multiparty summit in July. The CCG is attending an NHSE led CHC QIPP workshop on 13th July.

4.7 **MSK pathways** - The CCG has used the information thus provided to have discussions with both our local trust and private providers and thus far the discussions have been very positive. The CCG is looking at other best practice pathways to see if we can identify further improvements by following the same methodology with our data. A new MSK service started from 1 June and is recognised in our QIPP plans.

4.8 **Right Care** - The CCG has focused on 3 of the largest opportunities in Rightcare;

- **MSK** - New community MSK service and single point of access in place from June.
- **Neurological** – The CCG is in the process of redesigning the pain management pathway which should deliver significant savings.
- **Respiratory** – The CCG has invested in a community respiratory service which should reduce avoidable admissions to hospital. A review in underway to ensure delivering results expected.

4.9 **Better Care Fund (BCF) and Integration Better Care Fund Policy Framework 2017-19 (iBCF)** - Following the recent publication of guidance in relation to BCF and iBCF, the CCG is working with the council to ensure that BCF schemes are targeted to deliver reductions in admissions and reduction in length of stay. Recent data published this week shows that the
Calderdale path is in the bottom quartile for length of stay for people aged over 65yrs of age. A significant proportion of the BCF funds social services not NHS commissioned out of hospital services. Challenge is ongoing with the council around the overall effectiveness of BCF expenditure and its impact on the overall system. The Council were formally notified that the CCG was unable to continue to fund social services expenditure if performance continues as such a low level. Delays in Transfer of Care (DTOC) are a continual area we work on with both CHFT and Calderdale Council. Relationships with the Council remain good but are under additional pressure as a result of this stance by the CCG.

5.0 Running Costs

5.1 The CCG has a running cost budget of £4.7m for 2017/18 this is currently forecasting to fully utilise this budget.

5.2 Appendix A shows a summary of running cost financial forecasts.

6.0 Delegated Primary Medical Services

6.1 A summary of the month 3 delegated budgets and expenditure is shown in Appendix B the main variances.

7.0 Public Sector Payment Policy

7.1 The CCG is now above the 95% target, having previously reported being under the target, we are now achieving 95.84% for Non NHS invoices. Performance for NHS invoices is above target with 99.99%. Actions taken to increase performance ensure new suppliers are set up on the system before invoices are received. Invoices that are in query are dealt with in a timely manner.

7.2 Appendix C shows the public sector payment policy in more detail.

8.0 Risks/Opportunities

8.1 There are a number of financial risks and opportunities that the Governing Body needs to be aware of:

8.2 The table in Appendix D shows a summary of our known risks and mitigations. The CCG has assessed a 50% probability of reducing the £5.1m QIPP risk and has included an acute overtrade risk of £2.7m which is consistent with the acute trusts plan, giving a total delivery risk of £5.25m. Mitigations include the CCG contingency, any forecast underspends and some savings identified from budget realignment. The CCG therefore is showing a net risk of £2.4m against delivery of its financial plan.

- Risk – Increased and sustained level of activity at CHFT.
- Risk – That Acute and other budget areas overspend beyond the contingency.
- Risk – That additional QIPP plans are not developed to fund the gap.
- Risk – Better Care Fund not able to reduce length of stay for people aged over 65.
- Risk – That QIPP plans under-deliver in-year and fail to deliver the overall cash releasing QIPP requirement.
• **Opportunity** – Contract savings from contract challenges which are not currently included in the forecast position.

### 9.0 Recovery Report Key Messages

**9.1** The CCG has signed-off a Recovery Plan for 2017/18-2018/19. The Recovery Plan calls for the organisation to review its investments. Senior Management Team Recovery (SMTR) has been sighted on the broad range of contracts and investment being reviewed as part of this process. SMTR have agreed a process and template for decision making in order to progress this work, which was shared with Finance and Performance committee in April.

**9.2** The CCG has a QIPP target of £11.5m. The finance team have allocated £9.1m of QIPP to individual budget lines. This leaves a balance of £2.4m QIPP gap, which needs to be allocated against specific budgets. SMTR will be aligning further QIPP schemes against specific budget lines in order to reduce the amount of unallocated QIPP in the financial plan.

**9.3** Of the target of £11.5m, we are currently projecting delivery of £6.4m and a risk of £5.1m. This does not include any stretch to existing schemes or the potential positive impact of additional prescribing schemes discussed in July Recovery Operational Group (ROGr). This level of risk is consistent with our finance reports to NHSE for June.

**9.4** £6.7m of QIPP has been aligned against the CHFT budget line. This means that the overall budget is £2.7m less than the contract value. The CCG will therefore have to undertrade on this contract by at least £2.7m in order to deliver QIPP.

**9.5** The CCG did not receive any data for April and May 2017/18, due to Secondary Uses Service (SUS) data being unavailable. The CCG have however received confirmation that absence of data has been resolved due to Data Services for Commissioners Regional Offices (DSCRO) completing a bespoke download of data and THIS being able to process the data. On this basis, a first view of the contract position will be available to share with SMTR in August.

**9.6** The Month 2 position with CHFT is showing an undertrade of approx. £31k. However, this is based on an estimate due to Electronic Patient Record issues.

**9.7** All CCG programme leads were tasked to review and adjust QIPP projects to reflect part year effect (PYE), showing a revised projected QIPP saving of £3.2m.

**9.8** To reduce the £2.4m unallocated QIPP, the programme leads were tasked to a) review existing schemes and stretch targets, b) look at those areas included in the pipeline list and c) review any new opportunities. On this basis, the following areas are being discussed at ROGr and shared with SMTR:

- Stretch existing elective care thresholds (including Arthroscopy, Arthroplasty, Dupuytrens Contracture, and Carpel Tunnel Syndrome)
- Areas identified from the Procedures of Clinical Value (PoCV) – Deloitte report
- Stretch on Continuing Health Care
- Confirmation of plans to meet the QIPP target set for Medicines Management/Prescribing
- Re-charge for people out of area accessing the walk-in centre
- Refresh deep dives into opportunities from the Right Care Packs and additional Right Care intelligence emerging in year.

**9.9** Capacity was raised as an issue against moving at pace on thresholds and the ability to assess all areas identified in the PoCV. However, we will ensure that capacity is aimed at areas of largest opportunity.
9.10 The scale of the additional savings shows a potential for further £1.5m, if the full stretch is applied. SMTR assessed and discussed the opportunities along with the stretch proposed.

9.11 These proposals have been shared with the Finance and Performance Committee for agreement in relation to appropriate levels of stretch/opportunity and continued to be monitored.

9.12 ROGr was assured by programme leads that all the Right Care packs have been assessed with Key Lines of Enquiry (KLOEs) completed, identifying where opportunities can be achieved; for example, spinal injections and carpel tunnel procedures were identified from the MSK packs. Concerns were raised, as flaws were identified during interrogation of the packs and a caveat included that we don’t take the savings/opportunities at face value as they could be offset by low activity/cost elsewhere in the system. It was also noted that the data collated in the packs were old and when assessed against local data the same level of opportunity wasn’t presented.

9.13 A review against all KLOEs will be undertaken by the programme leads and any potential opportunities will be captured and discussed at the August ROGr meeting.

9.14 The approach below has been agreed in relation to contract reviews bundled under the following headings:

- **In-hospital** - reviews to identify costs of services already captured in tariff. Recommendations to include; (a) evidence if service is to continue (within existing tariff) or (b) cease.

- **Community** - recommendations based on evidence provided. (a) If no evidence, service either ceases or (b) revised Key Performance Indicators (KPIs) are produced to monitor service over a set period of time to understand the benefits of the service and impact if service is ceased. Clear instructions for contracting to be included in recommendations so that actions can be taken.

- **Whole service pathway reviews/BCF** for example end of life care & respiratory - undertake reviews with clear recommendations for future investment in integrated whole system/pathway changes including new or revised KPIs.

10.0 Contracting Report Key Messages

10.1 Calderdale & Huddersfield NHS Foundation Trust (CHFT)

The contract position as at the end of Month 2 is showing an undertrade of £31k and includes an estimate due to the implementation of Electronic Patient Record (EPR) which has caused a number of technical issues that are currently being corrected.

10.2 Other Acute and Independent Sector providers

The contract position at the main acute providers shows under-trades at Mid Yorkshire Hospitals (£51k), East Lancashire Hospitals (£20k), Bradford Teaching Hospitals (£12k) and Leeds Teaching Hospital (£152k); however, there is a slight over-trade at Pennine Acute Hospitals (£16k). In respect of the independent sector providers there are currently under-trades at Spire Elland (£89k) and The Yorkshire Clinic (£1k); with BMI Huddersfield showing an overtrade of £13k.
10.3  South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

There were 939 occupied acute-inpatient bed days in Month 2 which was 39.3% higher than expected and an increase compared to previous months. The increase reflects seasonal demand patterns. At the end of the month there were 30 patients receiving inpatient care, 12 of whom had a length of stay greater than six months. Four patients were receiving inpatient care out of area.

10.4  Yorkshire Ambulance Service (YAS) 999 Ambulance

The Ambulance Response Programme (ARP2.2) Month 2 performance is measured against a target of 75%. 76.4% of Category 1 calls were reached within 8 minutes. YAS overall performance was 72.9%.

10.5  NHS 111 and West Yorkshire Urgent Care (WYUC)

The Contract position at Month 2 based on 2017/18 values shows the validated activity allocated to Calderdale was 4,386 calls compared with 4,319 in Month 2 of 2016/17.

10.6  Quest for Quality in Care Homes

The main aim of this service is to provide and support the delivery of standardised, high quality, evidence based, and safe patient centred care for residents residing in the care homes involved in this project across Calderdale. There is also a QIPP benefit associated to this project as it is expected to reduce emergency admissions from care homes.

A&E attendances for Month 2 were 140% higher than Month 2 in 2016. Hospital admissions were 31% higher in Month 2 this year than in Month 2 2016.

10.7  Posture and Mobility (Wheelchairs) Service (Opcare)

The service continues to experience pressure in respect of increased demand and complexity. A number of KPIs are currently breaching the target in Calderdale. All waiting time indicators have seen a drop in performance. There has been a slight drop in performance in all but one of the delivery time indicators. The number of pathways completed in 18 weeks in Month 2 increased to 77.3% for Calderdale (70% in Month 1).

10.8  Walk-in Centre (WIC)

Walk-in Services are currently commissioned from Locala and based at Todmorden and Horne Street at weekends and Bank Holidays. Month 2 activity indicates that 838 patients were seen at the Walk-in Centres which is a decrease on Month 1 of 2017 (1017). Activity continues to be above contracted levels. The percentage of patients seen within 1 Hour of Arrival in Month 2 was 93.08% against the 95% target. All patients were seen within 4 hours. Due to lack of capacity, YAS closed the Park WIC profile on the 111 DoS on two occasions in May.

11.0  Recommendation

11.1  It is recommended that the Governing Body NOTES the content of this report.
12.0 Appendices

Appendix A shows a summary of running cost allocation and expenditure forecast

Appendix B shows a summary of delegated primary medical services expenditure and forecast

Appendix C shows a summary of the CCG public sector payment policy target performance

Appendix D shows a summary of the CCG resource allocations and adjustments to allocations

Appendix E letter from Paul Baumann Director of Finance for NHS England
## Calderdale CCG Running Cost Allocation Summary at 30th June 2017

### Appendix B

<table>
<thead>
<tr>
<th>Centre Code</th>
<th>Annual</th>
<th>In Month (£)</th>
<th>Year To Date (£)</th>
<th>Forecast (£)</th>
<th>Mth 2 Forecast</th>
<th>Outturn Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>ADMINISTRATION &amp; BUSINESS SUPPORT</td>
<td>0</td>
<td>0</td>
<td>(1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BUSINESS INFORMATICS</td>
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<td>44</td>
<td>37</td>
<td>101</td>
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<td>(21)</td>
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<tr>
<td>CEO/ BOARD OFFICE</td>
<td>742</td>
<td>62</td>
<td>67</td>
<td>185</td>
<td>204</td>
<td>19</td>
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<tr>
<td>CLINICAL SUPPORT</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>COMMISSIONING</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>COMMUNICATIONS &amp; PR</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>CONTRACT MANAGEMENT</td>
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<td>29</td>
<td>27</td>
<td>86</td>
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<td>(5)</td>
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<td>CORPORATE COSTS &amp; SERVICES</td>
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<td>17</td>
<td>31</td>
<td>52</td>
<td>51</td>
<td>(1)</td>
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<td>CORPORATE GOVERNANCE</td>
<td>317</td>
<td>51</td>
<td>64</td>
<td>79</td>
<td>75</td>
<td>(4)</td>
</tr>
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<td>EQUALITY AND DIVERSITY</td>
<td>34</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>0</td>
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<tr>
<td>ESTATES AND FACILITIES</td>
<td>500</td>
<td>45</td>
<td>42</td>
<td>125</td>
<td>125</td>
<td>0</td>
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<tr>
<td>FINANCE</td>
<td>515</td>
<td>43</td>
<td>38</td>
<td>129</td>
<td>100</td>
<td>(28)</td>
</tr>
<tr>
<td>GENERAL RESERVE - ADMIN</td>
<td>58</td>
<td>5</td>
<td>(103)</td>
<td>14</td>
<td>14</td>
<td>(14)</td>
</tr>
<tr>
<td>HUMAN RESOURCES</td>
<td>90</td>
<td>7</td>
<td>6</td>
<td>22</td>
<td>17</td>
<td>(6)</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>187</td>
<td>14</td>
<td>39</td>
<td>47</td>
<td>78</td>
<td>32</td>
</tr>
<tr>
<td>MEDICINES MANAGEMENT</td>
<td>510</td>
<td>58</td>
<td>49</td>
<td>127</td>
<td>48</td>
<td>(79)</td>
</tr>
<tr>
<td>MEDICINES MANAGEMENT</td>
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<td>0</td>
<td>(25)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PATIENT AND PUBLIC INVOLVEMENT</td>
<td>125</td>
<td>11</td>
<td>8</td>
<td>31</td>
<td>23</td>
<td>(8)</td>
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<tr>
<td>QUALITY ASSURANCE</td>
<td>234</td>
<td>19</td>
<td>22</td>
<td>59</td>
<td>68</td>
<td>9</td>
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<tr>
<td>RISK MANAGEMENT</td>
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<td>(8)</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>STRATEGY &amp; DEVELOPMENT</td>
<td>358</td>
<td>77</td>
<td>78</td>
<td>100</td>
<td>103</td>
<td>4</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4,666</strong></td>
<td><strong>392</strong></td>
<td><strong>288</strong></td>
<td><strong>1,166</strong></td>
<td><strong>1,063</strong></td>
<td><strong>4,666</strong></td>
</tr>
</tbody>
</table>

### Explanation of main variances between month 2 and 3 forecast position

- **Business Informatics**: A member of staff moved to correct cost centre
- **Commissioning**: Budget transferred to Strategy and Development
- **Communication & PR**: Budget transferred to Strategy and Development
- **Corporate Governance**: Budget moved from Risk Management, Communications and Datix budget
- **Strategy & Development**: As per above
## PRIMARY CARE SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget</th>
<th>Year To Date £</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>GMS</td>
<td>14,851</td>
<td>3,713</td>
<td>14,851</td>
</tr>
<tr>
<td>PMS</td>
<td>3,198</td>
<td>799</td>
<td>3,198</td>
</tr>
<tr>
<td>APMS</td>
<td>1,653</td>
<td>413</td>
<td>1,653</td>
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<tr>
<td>QOF</td>
<td>2,810</td>
<td>703</td>
<td>2,810</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>1,083</td>
<td>271</td>
<td>980</td>
</tr>
<tr>
<td>Premises - Reimbursed Costs</td>
<td>2,876</td>
<td>719</td>
<td>2,876</td>
</tr>
<tr>
<td>Premises - Other</td>
<td>561</td>
<td>140</td>
<td>561</td>
</tr>
<tr>
<td>Prof Fees Prescribing &amp; Dispensing</td>
<td>171</td>
<td>43</td>
<td>171</td>
</tr>
<tr>
<td>Collaborative Payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other GP Services (inc. PCO)</td>
<td>647</td>
<td>162</td>
<td>503</td>
</tr>
<tr>
<td>Other Non GP Services</td>
<td>143</td>
<td>36</td>
<td>143</td>
</tr>
<tr>
<td>Pensions</td>
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<tr>
<td>Reserves (91811030)</td>
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<td>112</td>
<td>696</td>
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<td>Reserves - Contingency (91811060)</td>
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<td>36</td>
<td>143</td>
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<tr>
<td>QIPP (91811040)</td>
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<tr>
<td><strong>Total Primary Care Medical</strong></td>
<td><strong>28,585</strong></td>
<td><strong>7,147</strong></td>
<td><strong>28,585</strong></td>
</tr>
</tbody>
</table>

### Reserves £'000
- General Reserves 306
- 0.5% NR Reserves 143
- **Total 449**
## Appendix C

**Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 30th June 2017**

<table>
<thead>
<tr>
<th>Supplier</th>
<th>In Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numbrer of invoices paid within target</td>
<td>% within target</td>
</tr>
<tr>
<td>NHS</td>
<td>230</td>
<td>100.00 %</td>
</tr>
<tr>
<td>Non NHS</td>
<td>750</td>
<td>99.73 %</td>
</tr>
<tr>
<td>Total</td>
<td>980</td>
<td>99.80 %</td>
</tr>
</tbody>
</table>

% within target
## Calderdale CCG Resource Allocation Summary at 30th June 2017

<table>
<thead>
<tr>
<th>Resource Allocation</th>
<th>Programme Costs (£'000)</th>
<th>Running costs (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed Allocation</td>
<td>(279,195)</td>
<td>(4,649)</td>
</tr>
<tr>
<td>Co Commissioning</td>
<td>(28,586)</td>
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<tr>
<td>17/18 Surplus</td>
<td>(5,783)</td>
<td>0</td>
</tr>
<tr>
<td>GPFV</td>
<td>(38)</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes Transformation Fund</td>
<td>(69)</td>
<td>0</td>
</tr>
<tr>
<td>GP Wi-Fi</td>
<td>(104)</td>
<td>0</td>
</tr>
<tr>
<td>Market Rents</td>
<td>(10)</td>
<td>(17)</td>
</tr>
<tr>
<td>Paramedic Rebanding</td>
<td>(81)</td>
<td>0</td>
</tr>
<tr>
<td>HSCN GP</td>
<td>(72)</td>
<td>0</td>
</tr>
<tr>
<td>CYPT</td>
<td>(20)</td>
<td>0</td>
</tr>
<tr>
<td>IAPT Adult</td>
<td>(188)</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>(314,146)</strong></td>
<td><strong>(4,666)</strong></td>
</tr>
</tbody>
</table>
To: CCG Accountable Officers
    CCG Chief Financial Officers

Cc: STP Leads
    CCG Audit Chairs
    NHS England Regional Directors and Finance Directors
    NHS England Directors of Commissioning
    Operations and Finance Directors

Gateway reference: 07036

26 July 2017

Re: System risk reserve and unplanned drug price reductions in 2017/18

I am writing to you about two related issues with regard to 2017/18 finances.

System Risk Reserve

Firstly, may I take this opportunity to thank you sincerely for the 100% professional discipline you demonstrated in the release of the 1% system risk reserve to the bottom line at the end of 2016/17. As you will have seen, this proved essential in securing financial balance across the health sector — reflected in an overall underspend on the Department’s core revenue measure (non-ringfenced RDEL) of £55m.

You will recall that we further developed this approach in the Planning Guidance for 2017/18 to feature a system risk reserve constructed from three elements:

- a reduced requirement of 0.5% non-recurrent investment reserves to be held uncommitted by commissioners (£360m);
- a contribution from reduced utilisation of commissioner drawdown funding (£200m); and
- for the first time, a risk reserve funded by providers from local CQUIN earnings (£270m).

CCGs’ plans confirm that the first of these elements is secure, and we have issued separate guidance asking for your help in relation to the third component, but higher than anticipated CCG drawdown requirements related to operating deficits have prevented the creation of the expected headroom in drawdown funding. The necessity of a system reserve at this level was clearly demonstrated in 2016/17, and it is already evident that risks in both the commissioner and provider sectors are no less challenging this year. It is therefore vital that we take urgent steps to restore the reserve to the specified level in the most expedient manner.

High quality care for all, now and for future generations
Community Pharmacy Medicine Margin

As you are probably aware, from time to time the Department of Health consults with the Pharmaceutical Services Negotiating Committee on adjustments to the fees and/or margin that we as commissioners pay to pharmacies to reflect any under/overdelivery of the agreed amounts in prior years. Recent discussions on the 2015/16 medicine margin survey and the provisional results of the 2016/17 medicine margin survey have resulted in a reduction in Category M (generic drugs) prices in the NHS Drug Tariff estimated to amount to £15m per month, to take effect from 1 August 2017. The revised Category M prices reflecting these changes have now been published. These changes could not have been anticipated in operational plans and therefore result in a windfall benefit of ca £120m which would normally accrue to CCGs through reduced medicines expenditure.

Immediate Action to Secure the Financial Position

Given the circumstances of the year, as described above, we intend to create a central fund to form part of the overall system risk reserve by asking the Business Services Authority, who administer medicines reimbursement on behalf of NHS commissioners, to retain the benefit that would otherwise flow to CCGs. Technical guidance explaining how this will be done will be issued shortly, but the impact will be that CCGs’ finances will not benefit immediately from the £15m per month reduction. For the avoidance of doubt, the reduction in Category M drug prices implemented in June 2016 is not being reversed.

Returning the Benefit to CCGs

It is our intention that the ca £120m benefit of the price reduction initially retained centrally should be available for investment by CCGs either in 2017/18 or in subsequent years. This will take one of the following forms:

- In the event that it becomes apparent that the system reserve will not be required to be deployed to offset the risk of a system deficit in 2017/18, we will return monies from the ca £120m central fund to CCGs during the year to be available for investment or carry forward for future drawdown (subject to business rules). The amount returned to each CCG will be aligned with the benefit they would have received in the absence of the measures described above.

- If the risk reserve does need to be deployed, as was the case in 2016/17, the appropriate share of funding – again based on benefit otherwise accrued – will be released at the end of the year to all CCGs that have delivered or improved on their control total and successfully released the 0.5% non-recurrent reserve as further underspend to the bottom line. Under these circumstances they will be required to add the funding from the central reserve to their financial performance for the year in final accounts as additional underspend. For CCGs already meeting business rules, the additional surplus will be available for drawdown in future years; for others,
the funding from the central reserve will accelerate their progress towards financial recovery.

We will discuss with STP leaders and with NHS Clinical Commissioners whether managed flexibility in the application of this process by agreement within STPs would be helpful, and in the case of conditional return for reserve purposes how best to deploy the amounts relating to any CCGs who do not meet the relevant conditions.

**Conclusion**

We fully recognise the challenges CCGs are facing in 2017/18, and we want to assure you that the decision to utilise a windfall benefit which would have made these challenges easier to manage has not been taken lightly. However, ignoring the need to secure the required commissioner contribution to the system risk reserve in a year when this may well again prove vital is simply not an option.

An alternative approach considered by the NHSE Board was to take the required funding from planned investment in areas such as transformation and General Practice. The immediate and longer-term consequences of that approach would not have been consistent with our commitment to the goals of the Five Year Forward View, so this option was rejected.

The approach we have developed to constructing the reserve should leave CCGs no worse off in the short term and with an opportunity to secure the benefit of the pharmacy price reduction in due course for in-year or future investment. It will also explicitly recognise those CCGs which succeed in delivering their financial goals.

On behalf of the NHSE Board I would like to thank you in advance for your cooperation with this measure and for maintaining the strong financial disciplines which made such a vital contribution to our success as a sector in 2016/17.

Yours sincerely

[Signature]

Paul Baumann
Chief Financial Officer
NHS England
This report provides the Governing Body with an update on progress against recent quality and patient safety activities including:

- Serious Incidents Quarter 1 2017-18
- Annual Complaints Report 2016 -17
- Children Looked After Annual Report 2016 -17
- Research Annual Report 2016-17
- Learning Disabilities Mortality Review Programme (LeDeR) update

The report also includes a copy of the Quality Dashboard for July 2017, providing quality and safety information for our main providers.

It is recommended that the Governing Body RECEIVES this report and NOTES the actions being taken within the dashboard.

This paper is applicable to vulnerable and protected patient groups. Concerns and risks relating to quality and safety are highlighted within the paper and reflected in the risk register.

None identified

Commission for Quality and Innovation (CQUINs) has a financial value attached to outturn contract value.

Achieving the agreed strategic direction for Calderdale
- Improving quality

984 Risk relating to HCAI
- 863 Risk relating to quality of services at CHFT

None identified

None identified
1.1 The quality dashboard provides a high level overview of the main acute, mental health and learning disabilities, ambulance and community care providers through the monitoring of key quality and safety measures. These include national quality requirements, the outcomes of Care Quality Commission (CQC) inspections, clinical and patient related outcome measures and patient and staff experience measures.

1.2 The quality dashboard seeks to provide the Governing Body with a view of individual areas of concern, shown on the exception report, and an overall summary of the provider. The aim is for the Quality Committee to agree the level of surveillance for each provider organisation and also for any individual areas that are performing below expected levels.

1.3 For any providers that have areas of concern showing enhanced surveillance, a plan will have been agreed, with timescales, and can be monitored for improvement by the Quality Committee. Individual areas that are on enhanced surveillance does not mean that the organisation as a whole is on enhanced surveillance, but that further scrutiny is being given to the areas causing concern.

1.4 Further information on these can be found in the Quality Dashboard, Appendix 1.

2.0 Serious Incidents Quarter 1 2017-18

2.1 The Quality Committee received and noted the following information at its meeting on 27 July 2017 in relation to serious incidents reported by Provider:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Q1 2017-18</th>
<th>YTD</th>
<th>2016-17 total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust (CHFT)</td>
<td>10</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)</td>
<td>14</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>NHS 111 (YAS)</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>

2.2 A summary on performance against the framework was considered by the Quality Committee and the following key messages noted:

2.2.1 Performance against the timescales within the National Framework:

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) remain challenged in their ability to submit reports within the 60 day timescale, with only 4 of the 20 reports received in quarter 1 being submitted within the deadline. Ten reports required two or more extensions and one report received had required 6 extensions. The CCG has declined two extension requests due to insufficient rationale being provided for the requests.

- Serious Incident investigation and learning has been identified as an area for improvement by the CCG Quality Team and Director of Nursing at CHFT, who has requested support from the CCG to try to make the required improvements. The CCG quality leads are meeting with CHFT representatives on 22nd August 2017 to discuss this further.

- South West Yorkshire Partnership Foundation Trust (SWYPFT) continues to show improvement in the submission of reports within the 60 day timeframe. Although only one report was submitted within timeframe, the serious incident team has noted a reduction in the number of reports with multiple extension requests. Internal SWYPFT investigation
monitoring processes continue to have a positive impact on the completion of reports in a timely manner.

2.2.2 Summary of work ongoing as a result of learning from investigations:

- Slips, trips and falls formed the majority of serious incidents at CHFT. The top three themes identified in the serious incident report action plans at CHFT were: care delivery issues, education and training, and assessment related.

- The majority of serious incidents at SWYPFT related to apparent, actual or self-inflicted harm. The main themes identified in the serious incident action plans were communication and assessment related.

- SWYPFT have been heavily involved within investigations where CHFT have been the lead. Opportunities for sharing good practice have been identified by SWYPFT in relation to reporting templates and SWYPFT have offered to share their template in order to encourage future collaborative working.

- The West Yorkshire learning forum was held on 20\textsuperscript{th} April 2017. Topics discussed included:
  - Feedback from Serious Incident Teams
  - Themes and trends from diagnostic serious incidents
  - Sharing learning from Serious Incidents (Yorkshire Ambulance Service)
  - Human Factors training (Mid Yorkshire Hospital Trust)

3.0 Annual Complaints Report 2016-17

3.1 At its meeting on 29\textsuperscript{th} June 2017, the Quality Committee received the Complaints Annual Report for 2016-17.

3.2 Between 1 April 2016 and 31 March 2017, Calderdale CCG directly received 132 enquiries, concerns and complaints. These are presented by provider in the table below.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q.1</td>
</tr>
<tr>
<td>Calderdale CCG Continuing Healthcare (CHC)</td>
<td>5</td>
</tr>
<tr>
<td>Calderdale CCG Commissioning</td>
<td>3</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust (CHFT)</td>
<td>15</td>
</tr>
<tr>
<td>South West Yorkshire Partnership Foundation Trust (SWYPFT)</td>
<td>8</td>
</tr>
<tr>
<td>NHS 111</td>
<td>2</td>
</tr>
<tr>
<td>Multiple organisations</td>
<td>1</td>
</tr>
<tr>
<td>NHS England</td>
<td>7</td>
</tr>
<tr>
<td>Yorkshire Ambulance Service (YAS)</td>
<td>1</td>
</tr>
<tr>
<td>Other enquiries</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

3.3 The levels of complaints received are as follows;
- Level 1 - Simple queries (mainly PALS queries)
- Level 2 - Low (simple non complex issues)
- Level 3 - Moderate (complex, several issues relating to a short period of care) requiring a written response and investigation by provider
- Level 4 - High (complex, multiple issues relating to a longer period of care, often involving more than one organisation or individual) requiring a written response and investigation by provider

3.3.1 Between 1 April 2016 and 31 March 2017 the numbers received for each level are presented in the table below.

<table>
<thead>
<tr>
<th>Number of Complaints received and responded to by level</th>
<th>Number of Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.1</td>
<td>Q.2</td>
</tr>
<tr>
<td>Level 1</td>
<td>18</td>
</tr>
<tr>
<td>Level 2</td>
<td>16</td>
</tr>
<tr>
<td>Level 3</td>
<td>9</td>
</tr>
<tr>
<td>Level 4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
</tr>
</tbody>
</table>

3.4 Action Taken and Learning from Complaints

3.4.1 The most important part of complaints handling is ensuring that lessons are learned wherever possible. The majority of responses to the client include a section which highlights the learning from their complaint and how this will be shared, or used in the future.

3.4.2 Lessons learned from the findings of complaint investigations are reported to the Quality Committee on an anonymised basis.

3.4.3 Some of the action taken and lessons learned in the complaint cases handled by the CCG during the year are outlined below.

- Nursing staff employed by Calderdale and Huddersfield NHS Foundation Trust (CHFT) have been reminded about the difficulties faced by patients with visual impairment.
- Calderdale CCG’s Continuing Healthcare Retrospective Team are looking at ways of ensuring that families making requests for review are informed of the procedure and processes that will be followed.
- South West Yorkshire Partnership Foundation Trust (SWYPFT) responded to concerns raised by the users of the art therapy service by putting on hold their decision to withdraw the service. This lead to an independent review of the service.
- CHFT have promoted the use of call bells in their hospitals.

3.5 Next Steps:

- Work will continue to ensure that lessons which are identified from complaints are implemented to improve services commissioned by the CCG.
- Complaint Managers from the Calderdale, Kirklees and Wakefield footprint have arranged a quarterly meeting to share good practice ensure a consistent approach across the patch and learn from experiences of complaint handling. Updates from this group will be reported to the Quality Committee as part of the quarterly Complaints Report.

4.0 Children Looked After Annual Report 2016-17
4.1 The Quality Committee received the Children’s Looked After Annual Report which, this year, covers a two year reporting period from 1st April 2015 to 31st March 2017 in relation to performance reporting. Members were assured of the health performance in relation to national health indicators with the position in 2015-16 and 2016-17, benchmarking strongly against the national average.

4.2 Of the cohort of children who had a health assessment during the 2016/17 reporting period 2.2% were identified as having a substance misuse problem during the year; 97% were up to date in their immunisations; 95% had their teeth checked by a dentist within the last 12 months and 95% had their annual health assessment within the last 12 months.

4.5 In addition, there are currently 130 looked after children placed by external local authorities residing in private fostering and residential care settings within Calderdale. The Committee was assured that those children placed in Calderdale by external local authorities, who are notified to the Calderdale and Huddersfield NHS Foundation Trust (CHFT) health team are registered with a GP and any requests by the originating area to undertake statutory health assessments are met.

4.6 The Care Quality Commission (CQC) Children Looked After and Safeguarding (CLAS) inspection took place between the 25th to 29th April 2016. The final report was published on 25th October 2016. The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

4.7 Outcome of the inspection noted a number of positive findings, including the good practice of having a designated doctor completing health assessments alongside a range of health professionals. The assessments were child centred and children are offered a choice of location for the assessment. The Children Looked After team have developed quality assurance arrangements to improve the standard of assessments.

4.8 Some of the recommendations following the inspection included; improving the timeliness of reviewing health assessments, reviewing and resolving access and visibility of the information on the children’s electronic health records, ensuring that care leavers receive timely health passports and information to help them prepare for adulthood and developing procedures that promote the effective engagement of GPs in health assessments. All recommendations have been incorporated into an action plan; progress against the action plan will be monitored by the CCG.

4.9 The Committee received the Children Looked After team’s priorities for 2017/18:

- Completion of all outstanding actions on the CQC CLAS inspection action plan; providing evidence to commissioners and the CQC of compliance.
- Service Specification renewal – Agreeing funding and service model to deliver against Key Performance Indicators.
- Incorporating the requirements made in the Children & Social Work Act 2017 into practice.

5.0 Research Annual Report 2016 -17

5.1 The annual research report 2016/17 was presented to the Quality Committee on 29 June 2017. The report provided a description of the work that the West Yorkshire Research and Development (WY R&D) team has undertaken in delivering a comprehensive research service on behalf of and in collaboration with Calderdale CCG to ensure that the CCG met its statutory
obligations with regards to research and can demonstrate its willingness to participate and use research evidence in its commissioning activities. Highlights included:

- National metrics for research were being exceeded and the team had been involved with the development of over 35 research studies totally over £20 million; were part of successfully securing over £12 million of funding.
- 65% of GP practices had recruited patients to research studies, compared with 19% the previous year; and 223 patients had taken part in research projects over the past year, compared to 82 the year before.
- This year has seen a ‘Cancer and Palliative Care Research workshop’ bringing together academics, clinicians and commissioners. The event presented an opportunity for discussion about cancer and palliative care research evidence to support local commissioning and to contribute to the West Yorkshire Sustainability and Transformation Plan.
- The Campaign to Reduce Opioid Prescribing (CROP) study had hoped to achieve a plateau in the prescribing of opioids for non-cancer patients, but had actually achieved a reduction of 3% across the study area, with a reduction of 1% in Calderdale.

### 6.0 Learning Disabilities Mortality Review Programme (LeDeR) update

6.1 The Quality and Safety Committee received an update in April 2017 in relation to this national programme. The programme has been established as a result of one of the key recommendations of the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD). It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England (NHSE) and supports local reviews of deaths of people with learning disabilities aged 4 to 74 across England.

6.2 The programme went live from 1 November 2016 and was co-ordinated by NHSE. The CCG received notification of the intention to delegate responsibility for co-ordinating this process to Local CCGs from 1 April 2017. Formal handover for Kirklees and Calderdale took place on 12 June 2017 with three Local Area Contacts being identified from the quality and safeguarding teams.

6.3 All cases have been reviewed prior to handover to ensure that any had been reported through appropriate existing routes. The numbers of reviews awaiting allocation reflect the challenge of recruiting reviewers. Letters have been sent to partners and providers requesting reviewers however there is a pressing issue with local available resource to complete these reviews. This risk has been identified and placed on the risk register.

6.4 NHSE has shared learning from Yorkshire and Humber from the cases reviewed so far. The common themes emerging are the appropriate management of physical health problems such as sepsis, aspirate pneumonia; the management of constipation and blockages; and the management of epilepsy. Consideration needs to be given locally as to how we share these messages in general practice and residential units in order for improvements to take place.

6.5 It has been agreed that the Transforming Care Partnership Meeting will receive regular reports in relation to progress of the programme and consider the findings in their transformation work. The Safeguarding Boards will be sighted on issues relating to safeguarding and it is suggested that the CCG Quality Committees receive a quarterly update to ensure specific clinical learning opportunities are identified and shared appropriately.
7.0 Quality & Safety Implications

7.1 The Governing Body should note that this report contains information relating to vulnerable patient groups and also contains information in relation to the quality of health services commissioned by the CCG.

8.0 Resources / Finance Implications

8.1 Commission for Quality and Innovation (CQUINs) have a financial value attached to outturn contract value.

9.0 Recommendations

9.1 It is recommended that the Governing Body RECEIVES this report and NOTES the actions being taken within the dashboard.

10.0 Appendices

10.1 Appendix 1 – Quality Dashboard
### CCCG Exception Report

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Month/Quarter</th>
<th>Month data from</th>
<th>YTD 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Diff</td>
<td>39</td>
<td>1</td>
<td>May 17</td>
<td>7</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>1</td>
<td>May 17</td>
<td>1</td>
</tr>
<tr>
<td>MSSA</td>
<td>No target</td>
<td>3</td>
<td>May 17</td>
<td>5</td>
</tr>
<tr>
<td>E-Coli</td>
<td>144</td>
<td>14</td>
<td>May 17</td>
<td>23</td>
</tr>
<tr>
<td>Complaints</td>
<td>No target</td>
<td>35</td>
<td>Quarter 4</td>
<td>132</td>
</tr>
</tbody>
</table>

**C-Diff** - 1 case reported in May giving a YTD figure of 7 against an annual target of 39

**E-coli** – this is a new measure with a required reduction of 10% in 2017/18 which means no more than 144 cases should be reported across Calderdale, 14 cases reported in May.

**Complaints** - Quarter 4: 9 level 3 and 0 level 4 complaints were received regarding services commissioned/provided by the CCG.

15 – level 1 enquiries, e.g. concerns about a GP surgery requiring signposting/advice

9 – level 2 concerns, e.g. providing advice on how to access hospital medical records.

Total complaints have increased from 22 in Q3 to 33 in Q4.
This page provides a summary in relation to the Quality and Safety of services provided at Calderdale and Huddersfield NHS Foundation Trust for the period up to May 2017.

The Electronic Patient Record (EPR) went live in May which required significant clinical, administrative and managerial input. Whilst the deployment was generally good and staff worked extremely hard, it still presented a number of challenges within the Trust, particularly in relation to productivity, capacity and the recording and reporting of data. This can be seen particularly in the friends and family test results on the dashboard. The Trust continues to work through these issues.

The appointment team had a particularly challenging month, some data migration issues impacted on bookings and in parallel the staff had to learn the new system. This combination led to patients waiting longer to get through to make an appointment. Work is ongoing to improve the process through dedicated support and a temporary move away from partial booking.

Flow was challenging in May as a result of continued high demand and the implementation of the new system, ward round productivity and discharge medication management was a particular challenge. Staff were supported to ensure patients were safe and cared for, staff’s own wellbeing was monitored and support given where required.

Following discussion at July’s Quality Committee further assurance is being sought from CHFT in relation to the quality of discharge information and mitigating actions to ensure timely appointments are made. The quality team are arranging visits to see the impact of EPR on practice.

Mixed Sex Accommodation Breach; two further breaches have been reported in ICU, one involving 3 patients on 12th June and one involving 2 patients on 20th June (the breach reported in February was also in ICU) both incidents were in relation to patients deemed fit to be transferred to the ward but no beds were available in the appropriate specialty. A Root Cause Analysis has been completed and will be shared with the CCG, the action plan is expected to include all three breaches with further assurance on how this will be prevented in the future.

Time to theatre for patient with a fractured neck of femur has worsened significantly to 55.88% in May 2017, following three consecutive good months, this was due to a number of spikes in trauma activity and additional challenges with the introduction of EPR. The meeting to discuss performance is arranged for 20th July 2017. Work is ongoing within the trauma team to agree guidelines to standardise practice, improve efficiency of the Trauma list utilisation (sending for patients early, avoiding delays between cases). The accurate capture of admission time on EPR was an issue but has now been resolved.

The stroke annual report for 2016-17 was presented at the Clinical Quality Board in June, information presented included attendance at multidisciplinary team meetings, training and education and stroke pathways. The report was generally positive and the position continues to improve. Comparative data submitted for the Sentinel Stroke National Audit Programme (SSNAP) 2015/16 and 2016/17 shows all areas have improved or stayed about the same with the exception of applicable patients screened and seen by a diettian. The Trust is also an outlier for the proportion of patients being artificially fed, work has begun to explore this further but access to dietetics remains an issue due to lack of resources, work is ongoing as part of a wider action plan to reduce the proportion of people being artificially fed.
<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period Target</th>
<th>YTD 2017-18</th>
<th>Month / Period / Year data from</th>
<th>Trend information</th>
<th>Corresponding month 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Previous Month/Period</td>
<td>2016-17</td>
<td>2017-18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA &amp; Exp.</td>
<td>ENSA</td>
<td>Monthly</td>
<td>0</td>
<td>5</td>
<td>May-17</td>
<td>↑    ↓    ↓    ↓</td>
<td>0    0    0    0    5</td>
</tr>
<tr>
<td></td>
<td>% Complaints closed within target timeframe</td>
<td>Monthly</td>
<td>100%</td>
<td>52.5%</td>
<td>May-17</td>
<td>↑    ↓    ↓    ↓</td>
<td>32.0% 37.0% 30.0% 68.0% 80.0% 80.0% 92.0% 60.0% 80.0% 39.0% 41.0% 54.0% 53.0% 52.0% 62.0%</td>
</tr>
<tr>
<td></td>
<td>C Diff</td>
<td>Monthly</td>
<td>Max. 31 for the year</td>
<td>2</td>
<td>2</td>
<td>May-17</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td>E Coll</td>
<td>Monthly</td>
<td>a/a</td>
<td>2</td>
<td>2</td>
<td>May-17</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td>MRSA</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>May-17</td>
<td>←    ←    ←    ←</td>
<td>0    0    0    0    0    0</td>
</tr>
<tr>
<td></td>
<td>NISSA</td>
<td>Monthly</td>
<td>a/a</td>
<td>5</td>
<td>May-17</td>
<td>↓    ↓    ↓    ↓</td>
<td>1    1    0    1    1    0</td>
</tr>
<tr>
<td></td>
<td>Never Events</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>Jun-17</td>
<td>←    ←    ←    ←</td>
<td>0    0    0    0    0    0</td>
</tr>
<tr>
<td></td>
<td>Serious Incidents</td>
<td>Monthly</td>
<td>a/a</td>
<td>6</td>
<td>Jun-17</td>
<td>↑    ↑    ↑    ↑</td>
<td>3    7    3    6    7    9</td>
</tr>
<tr>
<td></td>
<td>Safety Thermometer - % at harm free care</td>
<td>Monthly</td>
<td>n/a</td>
<td>93.06%</td>
<td>-</td>
<td>May-17</td>
<td>↓    ↓    ↓    ↓</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - registered nurses/midwives % (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>88.82%</td>
<td>-</td>
<td>May-17</td>
<td>↑    ↓    ↓    ↓</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - care staff % (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>105.91%</td>
<td>-</td>
<td>May-17</td>
<td>↓    ←    ←    ←</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - registered nurses/midwives % (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>95.96%</td>
<td>-</td>
<td>May-17</td>
<td>↑    ↑    ↑    ↑</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - care staff % (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>115.04%</td>
<td>-</td>
<td>May-17</td>
<td>↓    ↓    ↓    ↓</td>
</tr>
<tr>
<td></td>
<td>NPSA Safety Alerts - CAS alerts completed within 24 hours</td>
<td>Monthly</td>
<td>n/a</td>
<td>96.9%</td>
<td>-</td>
<td>-</td>
<td>↓    ↓    ↓    ↓</td>
</tr>
<tr>
<td></td>
<td>Percentage Non-elective AbD F Patients with admission to Procedure of c 36 hours</td>
<td>Monthly</td>
<td>63%</td>
<td>35.00%</td>
<td>May-17</td>
<td>↓    ↓    ↓    ↓</td>
<td>97.30% 97.40% 75.83% 52.30% 71.74% 95.03% 98.19% 90.12% 93.20% 93.30% 93.30% 93.30% 93.30%</td>
</tr>
<tr>
<td></td>
<td>VTE Risk Assessment</td>
<td>Monthly</td>
<td>65%</td>
<td>65.32%</td>
<td>Apr-17</td>
<td>↑    ↓    ↓    ↓</td>
<td>95.01% 95.14% 95.25% 95.14% 95.10% 95.14% 95.07% 95.20% 95.02% 95.03% 95.07% 95.08% 95.32% 95.32%</td>
</tr>
</tbody>
</table>

Arrow key:
- ↑ movement towards target
- ↓ movement away from target
- ↔ no change at/above target
- ↔ no change below target
- ↔ no change no target set
Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – July 2017

**NPSA NRLS 41.19**
- Incidents reported per 1000 bed days (April - Sept 16)
- 6 monthly – next update Sept 17

**SHMI 105**
- 1 year rolling data
  - Jan – Dec 16
  - Monthly – updated July 17

**HSMR 100.85**
- 1 year rolling data
  - April 16 – March 17
  - Monthly – updated July 17

**NPSA**

**SHMI**

**HSMR**

**CQUINS 92.5%**
- Quarter 4 2016-17

**CQC Rating**
- Inspection rating August 2016 – requires improvement

**Staff Survey**
- quality of work & patient care able to deliver
- 4.01/5 – better than average
  - Annually – updated March 17

**Staff Survey**
- recommend as a place work or receive treatment
- 3.72/5 – worse than average
  - Annually – updated March 17

**CQC Inpatient Survey – respect & dignity**
- 9.1 – about the same as other trusts.
  - Annually – updated August 16

**CQC Inpatient Survey - involved in care decisions**
- 7.7 – about the same as other trusts.
  - Annually – updated August 16
Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – July 2017

Friends and Family Test

**CHFT - Place to work**

<table>
<thead>
<tr>
<th>% would recommend</th>
<th>% would not recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHFT - Place to receive care**

<table>
<thead>
<tr>
<th>% would recommend</th>
<th>% would not recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHFT - % of patients that would recommend**

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>Inpatient</th>
<th>Maternity C1</th>
<th>Maternity C2</th>
<th>Maternity C3</th>
<th>Maternity C4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHFT - % of patients that would not recommend**

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>Inpatient</th>
<th>Maternity C1</th>
<th>Maternity C2</th>
<th>Maternity C3</th>
<th>Maternity C4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient-led Assessment of the Care Environment (PLACE) 2016**

| Cleanliness | 99.36% |
| Food & Hydration | 90.95% |
| Privacy, Dignity & Wellbeing | 89.61% |
| Condition, Appearance & Maintenance | 95.29% |
| Dementia | 80.01% |
| Disability | 85.46% |

Annually – updated September 2016

**CHFT Safety Thermometer**

- New Harms (total)
- All New Pressure Ulcers
- Catheter and New UTIs
- New VTEs
- Falls with Harm
The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

<table>
<thead>
<tr>
<th>Area under performance</th>
<th>Why off plan</th>
<th>Proposed actions</th>
<th>When expected back on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Events</td>
<td>Further never event reported in November in relation to a retained swab in General Surgery</td>
<td>The retained swab report received from CHFT</td>
<td>The final report has been reviewed and closed, however further assurance has been sought around repetition of training and dissemination of the policy to ensure this does not happen again.</td>
</tr>
<tr>
<td>Fractured Neck of Femur (NoF)</td>
<td>% of patients with fractured neck of femur getting to theatre within 36 hours has declined in month.</td>
<td>Work on the action to make improvements on the performance around NoF time to theatre are ongoing.</td>
<td>A meeting has been arranged for 20th July to allow the quality team and GH GP to further understand the information submitted in the report received in March 2017 committees.</td>
</tr>
<tr>
<td>Staffing</td>
<td>Vacancy rate remains a concern for both consultants and qualified nurses</td>
<td>Nurse recruitment visit to the Philippines was successful and new consultants contracts continue to be offered.</td>
<td>A detailed staffing report will be discussed at the Clinical Quality Board in July, a verbal update will be given at the meeting.</td>
</tr>
</tbody>
</table>
## Proposed indicators to return to Routine Monitoring:

<table>
<thead>
<tr>
<th>Area returning to routine monitoring</th>
<th>Reason</th>
</tr>
</thead>
</table>

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – July 2017
This page provides a summary in relation to the maternity services provided at Calderdale and Huddersfield NHS Foundation Trust for the period up to May 2017. The Quality Team will continue to monitor the regional dashboard against CHFTs local data, the local data is more timely.

The May data is displayed in the dashboard, Maternity Safety Thermometer information is also included on the dashboard slide. Overall the dashboard shows a slight decline in performance for May.

Areas where indicators are red in month are: 3rd and 4th degree tears in normal births, and delays in theatre access for category 1 and 2 C Sections, and repair of tears. However it should be noted that the numbers remain small compared to the total number of births. It should also be noted that 1:1 care in labour continues to remain above target and the number of still births has reduced in month.

Public Health Outcomes for May - the Trust is within target for the number of women breast feeding at delivery, and the number of woman smoking at delivery.
This page provides a summary in relation to the Quality and Safety of services provided at South West Yorkshire Partnership NHS Foundation Trust for the period up to May & June 2017.

**Changes to quality metrics**
Work has been undertaken by the Trust to identify additional quality metrics to measure progress against the quality priorities for 2017-18. On the back of this three additional indicators have been added to our quality dashboard. These are:

- Information governance confidentiality breaches
- Spend on agency staff against agency cap
- % of service users on CPA given or offered a copy of their care plan

In addition to this the data flow for % of service users on CPA having formal review within 12 months has been re-established and data up to May has been added to the dashboard.

The average number of information governance breaches remains largely the same and higher than an acceptable standard. The Trust has undertaken a piece of work and has identified that the category of breach has shifted from incidents caused by incorrect address (some of which were caused by incorrect information on the spine) to incidents of confidential conversations being overheard and confidential papers being left in consulting rooms and patients’ rooms. Further work is progressing to identify themes to allow for mitigating actions to be undertaken.

The safety thermometer data for number of restraints in the last 72 hours is no longer available from the safety thermometer website. The quality team are looking into the reason for this.

**Workforce**
A safer staffing summit took place at the beginning of June involving a wide range of staff groups from across the organisation. Workforce remains a challenge and a priority for the Trust and sickness rates were identified as a priority area due to the sickness rate at the end of May being slightly higher than the same time last year. A sickness reduction task group has been established following the safer staffing summit. Reduction in sickness forms part of the Trust’s Operational Excellence Programme and is an objective for all General Managers and Clinical Leads. In addition to this the Trust has an improved offer for staff health and well-being developed as part of the health and well-being CQUIN.

**CQUINS**
The final quarter 4 position has now been confirmed. Overall the Trust has performed well against the 2016-17 CQUIN targets achieving 84.2% for the year. Considerable improvements have been seen in the quality of care plans and some improvements have been seen in mental health clustering. Work is on going to develop a process for continuing the care plan audit and mental health clustering now forms part of the quality requirements in the contract.
### South West Yorkshire Partnership Foundation Trust
#### Quality Dashboard – July 2017

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period Target</th>
<th>Month/Period</th>
<th>YTD 2017-18</th>
<th>Month/Period Year/Date from</th>
<th>Previous Month/Period</th>
<th>Corresponding month 31/06/17</th>
<th>Trend Information 2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>EMISA</td>
<td>Monthly</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>May-17</td>
<td>←</td>
<td>←</td>
<td>←</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>EQUIR - monitor the quality of care plans</td>
<td>Quarterly</td>
<td>Q1 - 87% of requests to care plan meeting required standards</td>
<td>Q4 2018-17</td>
<td>↓</td>
<td></td>
<td>←</td>
<td>←</td>
<td>←</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>% Complaints incl staff attitude as an issue</td>
<td>Quarterly</td>
<td>&lt;20%</td>
<td>14%</td>
<td>May-17</td>
<td>↑</td>
<td>↓</td>
<td>8%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>% of Service Users on CPA given a copy of their care plans</td>
<td>Monthly</td>
<td>50%</td>
<td>80%</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Never Events</td>
<td></td>
<td>Monthly</td>
<td>n/a</td>
<td>6</td>
<td>14</td>
<td>Jun-17</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>CAHMS - under 18’s admitted to adult wards</td>
<td>Quarterly</td>
<td>n/a</td>
<td>1</td>
<td>1</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - registered nurses/ideives (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>91.1%</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>90.5%</td>
<td>92.5%</td>
<td>93.5%</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - care staff (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>126.2%</td>
<td>May-17</td>
<td>↑</td>
<td>↑</td>
<td>121.0%</td>
<td>116.1%</td>
<td>116.8%</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - registered nurses/ideives (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>101.9%</td>
<td>May-17</td>
<td>↑</td>
<td>↓</td>
<td>106.0%</td>
<td>104.3%</td>
<td>104.4%</td>
</tr>
<tr>
<td></td>
<td>Staffing levels - average fill rate - care staff (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>125.3%</td>
<td>May-17</td>
<td>↓</td>
<td>↑</td>
<td>117.4%</td>
<td>110.6%</td>
<td>123.0%</td>
</tr>
<tr>
<td></td>
<td>NPSA Safety Alerts - CAS plans completed within deadline</td>
<td>Monthly</td>
<td>n/a</td>
<td>98.9%</td>
<td>May-17</td>
<td>↑</td>
<td>↑</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Information Governance Confidentially Breaches</td>
<td>Monthly</td>
<td>n/a</td>
<td>99.9%</td>
<td>Oct-17</td>
<td>↓</td>
<td>↓</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Agency Cap</td>
<td>Monthly</td>
<td>E5 7m 2017-18</td>
<td>62.6m</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>% Service users on CPA followed up within 7 days from inpatient care</td>
<td>Monthly</td>
<td>95%</td>
<td>98.30%</td>
<td>May-17</td>
<td>↑</td>
<td>↓</td>
<td>96.72%</td>
<td>97.0%</td>
<td>97.3%</td>
</tr>
<tr>
<td></td>
<td>% Service users on CPA having formal review within 12 months</td>
<td>Monthly</td>
<td>95%</td>
<td>91.93%</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>98.1%</td>
<td>98.2%</td>
<td>73.3%</td>
</tr>
<tr>
<td></td>
<td>Delayed Transfers of Care</td>
<td>Monthly</td>
<td>0%</td>
<td>1.7%</td>
<td>May-17</td>
<td>↓</td>
<td>↓</td>
<td>2.13%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

**Arrow key:**
- ↑ movement towards target
- ↓ movement away from target
- ↔ no change at/above target
- ↔ no change below target
- ↔ no change no target set
South West Yorkshire Partnership Foundation Trust
Quality Dashboard – July 2017

NPSA
NRLS
43.79

Incidents reported per 1000 bed days (April - Sept 16)
6 monthly – next update Sept 17

CQC
Rating

Inspection rating April 17 – Good

Staff Survey – quality of work & patient care able to deliver
3.99 – better than average
Annually – updated March 17

CQUINS
85.6%

Quarter 4 2016-17

Staff Survey – recommend as a place to work or receive treatment
3.73 – better than average
Annually – updated March 17

Patient-led Assessment of the Care Environment (PLACE) 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>98.53%</td>
</tr>
<tr>
<td>Food &amp; Hydration</td>
<td>89.79%</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Wellbeing</td>
<td>89.29%</td>
</tr>
<tr>
<td>Condition, Appearance &amp; Maintenance</td>
<td>94.18%</td>
</tr>
<tr>
<td>Dementia</td>
<td>81.36%</td>
</tr>
<tr>
<td>Disability</td>
<td>82.44%</td>
</tr>
</tbody>
</table>

Annually – updated September 2016
South West Yorkshire Partnership Foundation trust
Quality Dashboard – July 2017

Friends and Family Test

Mental Health Safety Thermometer

Proportion of patients that have self harmed in the last 72 hours

Proportion of patients that have been the victim of violence/aggression (last 72 hours)

Proportion of patients that feel safe at the point of survey

Proportion of patients that have had an omission of medication in the last 24 hours
**Enhanced Surveillance**

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

<table>
<thead>
<tr>
<th>Area under performance</th>
<th>Why off plan</th>
<th>Proposed actions</th>
<th>When expected back on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Safety Thermometer medicines omissions for in-patient areas</td>
<td>Higher than the national average. Older Adult wards are outliers with significant variation between C&amp;K and Wakefield (33.3% compared to 17.7%) The Quality Manager met with the Trust in Q3 15-16 and developed a ward level action plan. May 17 – action plan does not seem to be having a significant impact on results.</td>
<td>Quality Manager to discuss what support is available from the Trust Quality Improvement and Assurance Team to work with ward staff on Quality Improvement methodology. Discussed at May Quality Board and CCG Quality team have offered support to the trust to improve performance against target. June 17 – Quality Manger has requested attendance at the sign up to safety working group and is awaiting confirmation of dates.</td>
<td>Unknown at present. No real improvement made in 2 years (&lt;5%) and still considerably higher than national average (18.5% at end of Q4 compared to 12.5%).</td>
</tr>
</tbody>
</table>

**Routine Monitoring**

Proposed indicators to return to routine monitoring:

<table>
<thead>
<tr>
<th>Area returning to Routine Monitoring</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quality Related Performance

LCD
Local Care Directs performance against National Quality Requirements (NQR) remains below target in all three areas.

1Hr (Emergency) Face to Face – 49.3% (target of 95%).
2Hr (Urgent) Face to Face – 58.4% (target of 95%)
6Hr (Less Urgent) Facet to Face – 91.2% (target of 95%).
Most failures of over an hour were generally due to a lack of appointments available within the next hour, so the appointment has to be booked further in advance. Clinical assessment (following arrival at PCC) continues to be consistently above target. The service continues to Triage patients waiting to be seen and re-designate urgency if required. PURM Scheme – a downward trajectory in repeat prescription requests continues within WYUC.

111
Warm transfers and clinical call backs remain below target levels. Challenges remain within the service due to clinical staffing pressures and demand levels, with 32.7% of all cases being successfully warm transferred (or called back within 10mins). During May, 82.1% of patients were called back within 2 hours, and improvement on the previous month. The clinical queue is managed by a Clinical Team Leader in order to ensure that call backs are clinically prioritised. Clinical Briefings are now to be produced by YAS on a weekly basis (was daily). 91.5% of calls were answered in 60 seconds (target 95%).

Serious Incidents (SIs)
111 – No SIs reported within April
WYUC – No SIs reported within April

An overview of SIs is now discussed with the Joint Quality Board, with in depth reviews with the provider(s) every 2 months (alternate with 111 End to End Reviews)

Complaints
111 – 30 (Representing 0.021% complaints ratio against calls answered)
WYUC – 26 (Representing a 0.186% complaint ratio against Face to Face contacts made)

WYUC Review
WYUC Review has now published and has been discussed at CMB(111) on 1st June 2017. An action plan has been agreed with consequent Task and Finish Group commence. The first meeting of the Task and Finish group was on 29th June. The group will initially meet fortnightly and report into the CMB(111). Local quality issue relating to the Action Plan to be discussed at the West Yorkshire Sub-Regional Quality Group.
## NHS 111/Local Care Direct
### Quality Dashboard – July 2017

### NHS 111

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period Target</th>
<th>Month/Year</th>
<th>Period</th>
<th>FYTD</th>
<th>Month</th>
<th>Previous Month</th>
<th>J</th>
<th>J</th>
<th>S</th>
<th>O</th>
<th>N</th>
<th>D</th>
<th>J</th>
<th>F</th>
<th>M</th>
<th>A</th>
<th>M</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Serious Incidents - reported * = joint SI</td>
<td>Monthly</td>
<td>n/a</td>
<td>May-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>SI Team</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>% Warm Transfer or callback &lt;10 mins</td>
<td>Monthly</td>
<td>≥ 65%</td>
<td>May-17</td>
<td>↑</td>
<td>40.8%</td>
<td>35.6%</td>
<td>31.6%</td>
<td>35.3%</td>
<td>32.8%</td>
<td>26.8%</td>
<td>29.1%</td>
<td>26.8%</td>
<td>31.3%</td>
<td>31.3%</td>
<td>31.7%</td>
<td>Performance Dashboard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>% of clinical callbacks &lt;2 Hrs</td>
<td>Monthly</td>
<td>≥ 95%</td>
<td>May-17</td>
<td>↑</td>
<td>81.2%</td>
<td>79.4%</td>
<td></td>
<td>82.6%</td>
<td>82.8%</td>
<td>79.7%</td>
<td>74.5%</td>
<td>72.8%</td>
<td>71.0%</td>
<td>71.1%</td>
<td>77.3%</td>
<td>76.9%</td>
<td>82.1%</td>
<td>Performance Dashboard</td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Clinical call backs &gt;4 Hrs (Days above not actual calls)</td>
<td>Monthly</td>
<td>n/a</td>
<td>May-17</td>
<td>↓</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>14</td>
<td>14</td>
<td>20</td>
<td>24</td>
<td>26</td>
<td>18</td>
<td>14</td>
<td>22</td>
<td>16</td>
<td>11 Daily Sitrep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Complaints received</td>
<td>Monthly</td>
<td>n/a</td>
<td>May-17</td>
<td>↑</td>
<td>39</td>
<td>26</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>24</td>
<td>30</td>
<td>35</td>
<td>13</td>
<td>27</td>
<td>TBC</td>
<td>30</td>
<td>Contact Performance Report</td>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Abandoned calls</td>
<td>Monthly</td>
<td>≤ 5% (after 30 seconds)</td>
<td>May-17</td>
<td>↑</td>
<td>0.84%</td>
<td>1.40%</td>
<td>0.70%</td>
<td>1.40%</td>
<td>1.30%</td>
<td>1.50%</td>
<td>0.80%</td>
<td>0.80%</td>
<td>1.10%</td>
<td>0.90%</td>
<td>1.1%</td>
<td>Performance Dashboard</td>
<td></td>
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### Local Care Direct (West Yorkshire Urgent Care)

<table>
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<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period Target</th>
<th>Month/Year</th>
<th>Period</th>
<th>FYTD</th>
<th>Month</th>
<th>Previous Month</th>
<th>J</th>
<th>J</th>
<th>S</th>
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<th>F</th>
<th>M</th>
<th>A</th>
<th>M</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Serious Incidents - reported * = joint SI</td>
<td>Monthly</td>
<td>n/a</td>
<td>May-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>SI Team</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Complaints received</td>
<td>Monthly</td>
<td>n/a</td>
<td>May-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31</td>
<td>18</td>
<td>18</td>
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<td>19</td>
<td>27</td>
<td>25</td>
<td>28</td>
<td>19</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Emergency Face to face consultation (&lt;1 Hr)</td>
<td>Monthly</td>
<td>95%</td>
<td>May-17</td>
<td>↑</td>
<td>50.0%</td>
<td>52.0%</td>
<td>58.0%</td>
<td>49.3%</td>
<td>47.8%</td>
<td>48.6%</td>
<td>41.9%</td>
<td>48.5%</td>
<td>49.2%</td>
<td>47.0%</td>
<td>48.3%</td>
<td>Performance Dashboard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Urgent Face to Face consultations (&lt;2 Hrs)</td>
<td>Monthly</td>
<td>95%</td>
<td>May-17</td>
<td>↓</td>
<td>61.0%</td>
<td>63.0%</td>
<td>64.0%</td>
<td>64.9%</td>
<td>61.4%</td>
<td>62.8%</td>
<td>58.7%</td>
<td>62.5%</td>
<td>65.7%</td>
<td>58.4%</td>
<td>Performance Dashboard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Less Urgent Face to face consultations (&lt;6 Hrs)</td>
<td>Monthly</td>
<td>95%</td>
<td>May-17</td>
<td>↓</td>
<td>95.0%</td>
<td>95.2%</td>
<td>98.0%</td>
<td>94.0%</td>
<td>90.0%</td>
<td>94.1%</td>
<td>87.7%</td>
<td>92.3%</td>
<td>95.5%</td>
<td>51.5%</td>
<td>91.2%</td>
<td>Performance Dashboard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Clinical assessment started within 30 mins (Urgent Cases), within 60 mins (other patients) of arriving at the PCC</td>
<td>Monthly</td>
<td>95%</td>
<td>May-17</td>
<td>↑</td>
<td>97.9%</td>
<td>98.5%</td>
<td>98.4%</td>
<td>90.1%</td>
<td>99.1%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>88.2%</td>
<td>90.3%</td>
<td>99.7%</td>
<td>90.2%</td>
<td>90.3%</td>
<td>98.9%</td>
<td>Performance Dashboard</td>
<td></td>
</tr>
</tbody>
</table>
The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

### Enhanced Surveillance

<table>
<thead>
<tr>
<th>Area under performance</th>
<th>Why off plan</th>
<th>Proposed actions</th>
<th>When expected back on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face consultation for emergencies within 1 and 2 hours</td>
<td>Inability to source required numbers of clinicians</td>
<td>An external review has been commissioned and the findings reported. An action plan is in place to support improvements and inform future models of working</td>
<td>No date given but mitigating actions in place to manage risk</td>
</tr>
<tr>
<td>Warm transfer within 10 minutes</td>
<td>And percentage clinical call backs within 2 hour</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Routine Monitoring

- Proposed indicators to return to routine monitoring:

<table>
<thead>
<tr>
<th>Area returning to Routine Monitoring</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Meeting</td>
<td>Governing Body</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Title of Report</td>
<td>Performance Report</td>
</tr>
<tr>
<td>Report Author</td>
<td>Tim Shields, Performance Manager</td>
</tr>
<tr>
<td>GB / Clinical Lead</td>
<td>Dr N Taylor</td>
</tr>
</tbody>
</table>

### Executive Summary

**Please include a brief summary of the purpose of the report**

The report provides an update on the progress being made with achieving the standards required by the NHS Constitution.

The report highlights the latest Delayed Transfer of Care position.

### Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Finance and Performance Committee</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of meeting</td>
<td></td>
<td>27/07/2017</td>
</tr>
</tbody>
</table>

### Recommendation (s)

It is recommended that the Governing Body:

1) **NOTES** the content of the report.
2) **CONSIDERS** the updated DTOC position.

### Decision

- ☐ Assurance
- ✗ Discussion
- ☐ Other

### Implications

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>None Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public / Patient / Other Engagement</td>
<td>None Identified</td>
</tr>
<tr>
<td>Resources / Finance implications (including Staffing/Workforce considerations)</td>
<td>Financial implications associated with achievement of key deliverables will be captured in the report</td>
</tr>
<tr>
<td>Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)</td>
<td>Achieving the agreed strategic direction for Calderdale, Improving quality</td>
</tr>
<tr>
<td>Risk (include link to risks)</td>
<td>62 - Sustaining the 4 hour target in A&amp;E</td>
</tr>
<tr>
<td>Legal / Constitutional Implications</td>
<td>None Identified</td>
</tr>
<tr>
<td>Conflicts of Interest</td>
<td>None Identified</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 The purpose of the report is to provide an update on the latest position with the delivery of the standards associated with the NHS Constitution.

2. Key Messages

2.1 In month (month 2 – May) and year to date progress against the constitutional standards is as follows:

2.2 Good progress can be noted in the following areas:

- Referral to treatment times for patients on incomplete non-emergency pathways
- Cancer waiting times – two-week wait for first outpatient appointment for patients referred urgently with breast symptoms
- Cancer waiting times – 31 days from diagnosis to treatment
- Cancer waiting times – 62 days from referral to treatment

2.3 Ambulance Response Times

2.3.1 Following the clinical ambulance trials in the Ambulance Response Programme, NHS England has announced the implementation of new ambulance standards across the country.

2.3.2 The new system will:

- Change the dispatch model of the ambulance service, giving staff slightly more time to identify patients’ needs and allowing quicker identification of urgent conditions;
- Introduce new target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted;
- Change the rules around what “stops the clock”, so targets can only be met by doing the right thing for the patient.

2.3.3 The new standards are captured in the table below:
3.0 Key Areas of Variance

3.1 Sustaining the 4 hour target in Accident & Emergency (A&E)

3.1.2 A&E at Calderdale and Huddersfield NHS Foundation Trust (CHFT) underperformed against the constitutional standard, achieving 94.1% during 2016/17. However performance at the year end for March was 97.4%.

3.1.3 April continued to see the constitutional standard (95.1%) sustained. However performance levels during May deteriorated with CHFT reporting 85.1% for the month. The decline has been linked with the introduction of the Electronic Patient Record (EPR) at CHFT which has seen waiting times increase during this period of transition.

3.1.4 The position was discussed at the A&E Delivery Board where assurances were sought on the impact to patients. CHFT indicated their confidence that services had remained safe during this period of change.

3.2 Diagnostic Waiting Times

3.2.1 Patients who require a diagnostic test should wait less than 6 weeks from their referral.

3.2.2 Calderdale delivered strong performance against this target throughout 2016/17. However performance deteriorated during March and April, achieving 93.8% and 90.4% respectively. This was due to pressures associated with a peak in referrals for access to MRI and non-
obstetric ultrasound scans at CHFT. These pressures were the result of an increase in the complexity of the scans required (arthrograms) and a reduction in workforce capacity available to undertake the tests.

3.2.3 An improvements plan and supporting trajectory has been developed by CHFT and has been shared with NHS Improvement. Performance levels improved during May (98%) are expected to achieve the required standard by June 2017.

3.3 Cancer Waiting Times

3.3.1 Two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP.

3.3.2 Patients with an urgent referral from their GP should receive their first outpatient appointment within 2 weeks. The constitutional standard to achieve is 93%.

3.3.3 Of the 554 patients referred for an appointment in May 2017, 78 patients breached the constitutional standard, thus achieving 85.9% for the period.

3.3.4 Key issues for May included the reduction in workforce capacity due to the impact of IR35 on agency locums and booking centre pressures post-EPR deployment.

3.3.5 These breaches and their cause will be reviewed at the Cancer Locality Network.

4.0 Transfers of Care from Hospital

4.1 Improvement Plan

4.1.2 It is widely acknowledged across the system (including at the Calderdale Health and Wellbeing Board) that there is a need to reduce the harm to patients associated with delays in discharge. The impact of long stays in a hospital environment is well documented, particularly its contribution to de-conditioning and newly-termed 'pyjama paralysis'. Evidence indicates that 10 days in hospital can result in de-conditioning equivalent to 10 years. On discharge, patients can be further impacted through social isolation and loneliness.

4.1.3 The Better Care Fund Policy Framework published in May 2017 outlined the requirement to use the national 'High Impact Change Model for Managing Transfers of Care' and to develop local plans to tackle delayed transfer of care (DTOC) in liaison with A&E Delivery Boards. However, the Calderdale & Greater Huddersfield A&E Delivery Board had already used the High Impact Change Model in April 2016 to develop its Transfer of Care Plan.

4.1.4 The Plan is based on national evidence and describes eight high impact changes that need to be delivered.
Working with local systems, we have identified a number of high impact changes that can support local health and care systems reduce delayed transfers of care...

4.1.5 The model also provides a framework for self-assessment of system status and improvement. An initial self-assessment was shared with the Governing Body in August 2016. A second self-assessment took place in June 2017. The diagram below shows the progress of the system in each of the eight areas. The first assessment is indicated by yellow boxes, the re-assessment by the green boxes, and movement by arrows.

<table>
<thead>
<tr>
<th>Local Assessment of Current State</th>
<th>8 High Impact Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharge Planning</td>
</tr>
<tr>
<td>1 - not yet</td>
<td></td>
</tr>
<tr>
<td>2 - in place</td>
<td></td>
</tr>
<tr>
<td>3 - established</td>
<td></td>
</tr>
<tr>
<td>4 - mature</td>
<td></td>
</tr>
<tr>
<td>5 - exemplary</td>
<td></td>
</tr>
</tbody>
</table>
4.1.6 Following the re-assessment the action Plan has been refreshed in order to confirm the improvements needed over the next 12 months. This Plan is to be shared with the A&E Delivery Board at their August meeting.

4.2 Definitions

4.2.1 The House of Commons Briefing Paper (7415/2015) describes the national context and provides useful definitions to guide improvement:

- **NHSE Formally Reportable Delayed Transfers of Care** - “where a clinical decision has been made that the patient is ready for transfer, and a MDT decision has been made that a patient is ready for transfer, and the patient is safe to discharge/transfer but has not yet been discharged”. This data is split into 3 categories – i.e. delays attributable to; (a) social care, (b) health care and then (c) joint health and social care delay.

- **Delayed Transfer of Care (non-reportable)** – “where an in-patient in hospital (excluding children) is ready to go home or move to a less acute stage of care but is prevented from doing so”

4.2.2 This paper considers performance related to both elements defined above. Whilst the formally reportable data is important nationally, locally the focus is on improving the experience and outcomes for all patients whose discharge is delayed.

4.3 Reportable Delays

4.3.1 Chart 1 below illustrates the percentage of occupied bed days relating to reportable delays in the transfer of care. NHS England continues to challenge systems to achieve and sustain the national ambition of 3.5%. The system has continued to meet the 3.5% target throughout the last 12 months.

![Chart 1: Percentage of occupied bed days due to delayed transfers of care](chart1.png)

4.3.2 NHS England (NHSE) has recently published national metrics for Better Care Fund (BCF) Plans, and they remain the same as those that have featured in previous years, and include the Delayed Transfer of Care (DTOC) reportable position. The four metrics are:

- Non Elective admissions
- Admissions to care homes
- Effectiveness of enablement
- DTOC – reportable position

4.3.3 NHSE has also published benchmarking data to support the BCF planning process. Overall (all indicators) Calderdale ranks 112th out 151 areas nationally. Whilst our position for DTOC
is strong, other metrics indicate the challenges our system is facing. The BCF Board (as part of integrated commissioning arrangements) continues to identify challenges and mitigating actions, and reports directly into the Health and Wellbeing Board. It will also continue to ensure that allocation of Improved BCF (iBCF) funding is targeted to improve patient care, efficiency and performance.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National Rank (out of 151) – higher = better</th>
<th>Rank amongst peers (out of 16) – higher = better</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Emergency Admissions (65+) per 100,000 65+ population</td>
<td>77</td>
<td>9</td>
</tr>
<tr>
<td>2 90th percentile of length of stay for emergency admissions (65+)</td>
<td>137</td>
<td>16</td>
</tr>
<tr>
<td>3 Total Delayed Days per 100,000 18+ population</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>4 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td>
<td>116</td>
<td>13</td>
</tr>
<tr>
<td>5 Proportion of older people (65 and over) who are discharged from hospital who receive reablement/ rehabilitation services</td>
<td>135</td>
<td>15</td>
</tr>
<tr>
<td>6 Proportion of discharges (following emergency admissions) which occur at the weekend</td>
<td>130</td>
<td>13</td>
</tr>
</tbody>
</table>

4.4 Non-Reportable Delays in Transfer of Care

4.4.1 The A&E Delivery Board continues to utilise the Transfer of Care Dashboard to gain intelligence about the entirety. The Dashboard is based on real-time, patient-level data and is used by providers to ensure that they are working together in the best interests of patients to reduce delays and integrate ways of working. The Dashboard also provides aggregated data that enables the system to track progress. The data in this section of the report is taken from the Dashboard.

4.4.2 The Dashboard is fed primarily by two joint health and social care discharge teams co-located at both Huddersfield Royal Infirmary and Calderdale Royal Hospital. A multi-disciplinary team approach provides a weekly confirm and challenge process to ensure the all data on the system is accurate and up to date. At that point there is also joint agreement on the number of formally reportable delays.

4.4.3 Chart 2 below illustrates the monthly volume of all patients on discharge pathways out of CHFT (both sites) by resident Local Authority since December 2015. All patients have completed the acute phase of their treatment, and could be receiving the next stage of their care in another setting or at home. The volume of Calderdale residents remains consistently higher than the number of Kirklees (Greater Huddersfield) residents. A further breakdown of the reason for delays and mitigating actions are set out further in this report.
4.4.4 Charts 3 and 4 below illustrate the trends associated with the monthly volume of all delays, split by resident local authority.

4.4.5 The data indicates a rising trend in non-reportable delays in Calderdale, compared to a more static position in Kirklees. The reasons for delay are further explored in later charts.
4.4.6 Charts 5 and 6 below split all delays by resident Local Authority and identify the agency ‘responsible’ for the delay. Both the Calderdale and Kirklees data has been included for comparison.

4.4.7 The A&E Delivery Board have noted the increasing trend in social care delays in Calderdale and has asked for a deep dive into issues and mitigating actions back to their August 2017 meeting.
4.4.8 Chart 7 illustrates the monthly volume of patients on discharge pathways by category of delay at CHFT since December 2015. This indicates significant issues; particularly in Calderdale relating to completion of assessments, and in both Local Authorities associated with home care capacity.
4.4.9 Using the data, the A&E Delivery Board (A&EDB) ensured that elements the 16/17 Acceleration Zone funding for this system was allocated to Local Authorities to commission improved assessment and home care capacity. Evaluation of the impact of the funding took place. Whilst this funding has now ended, both CCGs, and the A&EDB, will ensure that allocation of additional ‘Improved’ BCF (iBCF) funding in line with national conditions) is targeted at improvements in delayed transfers of care in line with dashboard intelligence.

4.5 Reducing Lengths of Stay

4.5.1 A key area of focus in the transfer of care work has been to deliver reductions in the number of people with extended lengths of hospital stay. The starting point has been those patients with lengths of stay over 50 days. Patients with such long lengths of stay often tend to be older people with complex needs who also require a large package of home care or re-ablement in order to stay at home, or access to a temporary or permanent care home bed.

4.5.2 Chart 8 below shows data for Calderdale patients with 50+ day length of stay. It is worth noting that the volume of Calderdale patients with stays of 50+ days has improved, and is now back in line with volumes seen in April 2015.

![Chart 8: Patients over 50 Days with a target of 14 - NHS CALDERDALE CCG](image)

4.5.3 The work is being focused on all patients with a Length of Stay (LOS) of over 10 days and the A&E Delivery Board is looking to see improvements and movement towards the target. The Board will again oversee improvements are part of their standing agenda, through highlight reports from its Transfer of Care Work-stream. The current position is set out in chart 9 below.
5. **Recommendations**

5.1 It is recommended that the Governing Body:

1. **NOTES** the content of the report.
2. **CONSIDERS** the updated DTOC position
Executive Summary

This paper presents an overview of the CCG’s workforce over the second half of the financial year 2016/17, in order to provide Governing Body with information and assurance on matters relating to the CCG’s workforce.

The paper includes the following workforce metrics:

- Workforce composition.
- Staff turnover.
- Sickness absence.

There is also a summary of workforce health and wellbeing and of the key headlines relating to the CCG’s workforce.

Recommendation (s)

It is recommended that the Governing Body RECEIVES and NOTES the content of this report.

Implications

Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)

All information in this report is presented in such a way that individuals cannot be identified from the data, in line with Information Governance requirements. As such, diversity information is not included in this report, and is reported to Governing Body separately as part of the Public Sector Equality Duty reporting.

Public / Patient / Other Engagement

None identified

Resources / Finance implications (including Staffing/Workforce considerations)

The report provides Governing Body with an overview of staff resource available to the CCG.

Strategic Objectives

- Achieving the agreed strategic direction for Calderdale
- Improving quality
- Improving value

Risk (include risk number and a brief description of the risk)

None identified

Legal / CCG

The paper provides

Conflicts of Interest

None identified
| **Constitutional Implications** | Governing Body with assurance that the CCG is operating in line with legal requirements, best practice and within agreed CCG policies. | (include detail of any identified/potential conflicts) |
1. Introduction

1.1 The purpose of the report is to provide Governing Body with an overview of the CCG’s workforce, in order to provide information and assurance on matters relating to the CCG’s workforce. The information contained within this paper relates to the second half of the financial year 2016/17.

1.2 Workforce reports are presented on a monthly basis to the CCG’s Senior Management Team (SMT) by a Human Resources (HR) colleague. The information provided enables the SMT to identify any patterns or trends associated with the workforce to enable the identification of any actions that need to be taken, both in the short and longer term. It also provides a vehicle for advising the SMT about any developments in employment law, best practice or other matters that may affect the CCG’s workforce.

1.3 The information presented to the SMT is at a more detailed level than the information contained in this report, to enable the monitoring and management of teams at an operational level.

1.4 The Governing Body report complements the reporting to SMT, providing assurance in relation to the effective management of the CCG’s workforce.

1.5 All information in this report is presented in such a way that individuals cannot be identified from the data, in line with Information Governance requirements.

2. Workforce Metrics

2.1 Workforce composition

2.1.1 As of 31 March 2017, the CCG employed 86 staff. This equates to 80.39 Full Time Equivalents (FTE).

2.1.2 The majority of the CCG’s staff are employed under Agenda for Change terms and conditions. Agenda for Change incorporates a clear job banding system and table 1 details the distribution of the directly employed workforce by job level. Levels 1 to 9 are staff employed under Agenda for Change, the “other” category refers to the 2 Very Senior Managers (VSMs).

Table 1: CCG Directly Employed Staff – Distribution by Job Banding

<table>
<thead>
<tr>
<th>Full Time Equivalent (FTE) by AfC Band - 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Non-M&amp;D ad hoc</td>
</tr>
<tr>
<td>M &amp; D</td>
</tr>
<tr>
<td>Band 9</td>
</tr>
<tr>
<td>Band 8d</td>
</tr>
<tr>
<td>Band 8c</td>
</tr>
<tr>
<td>Band 8b</td>
</tr>
<tr>
<td>Band 6a</td>
</tr>
<tr>
<td>Band 7</td>
</tr>
<tr>
<td>Band 6</td>
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<tr>
<td>Band 5</td>
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<tr>
<td>Band 4</td>
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<tr>
<td>Band 3</td>
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<tr>
<td>Band 2</td>
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<tr>
<td>Band 1</td>
</tr>
<tr>
<td>2.00</td>
</tr>
<tr>
<td>4.00</td>
</tr>
<tr>
<td>5.60</td>
</tr>
<tr>
<td>9.62</td>
</tr>
<tr>
<td>10.43</td>
</tr>
<tr>
<td>26.95</td>
</tr>
<tr>
<td>11.50</td>
</tr>
<tr>
<td>6.60</td>
</tr>
<tr>
<td>3.49</td>
</tr>
</tbody>
</table>
2.2 **Staff turnover**

2.2.1 Staff turnover refers to the proportion of employees who leave an organisation over a set period, and is expressed as a percentage of the total workforce average. The CCG calculates turnover both on a rolling annual basis, and on a monthly basis. The formula which is used to calculate annual employee turnover is:

**Leavers over a rolling 12 months**

\[
\text{average total number employed over a rolling 12 months} \times 100
\]

The formula which is used to calculate monthly turnover is:

**Leavers in a month**

\[
\text{headcount at the end of the month} \times 100
\]

2.2.2 Tables 2 and 3 include the CCG’s staff turnover rates for the second half of the financial year, and include a comparison with turnover for the previous financial year.

**Table 2 – CCG annual staff turnover**

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>11.33%</td>
<td>11.17%</td>
<td>11.03%</td>
<td>10.25%</td>
<td>10.39%</td>
<td>12.84%</td>
<td>10.53%</td>
<td>10.35%</td>
<td>10.45%</td>
<td>10.51%</td>
<td>16.80%</td>
<td>16.10%</td>
</tr>
<tr>
<td>2016-17</td>
<td>16.87%</td>
<td>17.92%</td>
<td>17.23%</td>
<td>13.44%</td>
<td>13.43%</td>
<td>12.93%</td>
<td>12.67%</td>
<td>12.03%</td>
<td>11.57%</td>
<td>11.30%</td>
<td>8.73%</td>
<td>9.02%</td>
</tr>
</tbody>
</table>

**Table 3 – CCG monthly staff turnover**

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>1.92%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>3.64%</td>
<td>3.85%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>3.08%</td>
<td>3.08%</td>
</tr>
<tr>
<td>2016-17</td>
<td>2.47%</td>
<td>1.22%</td>
<td>0.00%</td>
<td>0.60%</td>
<td>1.16%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.33%</td>
<td>0.00%</td>
<td>1.36%</td>
</tr>
</tbody>
</table>

2.2.3 It is important to note that the relatively small number of employees means that any leavers have a significant impact on the overall percentages. This is particularly relevant for annual turnover, where a spike in leavers at any point in the year, continues to impact on the turnover rate for the following 12 months. Rolling annual turnover reflects the total number of leavers over the past 12 months, as a percentage of the workforce. The rolling percentage at the end of March 2017 is 9.92% and reflects 6.8 FTE staff having left the CCG between April 2016 and March 2017.
2.2.4 Monthly turnover relates to the total number of leavers in a specific month, and as such is a good indicator of the organisation's most up to date position. A total of 3 FTE staff left the organisation during the second 6 months of the financial year.

2.2.5 It is noted that some level of turnover is to be expected in any organisation, in particular in view of the CCG's position in the wider system, where it is often beneficial for individuals to take up new roles in other health and social care organisations.

2.2.6 The turnover rate has dropped significantly since the beginning of the financial year, and is not at a level, which should cause any concern.

2.3 Sickness absence

2.3.1 Sickness absence figures are based on a percentage of total time available, based on the following calculation:

\[
\text{Total absence (hours or days) in the period} \times 100
\]
\[
\text{Possible total (hours or days) in the period}
\]

2.3.2 The sickness absence percentages for the second half of the financial year can be found in table 4. The table also includes information to demonstrate how the CCG's absence levels compare with those of the 2 local CCGs where comparison data is available.

Table 4 – CCG sickness absence percentages by month

2.3.3 There is an expectation that a degree of sickness absence will be present in any organisation. Similarly to turnover data, the relatively small size of the CCG means that the numbers are subject to fluctuation. Bearing this in mind, the CCG agreed a threshold of 2.5%, at which point further investigation would take place to understand whether any specific actions may
need to be taken in relation to sickness absence. Sickness absence levels are discussed at SMT on a monthly basis and detailed conversations take place to understand the data presented. The HR team works with line managers to ensure that the appropriate support is provided to individuals, in accordance with the Sickness Absence Policy. The policy includes trigger points, to alert the line manager if an individual’s sickness absence is beginning to give cause for concern.

2.3.4 Table 4 demonstrates that there has been an increase in sickness absence. The reasons for the level of sickness absence, and the management of this absence, are discussed regularly and in detail by SMT, supported by the HR Manager. The significant majority of sickness absence is due to a small number of long term sickness absence cases. These cases are being carefully managed on an individual basis, in accordance with the Sickness Absence policy, with oversight from the relevant SMT member and with support from HR and Occupational Health. Training in sickness absence management has been delivered to line managers, and supportive resources are available and continue to be developed. The CCG has a number of support mechanisms in place to complement the Sickness Absence Policy, including an Employee Assistance Programme and access to Occupational Health advice. The CCG has a strong focus on preventing ill health, and the next section provides more detail about this.

2.3.5 The Chief Officer and the HR Manager have held discussions with Staff Forum, to ensure that our staff are fully engaged in our approach to absence management as part of our health and wellbeing work. The Staff Forum reflected positively on the support available to staff who are suffering from ill health, and provided strong feedback that they believe that the actions and support that are in place, facilitate an earlier return to work of staff, than may otherwise be the case.

2.3.6 The Sickness Absence Policy is due to be reviewed as part of the policy review cycle, and Staff Forum will be involved in this process.

2.4 Workforce Health and Wellbeing

2.4.1 As a healthcare commissioner, the matter of workforce health and wellbeing is of great importance to the CCG, and our staff are an important part of the community we serve. As such, the CCG has undertaken, and continues to develop, a number of initiatives to support staff health and wellbeing. This has been managed in conjunction with Staff Forum, which plays an important role in supporting and promoting health and wellbeing alongside the Senior Management Team.

2.4.2 Key highlights of the second half of the financial year are:

- Full implementation of the Wellbeing Half Hour, which provides staff with a weekly opportunity to undertake activities to benefit their wellbeing, with an overall aim of contributing to overall wellbeing and benefitting productivity.
- Piloting an approach to volunteering to benefit our community, with the dual purpose of enhancing staff wellbeing.
- The introduction of internally-facilitated Mindfulness sessions, to support staff resilience.
- The continued promotion of the Employee Assistance Programme, which offers 24 hour advice and support to staff and their dependents on a range of work and home-related issues. It also includes access to face to face counselling sessions
- Further developing staff networking opportunities, such as lunchtime walks, a book club, and “tea and talk” sessions, with a quarterly focus on mental health issues.
- The completion of training for managers in how to manage sickness absence, including the promotion of positive health and wellbeing.
- Development of shared spaces to provide an environment, which encourages the sharing of positive messages about health and wellbeing.
- Working closely working with other public and private sector organisations in Calderdale to share best practice in relation to workforce health and wellbeing, as part of the Active Calderdale strategy.

2.4.3 Further plans for the next financial year include:

- The development of a dedicated wellbeing section on the intranet.
- Continued development of the volunteering strategy.
- Participation in the Global Challenge. This is a 100 day challenge, aimed at increasing physical activity and improving nutrition, sleep quality and psychological resilience. Key outcomes when the CCG participated previously, were that 72% of participants exceeded national guidance for physical activity, 74% reported feeling less stressed, and 78% said they felt more productive.
- The training and introduction of Mental Health First Aiders.
- Selecting a provider for winter flu vaccines.
- Working towards an external hallmark relating to workforce wellbeing.

2.5 Workforce Headlines

2.5.1 This section provides a summary of key activities, which have taken place in relation to the workforce, and are not already referenced in this report.

2.5.2 An important general point, is that a decision has been taken to introduce a regular Senior Management Team meeting during the next financial year, which will focus solely on workforce matters. The aim of this is to ensure that our workforce is well-positioned to support the CCG in achieving its strategic objectives, and is appropriately skilled and resilient.

2.5.3 Human Resources Policies

The CCG has a comprehensive suite of Human Resources (HR) policies, which are reviewed on a regular cycle to ensure they remain fit for purpose and compliant with employment law and best practice. This process is managed by the HR team in conjunction with Trade Union colleagues, SMT and Remuneration Committee. 6 policies have been reviewed and updated during the second half of the financial year

2.5.4 Training and Development

Training in the management of sickness absence was delivered to managers during the first and second halves of the financial year. The HR team is currently reviewing other development interventions, to support effective people management.

It has been identified that the ability to build effective networks and relationships is a key skill for all staff in the CCG, as we continue to lead the development of the wider health and social care system. Therefore the CCG has commissioned “Coaching Conversations”, a development intervention available to all staff to develop this skill across the workforce, which will run over a two year period. The first sessions have commenced, and evaluation of success and organisational benefits will be carried out.

2.5.5 Employee Relations

CCGs typically have low levels of employee relations issues and only two formal cases have arisen over the second half of the financial year. There was one grievance case, which resulted in a disciplinary case. The CCG’s policies promote the informal resolution of any
issues where appropriate and HR colleagues provide professional advice and support to line managers and individuals on an informal level in line with this approach. It is expected that there will continue to be low levels of formal cases.

2.5.6 There have been no whistle blowing disclosures.

2.5.7 **Terms and Conditions**

The majority of CCG staff are engaged under Agenda For Change terms and conditions, and as such their pay is negotiated and set nationally. The CCG provided feedback for consideration by the National Pay Review Body in relation to how Agenda for Change increases should be treated. A 1% pay increase was announced and applied for Agenda for Change staff in March 2017. Each year following the Agenda for Change pay award, the CCG’s professional advisors consider whether any changes to pay are appropriate for those individuals engaged outside Agenda for Change. This is to be considered by Remuneration Committee during the first half of the financial year 2017/18.

A Government consultation has taken place to amend exit payments for public sector employees. This is being negotiated at a national level, and the CCG has been observing progress, and will be required to adopt any changes agreed nationally for the NHS.

As of 1 July 2017, the CCG will be required to auto-enrol all eligible staff into a pension scheme. Work has taken place to ensure the CCG is ready to enact this statutory duty, including the establishment of a Secondary Pension Scheme, for staff with pension entitlement, who are not eligible for the NHS Pension Scheme.

3. **Next Steps**

3.1 The Senior Management Team will continue to manage and monitor all aspects of the workforce.

3.2 A further report will be presented to Governing Body, highlighting the key matters relating to the CCG’s workforce, for the first half of the financial year 2017/18.

4. **Recommendations**

4.1 It is recommended that the Governing Body RECEIVES and NOTES the contents of this report.
Executive Summary

Please include a brief summary of the purpose of the report

- This paper presents the high level risk report at the end of the second review cycle of 2017-18.
- The Calderdale Clinical Commissioning Group Risk Register currently contains a total of 36 risks, including 9 risks marked for closure, leaving 27 open risks.
- Of these open risks, there are:
  - 2 CRITICAL risks (scoring 20); and
  - 5 SERIOUS risks (scoring 15-16)

Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Quality / Finance &amp; Performance</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality / Finance &amp; Performance</td>
<td>27/07/2017</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Senior Management Team</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management Team</td>
<td>10/07/2017</td>
<td></td>
</tr>
</tbody>
</table>

Recommendation(s)

It is recommended that the Governing Body Confirms that it is 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 2 of 2017-18. Following reviews of their respective risks at the Quality and Finance & Performance Committee meeting on 27 July 2017.

Implications

- **Quality & Safety implications** (including Equality & Diversity considerations e.g. EqIA) None identified
- **Public / Patient / Other Engagement** None identified
- **Resources / Finance implications** (including Staffing/Workforce considerations) None identified
- **Strategic Objectives** (which of the CCG objectives does this relate to)
  - Achieving the agreed strategic direction for Calderdale;
  - Improving Governance
- **Risk** (include link to risks) None identified
- **Legal / Constitutional Implications** Risk is managed in line with the CCG’s Integrated Risk Management Framework.
- **Conflicts of Interest** None identified
1. Introduction

1.1 To provide assurance on the process for the detailed review of the CCG’s risks.

1.2 To set out all risks rated 15 or above (see Appendix 1).

1.3 To provide a summary of the CCG’s current risk profile and related comparative data via the CCG Risk Dashboard Report (see Appendix 2).

2. Risk Review: Risk Cycle 2

2.1 Risk Cycle 2 commenced on 19 June 2017. Following updates by Risk Owners and review of individual risks by the allocated Senior Manager, the Corporate Risk Register was reviewed by the Senior Management Team on 10 July 2017.

2.2 All risks were submitted to either the Finance and Performance or the Quality Committees for review at their meetings on 27 July 2017.

2.3 The CCG Risk Register for Risk Cycle 2 has now been archived and Risk Cycle 3 will commence soon.

Risk Register Summary: Risk Cycle 2

2.4 At the end of Risk Cycle 2, the CCG had 36 risks on the Corporate Risk register including 9 risks marked for closure, leaving 27 open risks (also 27 open risks at the last risk cycle).

2.5 9 of the CCG’s 27 open risks (33%) related to quality and clinical matters. The remaining 18 open risks (67%) related to finance, performance or corporate matters.

High Level Risks

2.6 There were 2 critical risks (scoring 20 or 25) on the CCG Risk Register during Risk Cycle 2; there were 4 risks as at the end of risk cycle 1.

The 2 critical risks on the risk register are:

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Summary</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>709</td>
<td>Risk that patients being discharged from hospital are subject to delays in their transfer of care</td>
<td>20</td>
</tr>
<tr>
<td>62</td>
<td>The system will not deliver the NHS Constitution 4-hour A&amp;E target for the next quarter due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system</td>
<td>20</td>
</tr>
</tbody>
</table>
2.7 The 2 additional critical risks that were on the risk register during risk cycle 1 were:

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Summary</th>
<th>Risk movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>829 (F&amp;P)</td>
<td>The CCG fails to deliver the 16/17 planned financial surplus. The 16/17 financial plan includes a number of pressures/risks which will need mitigating to ensure delivery. This may result in the CCG not achieving its financial targets.</td>
<td>Closed as risk 829 at the end of the last risk cycle and reopened as 1023 (risk score reduced to 16 - see 2.7)</td>
</tr>
<tr>
<td>988 (Q)</td>
<td>There is a risk that residents in a Calderdale nursing home will come to harm because of the significant issues within the home structure and leadership at all levels that have been identified and the poor quality of clinical care provided in the home.</td>
<td>Risk score reduced to 1 and has been closed during risk cycle 2 as the home has now closed and residents have been safely transferred to other homes</td>
</tr>
</tbody>
</table>

2.8 There are 5 open risks rated as Serious (with a score of 15 or 16) during the current risk cycle (there were 3 at the end of the last risk cycle) these are detailed below.

2.9 Those risks where the score remains the same are carefully reviewed (i.e. a static score does not mean that the risk has not been reviewed and that mitigating actions have not changed).

2.10 The 5 open risks rated as Serious this risk cycle are:

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Summary</th>
<th>Risk Score</th>
<th>Risk Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1053 (Q)</td>
<td>There is a risk that the 62 day cancer wait standard for first definitive cancer treatment following consultant upgrade will not be achieved consistently owing to pathway delays, resulting in treatment delays and harm to patients</td>
<td>16</td>
<td>New risk</td>
</tr>
<tr>
<td>1024 (F&amp;P)</td>
<td>The risk is that Calderdale CCG may not have the appropriate QIPP schemes in place to ensure its contribution to the system model is affordable going forward.</td>
<td>16</td>
<td>Closed as risk 826 at the end of the last risk cycle and reopened</td>
</tr>
<tr>
<td>1023 (F&amp;P)</td>
<td>The CCG will fail to deliver our 17/18 planned in year deficit of £3.13m and therefore fail to deliver a planned £2.7m cumulative surplus.</td>
<td>16</td>
<td>Closed as risk 829 at the end of the last risk cycle and reopened</td>
</tr>
<tr>
<td>849 (F&amp;P)</td>
<td>The main acute and community contract with Calderdale and Huddersfield NHS Foundation Trust (CHFT) over-trades significantly due to increased levels of A&amp;E attendances and emergency admissions and increased demand in terms of GP and other referrals, outpatient and diagnostic activity. This could result in a detrimental effect on the CCG financial position.</td>
<td>16</td>
<td>Static for 3 risk cycles</td>
</tr>
<tr>
<td>515 (F&amp;P)</td>
<td>There is a risk that the CHC/Specialist Care team may not be able to deliver the level of performance that is expected by the CCG due to increasing workload and the capacity within the current workforce.</td>
<td>16</td>
<td>Static for 2 risk cycles</td>
</tr>
</tbody>
</table>
2.11 The 3 open risks rated as Serious at the end of risk cycle 1 were:

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Summary</th>
<th>Risk movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>849 (F&amp;P)</td>
<td>The main acute and community contract with Calderdale and Huddersfield NHS Foundation Trust (CHFT) over-trades significantly due to increased levels of A&amp;E attendances and emergency admissions and increased demand in terms of GP referrals, outpatient and diagnostic activity. This could result in a detrimental effect on the CCG financial position.</td>
<td>Reviewed and risk score kept at 16</td>
</tr>
<tr>
<td>515 (F&amp;P)</td>
<td>There is a risk that the CHC/Specialist Care team may not be able to deliver the level of performance that is expected by the CCG due to increasing workload and the capacity within the current workforce.</td>
<td>Reviewed and risk score kept at 16</td>
</tr>
<tr>
<td>826 (F&amp;P)</td>
<td>The CCG may not have the appropriate QIPP schemes in place to ensure the system model is affordable going forward. This may result in the non-achievement of control total and/or failure to achieve QIPP targets</td>
<td>Closed as risk 826 at the end of the last risk cycle and reopened as 1024</td>
</tr>
</tbody>
</table>

F&P – Finance, performance, corporate
Q - Quality

3. Recommendations

3.1 It is recommended that the Governing Body confirms that it is 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 2 of 2017-18, following reviews of their respective risks at the Quality and Finance & Performance Committee meeting on 27 July 2017.

4. Appendices

Appendix 1: High Level Risk Log Risk Cycle 2 as at 10 July 2017

Appendix 2: CCG Risk Dashboard Cycle 1 2017-18

Appendix 3: Critical risk reports for 709 & 62
Risk register for Governing Body as at 13 July 2017

1. Item 12, Appendix 1

<table>
<thead>
<tr>
<th>ID</th>
<th>Date Created</th>
<th>Key Control Gaps</th>
<th>Assurance Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>709</td>
<td>17/08/2015</td>
<td>Quality</td>
<td>4 - Quality of Care</td>
</tr>
<tr>
<td>62</td>
<td>13/06/2016</td>
<td>Finance</td>
<td>F&amp;P - Performance</td>
</tr>
<tr>
<td>1053</td>
<td>11/07/2017</td>
<td>Quality</td>
<td>F&amp;P - Performance</td>
</tr>
</tbody>
</table>

**Item 12, Appendix 1**

**Risk ID:** 709

**Date Created:** 17/08/2015

**Key Control Gaps:**
- There is a risk that the system will not provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to a lack of staff capacity, increased demand and pressures associated with new guidance on A&E Streaming.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to a lack of staff capacity, increased demand and pressures associated with new guidance on A&E Streaming.

**Principal Risk:**
- Quality

**Risk Type:** F&P - Performance

**Rating:** 4 (High) (I4xL1)

**Score:** 16 (20)

**Impact:** 5*4 (I4xL2)

**Owner:** Matt Walsh

**Key Controls:**
- There is a risk that the system will not deliver the NHS Constitution 4-hour A&E target for the next quarter due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.

**Assurance Controls:**
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.

**Risk Score:** 16 (20)

**Risk Rating:** High

**Senior Manager:** Debbie Graham

**Key Risk Identifiers:**
- There is a risk that the system will not deliver the NHS Constitution 4-hour A&E target for the next quarter due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.

**Action Plan:**
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.

**Performance Rating:**
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.
- There is a risk that patients being discharged from hospital are subject to delays in their transfer of care due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.

**Score:** 16 (20)

**Risk:** 96.3%

**Rating:** 4 (High) (I4xL1)

**Risk Status:** New - Open

**Archives:** Static - 3

**Target not met in April**, but performance recovered in May

**Ability to sustain May performance**

**State:** New - Open

**Archives:** Static - 7 Archive(s)

**Archives:** Static - 3 Archive(s)
The CCG will fail to deliver out 17/18 planned £2.1m cumulative surplus. The 2017/18 financial plan included a number of pressures/risk which have been mitigated to ensure delivery. These risks include activity pressure on acute contracts, prescribing and under-delivery of QIPP. This resulted in the CCG not achieving its financial targets and forecasting a reduced surplus position for the year end.

The 2017/18 financial plan has been approved by Governing Body. A Quality Innovation Productivity and Prevention (QIPP) plan has been agreed at £1.5m but there is a £2.4m gap. There is a monthly budget monitoring process in place which reviews all expenditure against budgets and is shared with budget holders. In addition reports are produced monthly to the Finance & Performance Committee and Governing Body and also to NHSE England. The financial plan includes a £1.5m contingency budget to manage in year risk.

The CCG is aware of acute cost pressures in the 1st month of the year, this is in the CCG and needs to undertake against contract value to achieve QIPP targets. Current info suggests the contract as £1.5m plan and therefore creates pressure to the CCG. The CCG has a £1.5m contingency to help mitigate risk, predicated on full delivery of QIPP. However further mitigations need to be identified to close the gap in delivery of the planned surplus.

The CCG is currently forecasting an unmitigated financial risks of £2.4m.

The CCG is subject to delays in the availability of SUS data in line with the national timetable. There is no robust process in place to understand the expected impact of the new model on the CCG. The first cohort of thresholds to move to a reduced surplus position.

The impact of both thresholds and MSK in terms of cost out of the system is yet to be fully understood.

None at this stage

New - Open
<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Date Created</th>
<th>Risk Type</th>
<th>Risk Category</th>
<th>Risk ID</th>
<th>Risk Rating</th>
<th>Target Risk Score</th>
<th>Risk Score</th>
<th>Senior Manager</th>
<th>Principal Risk</th>
<th>Key Controls</th>
<th>Key Control Gaps</th>
<th>Assurance Controls</th>
<th>Positive Assurance</th>
<th>Assurance Gaps</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>829</td>
<td>07/06/2016</td>
<td>Finance</td>
<td>F&amp;P -</td>
<td>829</td>
<td>3</td>
<td>0 (OutLI)</td>
<td>3</td>
<td>Neil Smurthwaite</td>
<td>The CCG will fail to deliver its financial plan. The 17/18 financial plan included a number of pressures/risk which need to be mitigated to ensure delivery. These risks include activity pressures on acute contracts (contract value higher than CCG affordability), unidentified savings, prescribing, continuing health care and under-delivery of QIPP.</td>
<td>The financial plan has been approved by Governing Body. A Quality Innovation Productivity and Improvement Plan (QIPP) was agreed but there is a £2.1m gap. There is a monthly budget monitoring process in place which reviews all expenditure against budgets and is shared with budget holders. In addition reports are produced monthly to the Finance &amp; Performance Committee and Governing Body and also to NHS England. Internal governance has increased with the Recovery Operational Group, dedicated SMT session monthly and dedicated time at F&amp;P Joint transformation group established between acute trust and Calderdale/Greater Hudds CCGs with agreed programmes to deliver QIPP.</td>
<td>Minimal contingency is held by the CCG.</td>
<td>Internal and external audit reports. Role of Audit Committee. Quarterly Area Team Assurance Process where the CCG financial position is assessed. Monthly reporting to Finance and Performance Committee and Governing Body.</td>
<td>Significant assurance received on financial audit financial year 2017/18. Significant savings identified. In year review report and action plan for next year. Additional NHS England support provided.</td>
<td>Joint agreement across the health system on plans for financial sustainability. Additional support and scrutiny is being provided by NHSE. Consultancy days have provided to help review system accountability and deliver a joint project.</td>
<td>Closed - risk closed for 2017/18 Financial year. New risk 1023 created for 17/18 Financial year</td>
</tr>
<tr>
<td>826</td>
<td>07/06/2016</td>
<td>Finance</td>
<td>F&amp;P -</td>
<td>826</td>
<td>4</td>
<td>0 (OutLI)</td>
<td>4</td>
<td>Neil Smurthwaite</td>
<td>The risk that Calderdale CCG may not have the sufficient QIPP schemes in place to ensure the system model is affordable going forward. This may result in the non-achievement of control total through non-achievement of QIPP targets.</td>
<td>Monthly QIPP tracker reporting to QIPP Group, SMF, F&amp;P committee and Governing Body. A Clinical engagement in QIPP opportunities. A Medium term financial planning process in place. A Financial and contracting reporting arrangements in place through Senior Management Team, Finance and Performance Committee, and Governing Body. A Financial recovery plan being developed and 2 year contracts being negotiated.</td>
<td>Currently there is a QIPP gap on cash releasing schemes in 16/17 of £1.3m. If this is not achieved the CCG is at significant risk of not delivering its financial targets. A Controls not fully embedded and effective - these have improved through the QIPP meetings. A QIPP plans need further development to ensure granularity - plans have improved in terms of development and reporting. A Work underway in identifying measurement of schemes - significant improvements have been made through QIPP meetings. A Area Team Assurance process - Additional support being provided by NHS England to support plan in 17/18, particularly around QIPP opportunites. A Right Care rating as “Green”</td>
<td>Internal audit reports A Finance, contracting and QIPP reports A Area Team assurance role A 16/17 plan signed off A Area Team Assurance process - additional support being provided by NHS England to support plan in 17/18, particularly around QIPP opportunites. Right Care rating as “Green”</td>
<td>None</td>
<td>Closed - closed as new QIPP risk raised for 17/18 New risk 1024</td>
<td></td>
</tr>
<tr>
<td>515</td>
<td>26/11/2014</td>
<td>Finance</td>
<td>F&amp;P -</td>
<td>515</td>
<td>4</td>
<td>0 (OutLI)</td>
<td>4</td>
<td>Martin Pursey</td>
<td>There is a risk that the CHC/Specialist Care team (responsible for CHC/preservation, learning disabilities/mental health/adolescence/personal health budgets/appraisals/clinical compliance in care homes/hospital complex discharge team) may not be able to deliver the level of performance that is expected by the CCG due to increasing workload and the capacity within the current workforce.</td>
<td>Regular update and notification of pressures by Head of Commissioning to the Head of Continuing Care. A Process continues to rationalise workforce by identification of key priorities and reallocation of workloads. A Processes within the team to identify and escalate concerns to the manager. A Additional capacity agreed by SMF and 2 vacancies recruited to Summer 2016.</td>
<td>Limited capacity to cope with increasing workload. A Limited capacity to manage the increasing number of very complex cases. A Limited capacity to cope with crisis situations that require immediate attention such as nursing homes. A No capacity and limited skills to support the personal health budget offer. A Unable to recruit to 2 posts due to CCG financial position. A Additional posts vacant due to staff leaving and impact of long term sickness March 2017.</td>
<td>Close monitoring and supervision by Operations manager of team activity and performance. 2Weekly updates on performance to Head of Commissioning - CIC. A Prioritisation of work around clinical care to ensure patient safety. A Prioritisation of workload to ensure timely eligibility decisions in line with CIC/National Framework and action relating to client care and safety are prioritised. A Plans to provide resilience within the team and appointments of vacant posts agreed by SMF 03/04/17 A short term interim support at clinical level agreed to relieve some pressures upon the current sole clinical lead</td>
<td>1) Backlog of reviews for non-compliant patients and people with learning disabilities. 2) Backlog in DST completion and not meeting 28-day standard. 3) 2 senior clinicians off sick with work-related stress - this has a direct impact. 4) Additional sickness and vacancies are creating further pressure upon existing staff. 5) Unable to recruit to agreed vacancies due to CCG financial pressures. 6) Pressures will remain for a minimum of 3/12 until new staff in post.</td>
<td>Status - 2 Added</td>
<td></td>
</tr>
</tbody>
</table>
Open Risks | Cycle 1 | Cycle 2
--- | --- | ---
CCG | 32 | 36
Finance & Performance | 21 | 25
Quality | 11 | 11

Movement of CCG Risks during Cycle 2

- New: 9
- Marked for Closure: 9
- Risk Score Increasing: 2
- Risk Score Static (for 1 cycle): 2
- Risk Score Static (for 2 or more cycles): 13
- Risk Score Decreasing: 1
- Total Risks (including those marked for closure): 36
Critical Risk report

Risk ID: 709
Risk Type: Quality
Risk Category: Q – Quality of Care

Date: 20th September 2016  (Last Reviewed 28 July 2017)

1 Current risk score
   (Likelihood) x (Impact) = score
   5 x 4 = 20

2 Previous risk score
   (Likelihood) x (Impact) = score
   4 x 4 = 16

3 Risk description
   Risk that patients being discharged from hospital are subject to delays in their transfer of care due to (a) a lack of service capacity in NHS and non-NHS England (NHSE) services outside hospital, and (b) health and social care systems and processes are not currently optimised, resulting in; (a) poor patient experience, (b) harm from delays and associated deconditioning, (b) additional pressure on the current acute bed base and the need to open additional beds.

4 Current position (include any relevant data as attachments)
   In 15/16 the Calderdale system was an outlier nationally for reportable (formal) Delayed Transfers of Care (DTOC). Following actions by the A&E Delivery Board (A&EDB) the system is reporting sustainable performance for 17/18 under the 3.5% target set by NHSE (% of delayed days of all occupied bed days). Performance remains stabled into Q1.

   In terms of non-reportable delays, the local position remains challenging. From April 2016, there has been a significant increase in the number of delays for Calderdale patients associated with social care. In the same period the volume of health system delays and joint health and social care delays have reduced overall. The majority of the delays are associated with awaiting assessment and delivery of packages of home care.

5 Assessment of the issues
   Whilst we have significantly improved our performance as a system relating to formally reported Delayed Transfers of Care (DTOC), we have a significant issue locally around the discharge of patients who, whilst not technically delayed, are ready to leave hospital after their period of acute care. This has been exacerbated by increases in demand and a significant increase in the acute bed base through winter. We recognize that this has had a significant impact on patient care, patient experience and also delivery of the NHS Constitutional four hour A&E target.
| 6 | Future actions | 1. A formal TOC Improvement Plan was signed off by the CCG’s Governing Body in August 2016. We have completed a reassessment of our status against the 8 High Impact Changes and this was shared with the A&EDB in May 17. An action plan is being developed for the next 12 months.  
2. WY Acceleration Zone funding was targeted at increasing assessment and homecare capacity. The Local Authority has also commissioned additional home care capacity.  
3. The intention is to ensure that iBCF (Improving Better Care Fund) is targeted at both assessment and home care capacity.  
4. We have a TOC real-time dashboard as a system providing an overview of patients who are on a discharge pathway. Providers share data on delays and mitigating actions and commissioners see an aggregated version that gives them the opportunity to assess progress.  
5. We have engaged our system in the national Ambulatory Care and Frailty programmes where we are being exposed to national models of good practice and dedicated time to develop new ways of working to improve patient flow and patient experience.  
6. The A&EDB will begin to receive assurance about the work of the CHFT SAFER Board which delivers operational improvements related to patient flow which have a national evidence-base.  
7. The A&EDB’s TOC work-stream is undertaking a deep-dive into both assessment and care home issues. The GB will be in receipt of a deep-dive into TOC performance at their August 17 meeting. |
|---|---|---|
| 7 | Identified gaps | 1. Sustainable reduction in non-reportable delays  
2. Increasing volume of social care delays (assessment and packages of care) |

**Relevant data:** (attach as necessary)

**Risk Owner:** Debbie Graham

**Senior Manager:** Matt Walsh

**Date review completed:** 28.7.17
**Critical Risk report**  
**Risk ID:** 62  
**Risk Type:** Finance & Performance  
**Risk Category:** F&P – Performance

**Date:** 20\textsuperscript{th} December 2016  
(last reviewed 27 July 2017)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Current risk score ( (\text{Likelihood}) \times (\text{Impact}) = z )</td>
<td>( 5 \times 4 = 20 )</td>
</tr>
<tr>
<td>2</td>
<td>Previous risk score ( (\text{Likelihood}) \times (\text{Impact}) = z )</td>
<td>( 4 \times 4 = 16 )</td>
</tr>
<tr>
<td>3</td>
<td>Risk description</td>
<td>There is a risk that the system will not deliver the NHS Constitution 4-hour A&amp;E target for the current quarter due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system.</td>
</tr>
</tbody>
</table>
| 4 | Current position (include any relevant data as attachments) | For 16/17: performance did not achieve the 95% target (performance was 94.1%). The risk for 16/17 therefore materialised.

For 17/18 the following performance has been noted:
- April – 95.1%
- May – 85.1% (reduced performance was identified as EPR-related)
- June – 92.03%
- July – 93.59%

This means that Q1 performance was not delivered (90.58%) and the Q2 position is challenging (93.59% YTD) and therefore the risk for this Constitutional target remains at 5x4. |
| 5 | Assessment of the issues | Delivery of the 4-hour target is an important element of the NHS Constitution and the local urgent and emergency care system. Whilst performance is challenging locally, Calderdale and Huddersfield NHS Foundation Trust’s (CHFT) performance remains in the upper (best) performance nationally. |
| 6 | Future actions | 1. The system has been able to access non-recurrent West Yorkshire A&E Acceleration Zone funding in the early part of 2017/18 which has continued to be utilized to improve capacity and access into A&E/primary care streaming services and social work assessment and home-care capacity.  
2. Commissioners worked with CHFT and Local Care Direct in order to trial a new primary care offer at the front-end of A&E |
- which commenced December 2016. The evaluation is currently being completed and learning is being built into the development of proposed Urgent Care Centres and our response to national expectation on A&E Streaming.

3. The A&E Delivery Board is leading work which brings together work set out in (2) above, and work to develop community urgent care models built on our care closer to home model. This is being carried out in both Calderdale and Greater Huddersfield.

4. The A&E Delivery Board reviews capacity and demand issues from the system and potential solutions at every monthly meeting. It is also considers performance by site to identify actions and learning.

5. The system has continued to plan for each Bank Holiday, assessing risk and gaining assurance from each partner organization. Learning is identified every month by the Board.

6. CHFT remains one of the highest performing Trusts nationally.

7. The A&E Delivery Board has recognized the negative impact on A&E performance associated with Electronic Patient Record (EPR) cutover, and this is visible in the performance data.

<table>
<thead>
<tr>
<th>7</th>
<th>Identified gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Assurance on delivery of Q2</td>
</tr>
<tr>
<td>2.</td>
<td>Lack of information on patients experience of delay - this is becoming a feature of a new NHSE approach to monitoring the 4 hour target. Further detail is still awaited.</td>
</tr>
<tr>
<td>3.</td>
<td>Local model of community urgent care, linked to work to develop proposed urgent care centres and A&amp;E streaming models</td>
</tr>
</tbody>
</table>

**Relevant data:** A&E performance data is shared daily by CHFT to commissioners and is available on request

**Risk Owner:** Debbie Graham

**Senior Manager:** Matt Walsh

**Date review completed:** 27.07.17
**Name of Meeting** | Governing Body | **Meeting Date** | 10/08/2017  
**Title of Report** | Audit Committee’s Annual Report 2016-17 | **Agenda Item No.** | 13  
**Report Author** | David Longstaff, Deputy Chair and Audit Committee Chair | **Public / Private Item** | Public  
**GB / Clinical Lead** | David Longstaff | **Responsible Officer** | Neil Smurthwaite  

### Executive Summary

Please include a brief summary of the purpose of the report

- At the end of the financial year, the Audit Committee prepares an annual report for the Governing Body.
- The report sets out how the committee has discharged its responsibilities during the year and met its terms of reference.
- The attached is the Audit Committee Annual Report for 2016-17.

### Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
<td>18/05/2017</td>
</tr>
</tbody>
</table>

### Recommendation (s)

It is recommended that the Governing Body **RECEIVES** the Audit Committee’s Annual Report 2016-17

### Decision

☐ Assurance  ☒ Discussion  ☐ Other

### Implications

| Quality & Safety implications | None Identified  
| Public / Patient / Other Engagement | None Identified  
| Resources / Finance implications | None Identified  
| Strategic Objectives | None Identified  
| Legal / CCG Constitution Implications | None Identified  

| (including Equality & Diversity considerations e.g. EqIA) |  
| (including Staffing/Workforce considerations) |  
| (which of the CCG objectives does this relate to?) | Improving Governance  
| (include risk number and a brief description of the risk) |  
| (include detail of any identified/potential conflicts) |  

---

*Page 1 of 1*
1.0 Purpose of Report

1.1 The purpose of this annual report is to provide a summary of the Audit Committee’s activities, demonstrating compliance with the Committee’s Terms of Reference, delivery of the work plan, effectiveness and impact of the Committee.

2.0 Background

2.1 The Audit Committee is established as a sub-committee of the Governing Body and in accordance with the Clinical Commissioning Group’s Constitution and Scheme of Reservation and Delegation.

2.2 The role of the Audit Committee is to provide the Governing Body with an independent and objective view of the Clinical Commissioning Group’s (CCG) financial systems, financial information and compliance with laws, regulations and directions – directing the CCG in so far as they relate to finance.

2.3 The Committee has responsibility for maintaining an overview of the adequacy and effectiveness of the systems of internal control and risk management system across the whole of the CCG’s activities.

2.4 The Governing Body has delegated scrutiny of the following functions to the Audit Committee:

- Audit
- Governance, risk management and internal control
- Emergency Preparedness and Business Continuity

2.5 The Committee also has delegated authority to approve policies, guidelines and procedures in respect of all areas of the committee’s responsibilities.

2.6 The details of the roles and responsibilities are set out in the terms of reference (https://www.calderdaleccg.nhs.uk/wp-content/uploads/2016/06/Audit-Committee-ToR-FINAL-June-2017.pdf) and the activity is incorporated into an annual work plan.

3.0 Membership

3.1 The membership of the committee as set out in the terms of reference is as follows:

Members:

- Lay member with expertise/experience in financial management/audit matters (Chair)
- Lay Member (Finance, Performance and External Relations)
- Two other non-GP members of the Governing Body (Lay Member – PPI, Registered Nurse or Secondary Care Specialist)
- One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.
Required Attendees:

- Chief Finance Officer/Deputy Chair or the Head of Finance
- Corporate and Governance Manager
- External and internal audit representatives shall normally attend meetings.

3.2 The membership of the committee has been consistent throughout the year ensuring good continuity and committee effectiveness in carrying out its role.

3.3 The committee met six times in 2016-17. The additional meeting was held on the 12 May (2016) in order to carry out a ‘page turn’ of the annual report and accounts. All Governing Body members were invited to this meeting. The committee has been quorate on all occasions.

4.0 Review of Committee Activities

4.1 The Audit Committee work plan is developed in line with the responsibilities of the committee as set out in the Terms of Reference. It also takes a risk based approach, reflecting the changing context in which the CCG has operated over the past year.

4.2 The work plan was formally reviewed in May, November and January. I am pleased to be able to report that all items have been considered in a timely manner.

4.3 Key areas considered during 2016/17

The Audit Committee has had a full and productive year, working to provide the Governing Body with the necessary assurances that there are effective systems and processes in place to keep the organisation safe, to comply with statutory and constitutional requirements and to be able to deliver the CCG’s objectives.

**Key areas of focus were:**

- “We have received assurance about the additional systems and processes being put in place to manage conflicts of interest.”
- “The Head of Internal Audit Opinion provided significant assurance that a generally sound system of internal control, designed to meet the organisation’s objectives is in place.”
- “We achieved 98% compliance against a target of 94% in the Information Governance Toolkit.”
- “We approved policies on Local Security Management, IG, Prime Financial Policies and the Standing Financial Instructions.”
- “We kept an overview of the process for appointing our external auditors and the establishment of the Auditor Panel.”
- “We received a report and assurances on actions taken to prevent a re-occurrence of an IG serious incident.”
4.4 Annual Report (2016/17)

The Audit Committee has delegated authority from the Governing Body to approve the CCG’s Annual Report, Annual Governance Statement and Accounts on its behalf.

The review of the draft and approval of the final Annual Report and Accounts forms one of the key activities of the Audit Committee at the end of the financial year.

Each year, all members of the Governing Body are invited to attend a ‘page turn’ review of the draft documentation prior to final approval. This took place on 11th May (2017). The final Annual Report, Accounts and Annual Governance Statement were approved by the Audit Committee on the 18th May 2017.

I would like to take this opportunity to express my thanks to the Finance Team for its hard work producing the accounts to a demanding timescale.

4.5 Other areas of focus in 2016/17

Managing conflicts of interest

Clinical Commissioning Groups are required to make arrangements to manage actual or potential conflicts of interest so that decisions made by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interests. The CCG has a number of systems and processes in place to manage conflicts of interests – both real and perceived. These include the maintenance of registers of interest and arrangements for the declaration and registering of gifts, hospitality and sponsorship.

In June 2016, NHS England issued revised statutory guidance for CCGs on the management of conflicts of interest. This introduced a number of new processes and the new role of Conflict of Interest Guardian (Chair of the Audit Committee). The Audit Committee received regular updates throughout the year on the actions being taken to introduce new processes in line with the guidance or tighten up existing processes. I am pleased to be able to report that we received an internal audit opinion of significant assurance in this area.

The processes for managing conflicts of interest will continue to be reviewed by the Audit Committee so that the CCG is able to provide the necessary assurances to the public, potential and existing providers and the regulators that we are acting with integrity and operating in an open and transparent way.

Working with the Auditors

In 2016/17, the Audit Committee was supported in its work by Audit Yorkshire (Internal Auditors) and KPMG (External Auditors).

The internal auditors provide the committee with independent and objective opinions on the degree to which risk management, control and governance supports the achievement of the CCG’s objectives. They are also able to provide independent advice and support the improvement of our systems and processes. Over the past year, our internal auditors have reported the outcomes of reviews conducted as part of the agreed audit annual work plan. Areas reviewed this year have included:

- Governance & Risk Management Review
- Conflicts of Interest,
- Business Continuity,
- Planning Quality, Innovation, Productivity and Prevention (QIPP),
- Business Intelligence,
They have also supported the self-assessments made as part of the Information Governance Toolkit submission, by providing assurance on the adequacy of the evidence provided.

Following completion of the planned audit work for 2016/17, I am pleased to be able to report that the Head of Internal Audit Opinion was of “Significant Assurance” that a generally sound system of internal control, designed to meet the organisation’s objectives was in place and that controls are generally being applied consistently. Further detail can be found in the CCG’s Annual Report and Accounts 2016-17 (pp 84-86).

I would like to thank all the CCG’s staff for their hard work which has resulted in the Head of Internal Audit Opinion of “Significant Assurance”.

External Auditors

The role of the external auditors primarily is to review and report on the CCG’s financial statements and whether the CCG has proper arrangements in place for securing economy, efficiency and effectiveness in respect of its use of resources. KPMG has attended all the Audit Committee meetings and their contribution is always valuable in terms of providing external scrutiny and challenge as well as keeping the audit committee members up to date with key areas of focus through the provision of technical updates.

Appointing an external auditor

Following changes to the local external audit arrangement as part of the Local Audit Accountability Act 2014, CCGs were required to appoint their own external auditors before the 31st December 2016 in readiness for the 2017/18 financial year. The CCG established an Auditor Panel in line with the national guidance and procured the external auditor appointment by using a ‘mini-procurement’ (competitive tender) process in conjunction with the Crown Commercial Service Consultancy One Framework. Following approval of the preferred bidder by the Governing Body in December, I am pleased to confirm that KPMG were successful and will be continuing to fulfil the CCG’s external auditor role from April 2017/18.

Private discussions between audit committee member and auditors

Private discussions between audit committee members, the external and internal auditors without management present is a key part of ensuring that there is a good relationship of trust between the auditors and allows those present to raise any issues or questions. The meetings allow committee members and the auditors the opportunity to discuss a range of matters without any actual or perceived management influence. As Audit Committee members we have met with each of internal and external audit on two occasions.

Audit Chairs’ briefings

As Audit Chair I also attended two Audit Chairs briefings organised by NHS England which were useful in ensuring that the CCG was up to date with the latest national developments and have the opportunity to shape policy. The slides from these events are circulated to members of the Audit Committee.
5.0 Reviewing the effectiveness of Committees

5.1 The Audit Committee has the role of undertaking an annual review the effectiveness of the Governing Body’s Committees. One of the ways in which it does this, is by receiving an annual report from each of the committees which set out their attendance, key activities throughout the year, delivery of their terms of reference and the outcome of their self-assessment. The annual reports were presented to the Audit Committee by a representative of each of the committees on the 18 May.

5.2 I am pleased to be able to report that there has been good attendance at each of the committees and would like to acknowledge the commitment of the members and managers in delivering the committee work plans and in discharging their responsibilities as set out in the Terms of Reference. The Annual Governance Statement which forms part of the CCG’s Annual Report 2016/17 provides a useful summary of the work of our committees and the areas that have been identified in terms of development for 2017/18.

6.0 Review of the Audit Committee’s effectiveness

6.1 The Audit Committee keeps under review its own effectiveness and in 2016-17 took a number of actions to amend its terms of reference and streamline the annual work plan. The aim of this has been to reduce duplication and release more time to focus on our role in ensuring the adequacy and effectiveness of the CCG’s policies, systems and processes. This has facilitated a reduction in frequency of the Audit Committee meetings.

6.2 Following a self-assessment of our effectiveness in May, we agreed a number of development actions to improve the way that we worked. These include the development of a systematic programme of induction and training for committee members and their deputies, improving the way that we work with external and internal audit as well as creating the space to have the right quality of debate in committee meetings.

7.0 Recommendations

7.1 It is recommended that the Governing Body RECEIVES the Audit Committee’s Annual Report 2016-17.
Finance and Performance Committee Meeting
held on 27\textsuperscript{th} April 2017; 15:00 – 17:00,
in Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present
Dr Nigel Taylor (NT) Chair, GP Governing Body
Dr Steven Cleasby (SC) GP Governing Body
Neil Smurthwaite (NS) Chief Finance Officer/Deputy Chief Officer
John Mallalieu (JM) Lay Advisor to the Governing Body

In attendance
Penny Woodhead (PW) Head of Quality
Debbie Robinson (DR) Head of Primary Care Quality and Improvement
Martin Pursey (MP) Head of Contracting and Procurement
Dr Alan Brook (AB) GP Governing Body
Lesley Stokey (LS) Head of Finance
Tim Shields (TS) Performance Manager
Robert Gibson (RG) Risk, Health and Safety Manager (for item 7)

Observing
Shabana Bari (SB) Business Intelligence Analyst
Dr Helen Davies (HD) GP Governing Body
Dr Farrukh Javid (FJ) GP Governing Body
Fiona Murray Corporate Services

242/17 APOLOGIES FOR ABSENCE Action
Apologies were received from Matt Walsh, Chief Officer

243/17 DECLARATIONS OF INTEREST

NT invited the Committee members to declare any interests relevant to items on
the agenda. None were declared.

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.

244/17 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE MEETING
HELD ON 30TH MARCH 2017

DECISION:

The minutes of the 30\textsuperscript{th} March 2017 meeting were RECEIVED and ADOPTED as
a correct record, subject to the following amendment(s):
‘Chair’ should read: ‘Chair or vice-Chair’.

**245/17 ACTIONS AND MATTERS ARISING**

**Minute 188/16**

This has been carried forward to Senior Management Team (SMT) Meeting.

**Minute 215/17**

This is to be picked up at the next Cancer Network Meeting, due 25.05.17.

**Minute 216/17**

MP informed the meeting that the Contract Report includes all information available to date, with specific reference to Section 3.2.2 of the Report.

**Minute 217/17**

NS advised that the draft letter was discussed at both SMT and SMT-Recovery as well as at the Integrated Commissioning Executive (ICE) Meeting due 28.04.17. NS advised that the letter, with its initial responses, will be shared at the next Meeting.

The SMT had discussed over-75s funding with Secondary Care as part of Recovery. The meeting was informed that it was to be signed off as part of the financial plan at next Governing Body (GB) Meeting. Action completed.

**Minute 230/17**

DR provided an update on the sign up to the commissioning engagement scheme for 2017/18. DR will update SMT regarding the outcome. Carried forward to SMT meeting.

**Minute 231/17**

NT informed the meeting that the TOR has been updated. Action completed.

**Minute 232/17**

DR advised that this action was now closed.

**Minute 234/17**

NS stated that this should read ‘review’ rather than ‘investigation’. Further to the Assurance Meeting with NHSE, the CCG was awaiting confirmation of available additional support. MP and NS were following this through.

**Minute 237/17**

This action has been completed.
ITEM 3 RECOVERY UPDATE

NS, in presenting the report said that the first Recovery Operational Group (ROGR) meeting was held in April. This group would be reviewing all schemes and all organisational areas were involved. The outcome of recovery discussions were fed into the SMTR meeting.

In discussion, the following was concluded:

- **Early Supported Discharge**: To ensure clarity it was suggested to have a clinical review via CDF where data and finances could be reviewed.
- **Clarity and transparency regarding Stroke costs**: To meet budgets there needed to be clarity on how any efficiency savings would be achieved.
- **Payment By Results (PBR)**: The CCG was keen to move away from this model. Discussions continued around other cost-improvement programmes/income generating schemes.
- **Outcome of Assurance Meeting**: NS provided feedback from the Assurance meeting.

Conversations had taken place at the Transformation Group on those services that were needed combined with what was affordable and workable. There is a need to reduce costs but also to highlight ownership and identify opportunities with all providers. The forum necessary for working out this process was discussed.

**Action**: DG to set up the clinical conversations via CDF

- **ECIB**: Threshold work is underway. The CCG may want to be audited with respect to compliance.
- **Impact on MSK**: new service coming on line with effect from 01.06.17. Using the threshold guidance will reduce the number for referrals to MSK. The team was working with communications colleagues on the documentation and access to templates.
- **Arthroscopy guidelines** and matching the threshold: The Clinical Lead would be reviewing the guidelines. It was noted that the Governing Body would be informed of every decision.
- **Recovery Dashboard**: to be used as a metric when the information is available.

Clarity was given regarding the process being taken forward now as compared to the QIPP process in previous years and about the ways in which the CCG could validate this work. MP felt that the new process supported the transformation work of the teams across Calderdale and Greater Huddersfield. In addition, the establishment of ROGr and SMT-R which reported into the Finance and Performance Committee facilitated open and transparent discussion within the organisation.

**DECISION:**

The Finance & Performance Committee:

a) **APPROVED** the recommendations for the 2 thresholds reviewed at the Recovery Operational Group
b) **ACKNOWLEDGED** proposals for next steps/future monitoring of Recovery

The Finance & Performance Committee agreed to **SUPPORT** the Recommendations and the next steps.
ACTION:

The Recommendations will be brought forward to the Governing Body.

247/17 ITEM 4 PERFORMANCE REPORT

TS highlighted that Calderdale ranked overall as ‘Good’ within the Top 3, as confirmed by the Q4 Assurance Meeting.

- A&E performances were strong in March 2017, with a step change to 97%. Internal work to be undertaken regarding this and the business intelligence, with respect to A&E activity.
- Performance continued to be sustained at 95.5%; stronger in Calderdale than Huddersfield. Further work on ‘drilling down’ into the information is required.
- Waiting times for first definitive cancer treatment: TS reported a in February; below the required standard to achieve of 85%. With respect to breach incurrence there have been difficulties in the data which will be rectified with the new Cancer Locality Group starting 25.05.17

Action: Raise with Helen Wraith regarding clarity, and escalating issues from the Cancer Locality Group.

- TS highlighted that Quarter 4 performance drives eligibility for the Quality Premium; two out of three indices have not been met, representing a risk of ineligibility.
- Discussion held on delays outside of CCG control, e.g. occurring within Bradford locality.

Action: NT, HW and PW to meet to consider where delays were occurring on the cancer pathway and what was outside CHFT’s control.

248/17 ITEM 5: CONTRACTS REPORT

MP highlighted that the Month 11 (M11) position is anomalous; not being a year-end figure. Details are being finalised on the contract regarding overtrading; with full understanding required of what the expected position is. Work is ongoing with respect to the Dashboard. There is an early indication of M12 showing an overtrade. There are no substantial differences observed compared with previous months with continued pressure regarding other acute providers.

There has been little reduction during 2016 on 111 activities and showing a steady increase since then, with Easter influencing numbers. The YAS pilot has been extended to April 24. It was reported that some improvement has been made even though data was not complete.

It was noted that only Calderdale performance data had previously been available; this reported reflected overall performance which the committee found helpful.

249/17 ITEM 6 FINANCE REPORT

LS informed the meeting that 2016/17 is M12. Key messages were:

- CCG is delivering a £5.8M control total, of which £2.7M has already been reported, with £3.1M representing a release of risk reserve.
• CCG has not met its financial plan, and this will impact on eligibility for the Quality Premium
• Financial duties have been met and are summarised on page 1 of the report. Targets have been met; with the exception of delivering on CCG QIPP targets.
• Cost Pressures were still an issue. The position in the paper reflects the annual accounts due for release on 02.05.17.
• Auditors were currently on-site; with the Finance Team working to have all the necessary information available.
• JM thanked all in the CCG for staying on track and setting a good foundation for the next financial year.
• NS noted the discussions on the budget plan for CHFT with a need to deliver an underspend in order to meet targets.
• The Committee extended thanks to the Financial Team for the work undertaken.

250/17 ITEM 7 RISK REGISTER (RG)

RG referred to 26 total risks identified for the CCG; due for Finance Committee consideration of which there were 18 ‘Open’ risks:
• No new risks
• 2 ‘Critical’ risks
• 3 ‘Serious’ Open risks

The committee proposed closing risk 866 (primary care prescribing budget 2016-17) as it was no longer relevant.

JM queried the increased rating for Risk 62, as A&E four-hour waiting times was a constant.

Action: Discuss this risk at SMT during the next risk cycle.

251/17 ITEM 8: REVIEW OF WORK PLAN

NT informed the meeting that work has been carried out to improve clarity on different meeting styles, within the work plan.

252/17 ITEM 9: MATTERS FOR

• Governing Body - Recovery paper.
• SMT - Outcomes for next year and identifying clinical leads.
• LMC – None to report.
• CHFT Partnership Board – JM requested consideration of what can be obtained from these meetings viz. the action points raised by PW.
• Primary Medical Service Committee: NS advised that view is informed from point of primary care.

253/17 ITEM 10: MINUTES FROM A&E DELIVERY BOARD

PW referred to the work carried out in preparation for Easter work, social care and those within the acute sector

254/17 ITEM 11 ANY OTHER BUSINESS

None
DATE AND TIME OF THE NEXT MEETING

The Finance and Performance Committee **NOTED** that the next meeting would take place as follows:

25\textsuperscript{th} May 2017; 15:00 – 17:00 - Shibden Room, Dean Clough
## Finance & Performance Committee Meeting 27th April 2017 – Action Sheet

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/ Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Report</td>
<td>215/17</td>
<td>Action to be picked up at next Cancer Network Meeting</td>
<td>NT/DG</td>
<td>In progress</td>
<td>due 25.05.17</td>
</tr>
<tr>
<td>Financial Plan</td>
<td>217/17</td>
<td>(a) Letter regarding Better Care Fund, with initial responses, will be submitted at the next F&amp;P Meeting</td>
<td>NS</td>
<td>In progress</td>
<td>due 25.05.17</td>
</tr>
<tr>
<td></td>
<td>217/17</td>
<td>(b) Funding – to signed off as part of financial plan at next GB Meeting</td>
<td>NS/LS</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Commissioning Engagement Scheme</td>
<td>230/17</td>
<td>DR to update next SMT meeting regarding outcome of sign-up to Scheme by practices</td>
<td>DR</td>
<td>Carried forward to SMT</td>
<td></td>
</tr>
<tr>
<td>Recovery Update</td>
<td>246/17</td>
<td>(a) DG to set up CDF for clinical review</td>
<td>DG/NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>247/17</td>
<td>(b) Recovery Recommendations to be brought forward to Governing Body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Update</td>
<td>247/17</td>
<td>(a) Seek clarity about breaches and escalating issues from the Cancer Locality Group</td>
<td>PW/HW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>247/17</td>
<td>(b) Meet to consider where delays were occurring on the cancer pathway and what was outside CHFT’s control</td>
<td>NT/PW/HW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Register</td>
<td>250/17</td>
<td>Discuss risk 62 at SMT during the next risk cycle</td>
<td>LS</td>
<td></td>
<td>Carried forward to SMT</td>
</tr>
</tbody>
</table>
Finance and Performance Committee Meeting  
held on 25th May 2017; 15:00 – 17:00,  
Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present:  
Dr Nigel Taylor (NT)  
Matt Walsh (MW)  
Dr Steven Cleasby (SC)  
Neil Smurthwaite (NS)  
GP Member Governing Body and Meeting Chair  
Chief Officer  
GP Member Governing Body  
Chief Finance Officer/Deputy Chief Officer

In attendance:  
Penny Woodhead (PW)  
Lesley Stokey (LS)  
Tim Shields (TS)  
Robert Lees (RL)  
Rhona Radley (RR)  
Fiona Murray (FM)  
Head of Quality  
Head of Finance  
Performance Manager  
Contracting Manager  
For Item 4  
Corporate Services – minute taking

Observing:  
Dr Helen Davies (HD)  
Dr Farrukh Javid (FJ)  
Matthew Bleach (SB)  
GP Governing Body  
GP Governing Body  
Business Intelligence Analyst

Apologies:  
Alan Brook  
Debbie Graham  
John Mallalieu  
Martin Pursey  
Debbie Robinson  
Kate Smyth  
CCG Chair  
Head of Service Improvement  
Lay Advisor to the Governing Body  
Head of Contracting and Procurement  
Head of Primary Care Quality and Improvement  
Lay Member (PPI)

256/17 APOLOGIES

Apologies noted as shown above

NT informed attendees that the meeting was inquorate as due to unforeseen circumstances the Lay Member (PPI) was deputise for the Lay Advisor. Whilst the meeting was able to proceed, it would be unable to approve the minutes of the previous meeting or take other formal decisions. Caution must be used with regards to receiving assurance on any agenda items and on forwarding of any recommendations to the Governing Body.

257/17 DECLARATIONS OF INTEREST

NT invited the Committee members to declare any interests relevant to items on the agenda.

- SC and NT declared conflicts of interest with respect to two service reviews listed for discussion: Over 75s and Diabetes.
- MW noted conflicts of interest also for the two other GPs observing the meeting (FJ and HD).

NT declared an interest on behalf of the GPs regarding a proposal for cessation of Local Enhanced Services, It was AGREED that as no decisions or recommendations were being made
about the above items, the conflicts be noted and the GPs would be able to remain in the room, with the GP committee members being able to take full part in the discussion.

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.

### 258/17 MINUTES OF THE LAST MEETING AND MATTERS ARISING

Approval of the minutes of the previous meeting would be deferred to the next formal meeting of the committee.

### 259/17 ACTIONS FROM THE MEETING

The action log was updated from the discussions held in the meeting which resulted in all actions being completed except:

215/17 NT reported that the Cancer Network meeting received assurance from Calderdale and Huddersfield Foundation Trust (CHFT) on issues arising from breaches of the two week and 62 day performance targets. No further breaches had been noted in the subsequent month. The new Cancer Network Meeting would enable Matt Kaye and NT to review each breach prior to discussing them in the Cancer Network Meeting. Any issues from the Cancer Network Committee would be escalated to the Quality Board for the necessary action to be taken and to the CCG’s Quality Committee to identify any assurance required on the current breaches.

**Action:** Review the way in which the cancer breach risk, controls and assurances are expressed on the CCG’s risk register and where the Cancer Network minutes should be received by the CCG.

MW

217/17(a) Better Care Fund (BCF).

MW advised that five actions were agreed at the meeting held on the 25 May; Review the Terms of Reference of ICE including strategic objectives and delegated responsibilities, agree a set of metrics and review existing BCF schemes against the agreed metrics, develop a joint strategy on reablement and on reducing delayed discharges.

**Action:** A formal update on the BCF would be brought to the next F&P meeting.

MW

230/17 Commissioning Engagement Scheme – *carried forward*

MW

246/17(b) Recovery Recommendations - due for next Governing Body Meeting. *Carried forward*

MW

250/17 Risk register - Consider the decline in A&E performance is having an impact on patient safety and experience and how this might be reflected in the risk register. *Carried forward.*

MW

### 260/17 RECOVERY GROUP REPORT MONTH 12

NS presented the report which covered 2016-17 and detail on QIPP assumptions for 2017-18 (section 3). Areas highlighted were:
‘Right Care’, the capacity review being undertaken by commissioning managers in Manchester; CSU and CHC QIPP. It was reported that the final report following National Exercise carried out by Price Waterhouse and Cooper (PWC) and NECS had been considered at SMTR. The three areas highlighted nationally (MSK, Procedures of Limited Clinical Value (PLCV) and Continuing Health Care (CHC)) were being examined in detail by the CCG as part of the QIPP programme. No new information had transpired from the national work undertaken. The CCG was awaiting further interpretation of the analysis undertaken by PWC on MSK and PLCV.

MSK: A £200K opportunity had been identified by PWC; this was noted to be significantly less than the Right Care opportunity, with work already in progress. PWC had not clarified the £5.6M opportunity identified, which appeared to equate to expenditure: NS was now awaiting data to clarify this, in order for the ROGR and SMT meetings to identify further areas of focus.

CHC: PW had held discussions with NHSE regarding additional support to assist with a CCG review of policies and processes, including the fast track processes. A diagnostic was also being carried out with Ardon and GEM CSU. National highlights indicated significantly higher spend on CHC as compared to CCG peers. This would help the CCG to understand the reason for the spend and whether it was appropriate.

Stage 2 of the national review processes: The CCG was submitting a bid with GH/NK against the fund for additional national support. A new benchmarking tool has been developed nationally which helps analyse CCG contract plans compared with how the CCG allocation is calculated as well as with CCG Right Care Comparators. This would help identify areas where expenditure may be being inappropriately targeted. The bid includes a request for additional capacity to carry out an analysis of the information in the toolkit and to identify opportunities for more shared working/working at scale.

An Internal Audit review of QIPP provided significant assurance on governance and the programme office approach being taken in Calderdale.

Members discussed the merits of the national benchmarking tools to identify local opportunities particularly regarding thresholds. Discussions were being taken forward with NHSE on this, including work being undertaken by LS on nursing home costs.

NHSE had shared guidelines on the ‘capped expenditure approach’. Good conversations had been held with the Transformation and Partnerships groups on how the system would bridge the financial gap. It was noted that the CHFT Board had committed to meeting with the Calderdale and Greater Huddersfield Governing Bodies in early July to discuss the need to deliver a balanced financial position and sustainable clinical model.

It was agreed that the F&P Committee would need to understand the high level assumptions being made in the full business case; the assurance available from the CCG’s finance team that the assumptions were reasonable and have an understanding of the affordability of the model. This would enable the F&P Committee and the Governing Body to satisfy themselves whether the three tests had been met:

- Is this the model we have consulted on
- Is this model affordable to us as commissioners
- Is this affordable to us as a system.
A further discussion was held on the financial situation, the need to have a system in financial balance and the need to demonstrate that plans were in place to address the system deficit.

**Action:** Provide the F&P Committee with a summary of the work being carried out to test financial assumptions.  

LS/NS

The dashboard (2017/18) was now in progress;

**Action:** LS and DG to present the Recovery Dashboard at the next F&P recovery meeting.  

LS/DG

An update on other areas of QIPP focus including CHC and medicines management would be provided at the next F&P meeting.

**Over 75s Scheme**

The Over 75s scheme had been discussed at SMT-R with a recommendation that it be extended to July; however at SMT-R there was an acceptance that there might be a delay in designing a replacement scheme. The original recommendation from ROGR was for any savings from the new scheme would contribute towards QIPP; however SMT-R had proposed that any savings would be invested in primary care but should be used to achieve some high level objectives that would contribute to the recovery process assessed some high level metrics.

The recommendation from SMT-R was to continue funding primary care at full level with a view to explore place-based commissioning to support the delayed discharge agenda.

*The recommendation from SMT was ENDORSED by the committee members.*

**Level 4 Diabetes Service Review**

The recommendation from ROGR was that the CCG to use the potential for this service when financial position improves. This recommendation was supported by SMT and the clinical lead (SC). It would be revisited in 2017/18. LS said that the next steps of the report included communication with practices.

*Outcome:* The members of the committee AGREED that there was no decision to be taken.

**261/17 PERFORMANCE REPORT**

TS reported that the overall position remained good. The following points were made:

- Improvement had been seen in the published position on 62-day cancer waiting times. There had been a decline in performance since May for the two-week waits, in part due to EPR implementation and capacity issues. Appointment issues were now believed to be resolved, however capacity issues remain ongoing.
- A&E: the position had deteriorated in May with EPR felt to be responsible.
Action: MW would circulate correspondence with Helen Barker to committee members.

- **Diagnostic waiting times**: There was a decline in performance in March. Underperformance was forecast to continue for April and May. Due to an increase in referrals for MRI and non-obstetric ultrasounds and the increasing complexity of MRI procedures. This was said to be compounded by workforce constraints. CHFT had agreed an improvement plan with NHS Improvement; with the expectation that the position would improve by June.

PW highlighted discussions within Quality Committee on the Cancer waits and A&E and the possible implications for patient safety and would be seeking further reassurance about actions being taken and whether further feedback needed to be sought about the implications in particular of EPR as well as the CCGs response to this. NT reported on a discussion held between the LMC and CHFT about the issues being experience with the implementation to EPR.

### 262/17 CONTRACTS REPORT

**Wheelchairs**

RR presented an update on the Posture Mobility Contract (wheelchairs) and briefed committee members on emerging risks in the Op Care contract with some options explored and the assurance process that had been undertaken earlier in the year.

**Action:** This item to be put on the SMT agendas for the three CCGs. RR

**RR left the meeting at 16:30**

**Contracting report (section presented by RL)**

CHFT indicates £7.7m overtrade which represents an increase from £7.1m, following adjustment.

ASI Performance had declined and was felt to be due to staffing issues in areas such as Ophthalmology, rather than EPR.

There was an overtrade position in most areas with the exception of Elective. RL has requested further information from CHFT about data received with no procedure details.

*Referring to Appendix 1* Some services have shifted away from Bradford within Dermatology, Plastics and non-contracted activity. The ENT service has returned to BMI and CHFT from Spire.

LTHT figures showed an overtrade of £172K; a substantial proportion of which was critical care. NHS 111, West Yorkshire Urgent Care and Walk In Centre reported activity was lower than comparable period for last year due to an early Easter in 2016.

The annual plan values for 2017-18 were discussed. Demand planning began in September which would affect some of the assumptions. NS advised that it was too early for a forecast position.
FINANCE REPORT

LS provided a summary of the current financial position and the work being carried out in relation to budgets and the QIPP schemes being developed to close the anticipated gap. There were significant challenges to ensure that sufficient QIPP schemes were developed and that they met their targets.

The key message was that there remained a £3.5m QIPP gap plus an undertrade against the CHFT contract of £2.7m that needed to be achieved.

Members discussed the financial challenge, trading position and contract form. It was considered that the gap would close through the recovery process but the ability to deliver against the schemes and the trading position were key factors. More detail would be reported at future meetings.

Delegated primary care budgets

A more detailed paper was due to be considered by the CPMSC on the 1st June. Committee members were asked to note the delegated budget of £28.6m which included an £800k uplift (3%) on last year. The paper indicates how the budget has been aligned. The CCG needs to contribute towards 0.5% contingency and 0.5% risk reserve from delegated budgets. The paper being submitted to CPMSC would show the underspend against the 2016/17 budget. LS will further report on delegated budgets in future F&P meetings.

Work Plan

The following actions were agreed:

- Remove the KPMG Governance Review – work completed.
- Improvement Assessment Framework requires formal response from Q4 meeting and would not be available for the next F&P business meeting.
- Commissioning Engagement Scheme is for September review of 17/18 with sign-off in 2018/19.
- Confirm whether a review of the Dispute Resolution Policy by the F&P Committee was still required.
- Remove the External Medicines Management Re-procurement - completed.
- Confirm whether the Tier 3 Weight Management: Review was still required.
- The Records Management and Freedom of Information Policies were not due for review in 2017/18.

KEY MESSAGES

- SMT - Wheelchair Service
- LMC - Over 75s – no change to investment profile therefore only to note that Service Improvement will prepare the project for submission to Quality Board and the Governing Body
- CHFT Partnership Board: The slot issues and A&E performance on cancer are two issues to be escalated; however these may also need to go to CHFT contract and Quality Board.
MINUTES FROM A&E DELIVERY BOARD

The minutes were received. Members discussed the information being presented on the slide packs/dashboard at the A&E Delivery Board.

Action: Next F&P Committee to consider key themes being discussed at the A&E Delivery Board as well as intelligence from other system boards and committees including quality.

ANY OTHER BUSINESS

None identified

DATE AND TIME OF THE NEXT MEETING

29th June 2017; 15:00 – 17:00 - Shibden Room, Dean Clough
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Engagement Scheme – practice signup</td>
<td>230/17</td>
<td>Update next SMT meeting regarding outcome of sign-up to Scheme by practices, further to closing date of 31/05/17</td>
<td>DR</td>
<td>Carried forward to SMT</td>
<td>Complete</td>
</tr>
<tr>
<td>Recovery Update</td>
<td>246/17(b)</td>
<td>Recovery Recommendations to be brought forward to Governing Body</td>
<td>All</td>
<td>Carried forward</td>
<td></td>
</tr>
<tr>
<td>Risk Register</td>
<td>250/17</td>
<td>Consider the decline in A&amp;E performance is having an impact on patient safety and experience and how this might be reflected in the risk register.</td>
<td>PW/DG</td>
<td>Due next risk cycle</td>
<td></td>
</tr>
<tr>
<td>Cancer Network Meeting governance</td>
<td>259/17 (a)</td>
<td>Review the way in which the cancer breach risks, controls and assurances are expressed on the CCG’s risk register and where the Cancer Network minutes should be received by the CCG.</td>
<td>MW</td>
<td>Due next risk cycle</td>
<td></td>
</tr>
<tr>
<td>Financial Plan and BCF</td>
<td>259/17(b)</td>
<td>A formal update on the BCF to be brought to the next F&amp;P meeting</td>
<td>MW</td>
<td>Due 29 June</td>
<td></td>
</tr>
<tr>
<td>Recovery report – full business case</td>
<td>260/17 (a)</td>
<td>Provide the F&amp;P Committee with a summary of the work being carried out to test financial assumptions.</td>
<td>NS/LS</td>
<td>Underway</td>
<td>Due 29 June</td>
</tr>
<tr>
<td></td>
<td>260/17(b)</td>
<td>Bring the Recovery Dashboard 2017-18 to next F&amp;P recovery meeting</td>
<td>LS/DG</td>
<td>Underway</td>
<td></td>
</tr>
<tr>
<td>Performance report – A&amp;E</td>
<td>261/17</td>
<td>Correspondence with Helen Barker to be with shared with members of F&amp;P Committee</td>
<td>MW</td>
<td>Underway</td>
<td></td>
</tr>
<tr>
<td>Contract report – Wheelchairs</td>
<td>262/17</td>
<td>Item to be put on the SMT agenda at the three CCGs</td>
<td>RR</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Work plan</td>
<td>264/17</td>
<td>Work plan to be amended</td>
<td>ZA/NT</td>
<td>Underway</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Delivery Board minutes</td>
<td>266/17</td>
<td>Next F&amp;P Committee to consider key themes being discussed at the A&amp;E Delivery Board as well as intelligence from other system boards and committees including quality.</td>
<td>NS/TS</td>
<td>Underway</td>
<td></td>
</tr>
</tbody>
</table>
Minutes of the Finance and Performance Meeting
held on 29 June 2017, 3pm,
in Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present
Dr Nigel Taylor (NT) GP Member Governing Body and Meeting Chair
Matt Walsh (MW) Chief Officer
Dr Steven Cleasby (SC) GP Member Governing Body
Neil Smurthwaite (NS) Chief Finance Officer/Deputy Chief Officer
John Mallalieu (JM) Lay Member to the Governing Body

In attendance:
Lesley Stokey (LS) Head of Finance
Tim Shields (TS) Performance Manager
Martin Pursey (RL) Head of Contracting and Procurement
Zoe Akesson (ZA) Corporate Services – minute taking

Observing:
Dr Helen Davies (HD) GP Governing Body
Dr Farrukh Javid (FJ) GP Governing Body
Alan Brook (AB) CCG Chair
Judith Clarke (JC) Contracting Manager

269/17 APOLOGIES FOR ABSENCE

Apologies were received from Penny Woodhead (PW) (Head of Quality Calderdale CCG), Debbie Graham (DG) (Head of Service Improvement Calderdale CCG), and Debbie Robinson (DR) (Head of Primary Care Quality and Improvement Calderdale CCG).

270/17 DECLARATIONS OF INTEREST

NT invited the Committee members to declare any interests relevant to items on the agenda.

NT declared a declaration of interest on behalf of the GPs interest in agenda item 3, minute no. 275/17 – Recovery Report, the review of the 75 and over Holistic Health Check and Polypharmacy review and the review of the Level 4 Diabetes Service. This was because the GPs and the decision being proposed could have an impact on general practice.

NT advised that the declarations of interest were noted and it was recognised that the mitigations against these were recorded within the papers of the meeting and as such NT proposed that the GPs would take part in the whole item.

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.

271/17 MINUTES OF THE FINANCE AND PERFORMANCE MEETING 24/04/17

DECISION:

The minutes of the 24 April 2017 meeting were RECEIVED and ADOPTED as a
272/17  MINUTES OF THE FINANCE AND PERFORMANCE MEETING 25/05/17

DECISION:

The minutes of the 25 May 2017 meeting were RECEIVED and ADOPTED as a correct record, subject to the following amendment(s):

Action Log

Title should read 25 May 2017

273/17  ACTIONS AND MATTERS ARISING

The action log was reviewed and updated from the discussions held in the meeting, which resulted in all actions being completed except:

246/17(b) Recovery Recommendations - due for next Governing Body Meeting. To be carried forward.

250/17 Risk Register – to consider the decline in A&E performance is having an impact on patient safety and experience and how this might be reflected in the risk register. To remain on the action log, due next risk cycle.

259/17(a) Cancer Network meeting governance – to review the way in which the cancer breach risks, controls and assurances are expressed on the CCG’s risk register and where the Cancer Network minutes should be received by the CCG. To remain on action log, due next risk cycle.

259/17(b) Financial plan and business plan - MW provided a verbal update on the Better Care Fund (BCF).

Central guidance, issued on improved BCF, was received by the CCG. Following a challenging conversation with the Local Authority (LA), both organisations agreed the need to review the Terms of Reference of the arrangements of BCF and Integrated Commissioning Executive (ICE) boards that operate between the CCG and the LA. The main area of conversation was the delayed discharge position in Calderdale, which is deteriorating month on month in contrast to the position in Kirklees, thought to be due to delays attributed to social care.

The LA has agreed to do piece of work in partnership with the CCG. Any existing schemes under BCF would be reviewed for their effectiveness against revised metrics.

Initial discussions took place at BCF on 29/06/17 around setting up a task and finish group to look at the impact on the system and the BCF’s financial principles will be discussed at the next BCF meeting on 08/07/17.

It was pointed out that there is clear guidance around additional monies and how the money is to be spent i.e. on additional capacity. In light of this, the CCG will be required to sign off a plan that clearly demonstrates additional capacity going into the system. The Committee agreed to approach Scrutiny for their help to support this process.
ACTION:

a) To circulate BCF update paper, which was tabled at Health and Wellbeing Board 15 June 2017.

274/17 FINANCE REPORT

The paper was noted by the Committee. LS highlighted the key messages.

The CCG planned to deliver an in year deficit of £3.14m (cumulative £2.7m surplus) however there was an unmitigated £2.4m risk in achieving this. The organisation met their statutory duty for 2016/2017 but still awaited guidance from NHS England around the statutory duty for 2017/2018. Attention was drawn to the Committee about the importance of helping the CCG deliver the statutory duty for this year.

The QIPP target was £11.5m allocating £9.5m, leaving a gap of £2.4m risk. The Recovery Operational Group (ROGr) is currently working on identifying additional schemes.

The major risk around increased activity at Calderdale and Huddersfield NHS Foundation Trust (CHFT) was raised. QIPP had been taken from the CHFT budget line with an expectation for CHFT to underspend however there was a small overspend in month1. It was highlighted that if this continued it would result in a significant risk.

NS shared the ‘National Guidance on Failure’ with the Committee.

In discussion, the following was concluded:

• The Recovery Operational Group (ROGr) would be more ambitious in developing and making its recommendations and the committee wants to see more explicit clinical leadership in bringing recommendations through the organisations governance.
• The committee agreed that the organisation’s approach to Board:Board:Board should be to focus upon system financial balance and the need to develop a culture whereby the system collaborates to deliver care within the financial envelope available.
• The Committee does not accept unmitigated risk and the Senior Management Team was asked to ensure that a plan for mitigation was developed and presented to the next meeting of the committee.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.

ACTION:

a) To develop a management plan to address the £2.4m unmitigated risk

275/17 RECOVERY REPORT

Recovery Plan update for 2017/18

NS updated the Committee on Community Healthcare (CHC) and Medicines Management.

CHC - benchmarking information showed the CCG to have a significantly higher
spend than other areas/peers. LS was preparing a report on thresholds which would be tabled at SMTR then Finance and Performance Committee.

Medicines Management – Right Care data would be used to review the level of prescribing demand in primary care. The current spending was significantly higher than what the CCG was funded for making us an outlier on a number of areas. In light of this, the CCG was working up additional medicine management schemes. The Committee agreed to take back to ROGr how the organisation could target specific areas and or particular practices.

**Over 75s Scheme**

The recommendation from SMT was to develop a service change to redirect BCF funding to support care for a wider population at risk due to frailty, taking into account the risks and mitigating actions identified.

**The recommendation was ENDORSED by the Committee.**

**Level 4 Diabetes Service Review**

The recommendation from ROGr (option 2) was for the CCG to use the potential for this service when financial position improves.

**The recommendation was RECOGNISED by the Committee.**

**Cancer Laryngectomy Society Review**

The recommendation from SMTr (option 2) was that the CCG decommissions the whole contract/service as currently commissioned, taking into account the risks and mitigating actions identified.

**The recommendation was RECOGNISED by the Committee however approval by the Committee is subject to a conversation happening with the charity.**

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

The Committee ENDORSED the over 75s scheme recommendation to develop a service change to redirect BCF funding to support care for a wider population at risk due to frailty, taking into account the risks and mitigating actions identified.

The Committee RECOGNISED the L4 Diabetes service review recommendation from ROGr (option 2) for the CCG to use the potential for this service when financial position improves.

The Committee RECOGNISED the Cancer Laryngectomy Society review recommendation however approval by the Committee is subject to a conversation happening with the charity.

The Committee AGREED to take back to ROGr how the organisation could target specific areas/practices in relation to medicines management.

**ACTION:**

a) To add prescribing to the next practice leads meeting agenda

ZA/DR
b) To review existing schemes, look at set budgets, saving targets and incentive schemes

276/17 PERFORMANCE REPORT

The paper was noted by the committee. TS in presenting the report said the overall position remained good however there were 3 exceptions to note;

A & E Performance; a decline was reported in May and June, possibly due to the introduction of EPR and the impact it had on internal processes within A & E and throughout the hospital. Equally there were ongoing challenges with DTOC still impacting on patient flow.

Diagnostic Waiting Times; April’s performance was linked with the increase in demand for non-obstetric ultrasound scans possibly due to EPR but equally capacity issues were mentioned. Improvement plan was put in place and shared with NHS Improvement. Early indications for May are suggesting the trajectory is not on track.

Cancer Waiting Times; breached 62 day standard for access to treatment. Initial review showed the reason being the majority of beaches to be for patients needing transfer to tertiary providers breaching to 38 days post which was a high percentage. A new clinically led process was introduced. All cases are being reviewed in the Cancer Network meeting which will then report into the Quality Board.

The Committee questioned the small number of cancer patients (40) referred for treatment. TS agreed to check for any special causes.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.

ACTIONS:

a) To review A & E data and bring back findings to next meeting

b) To check trend of patients referred for cancer treatment and bring back findings to next meeting.

277/17 CONTRACTING REPORT

The report was received by the meeting. MP asked for the report to be taken for information rather than detail.

The exception report provided a detailed update on the CHFT contract, acute bed sector including narrative around month1 caveats, end of year report - non contract activity (NCA) for 2016/17 and breakdown of elective/ non-elective, standard reporting with regards to procurement activity contracts nearing expiry date and procurement risks.

QUEST
NT asked how QUEST and its delivery would be reviewed going into next year. Previously data prior to QUEST was used to make the comparison but now it is being compared to the years when QUEST has been in place. MP agreed to look into this and include the findings in his report at the next meeting.

Following on from this, MP explained how the QUEST contracts would be rolled on and a waiver would be produced. Terms, when the service was originally set up, would be checked to see if they are still working. There is a piece of ongoing work looking at reframing and setting refreshed outcomes, which would be monitored on a regular basis.

NT pointed out that SpaMedica’s activity had gone up possibly due to cataract operations. MP explained to the Committee, this is due to a system issue whereby it allows referrals into the system which the organisation has not directly commissioned. MP agreed to provide a full update at the next meeting.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**ACTION:**

a) To clarify how QUEST and its delivery will be reviewed in the future. MP

b) To provide an update on SpaMedica’s activity at July’s meeting. MP

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**278/17 WORK PLAN**

The work plan was reviewed and refreshed.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**ACTION:**

No further action required

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**279/17 RCRTRP**

Jen Mulcahy joined the meeting.

RCRTRP slides were presented at the Board:Board:Board meeting held on 28 June 2017 to which the Governing Body members were invited. Following discussion, JM who was not present at the meeting was happy for the slides to be sent to him to view. Any questions to be directed to NS.

**DECISION:**

The Committee AGREED there was not a need for the slides to be shown again at this meeting. The committee was ASSURED around the detail of conversation that happened at the Board:Board:Board meeting.

**ACTION:**

To send presentations slides to JM. Jen Mulcahy

Jen Mulcahy left the meeting.
KEY MESSAGES

Matters for the Governing Body
- Developing a management plan to address the £2.4m unmitigated risk
- Approvals granted and affirmed:
  - Over 75s scheme
  - Level 4 Diabetes Service Review
  - Cancer Laryngectomy
- IG arrangements for retaining recordings of F & P meetings

Matters for SMT
- Manage process around plan to address the £2.4m unmitigated risk
- Risk Cycle – Cancer

Matters for CHFT Partnership Board
- Board:Board:Board items

Matters for LMC
- Over 75s scheme
- Medicine Management conversation
- Diabetes

DECISION:
The Committee AGREED the referrals to the above meetings.

ACTION:
To inform the relevant admin support of F & P referrals to the above meetings.

MINUTES FROM THE A & E DELIVERY BOARD 09/05/17
The minutes were received by the meeting. MW highlighted the graph around delayed discharges (page 5, item 6), which demonstrates the social care trend line, which was the focus at the HWB.

The key themes from the meeting were discussed;
- Care homes
- Deconditioning
- Workforce and agency spend
- Weekend effect
- Plus responding to the national mandated areas

MW confirmed he would continue to drive conversations on these 5 areas.

ANY OTHER BUSINESS

Finance and Performance Meeting Recordings
MW invited the Committee for their views on retaining recordings of the F & P meetings in order to evidence the whole conversation. The minutes would give a high level sense of conversation and decisions but the recording would be available to refer to if required. A conversation is required with Judith Salter around IG timelines for keeping recordings.

DECISION:
With appropriate IG advice, the Committee has **DECIDED** to retain the recordings of these meetings. There will be a set of minutes produced that give a high level sense of the decisions that were made.

**ACTION:**

To check the IG rules around the length of time a recording can be retained.  

**Annual Leave for Committee Members**

A number of apologies were received for July’s meeting, including those of the Chair and Deputy Chair. It was agreed that NS (Deputy Chief Officer) supported by AB (CCG Chair) would chair July’s meeting. Discussion took place around establishing a process to ensure future meetings are quorate.

**DECISION:**

The Committee **AGREED** that on an extraordinary basis it would support NS to Chair July’s meeting.

**ACTION:**

To seek advice outside the meeting around appropriate chairing arrangements.

**DATE AND TIME OF THE NEXT MEETING**

The Finance and Performance Committee **NOTED** that the next meeting would take place as follows:

Finance and Performance Committee Meeting  
27 July 2017, 3.00 – 5.00pm  
Shibden Room, Dean Clough
# Finance and Performance Committee Meeting 29 June 2017 – Action Sheet

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Update</td>
<td>246/17(b)</td>
<td>Recovery Recommendations to be brought forward to Governing Body</td>
<td>All</td>
<td>Not yet due</td>
<td></td>
</tr>
<tr>
<td>Risk Register</td>
<td>250/17</td>
<td>Consider the decline in A&amp;E performance is having an impact on patient safety and experience and how this might be reflected in the risk register.</td>
<td>PW/DG</td>
<td>Due next Risk cycle</td>
<td></td>
</tr>
<tr>
<td>Cancer Network Meeting governance</td>
<td>259/17 (a)</td>
<td>Review the way in which the cancer breach risks, controls and assurances are expressed on the CCG’s risk register and where the Cancer Network minutes should be received by the CCG.</td>
<td>MW</td>
<td>Due next risk cycle</td>
<td></td>
</tr>
<tr>
<td>Recovery report – full business case</td>
<td>260/17 (a)</td>
<td>Provide the F&amp;P Committee with a summary of the work being carried out to test financial assumptions.</td>
<td>NS/LS</td>
<td>In progress</td>
<td>Completed 29/06/17</td>
</tr>
<tr>
<td></td>
<td>260/17(b)</td>
<td>Bring the Recovery Dashboard 2017-18 to next F&amp;P recovery meeting.</td>
<td>LS/DG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matters Arising</td>
<td>273/17</td>
<td>To circulate BCF update paper, tabled at Health and Wellbeing Board, 15 June 2017.</td>
<td>MW</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td>Finance Report</td>
<td>274/17</td>
<td>To develop a management plan to address the £2.4m unmitigated risk.</td>
<td>SMT</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td>Recovery Report</td>
<td>275/17</td>
<td>a) To add prescribing to the next practice leads meeting agenda</td>
<td>DR/ZA</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) To review existing schemes, look at set budgets on prescribing, saving targets and incentive schemes.</td>
<td>LS/HD</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) To seek assurance that a conversation has happened with the Cancer Laryngectomy Society.</td>
<td>NT</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td>Category</td>
<td>Report No</td>
<td>Task</td>
<td>Responsible</td>
<td>Status</td>
<td>Date</td>
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</tr>
<tr>
<td>Performance Report</td>
<td>276/17</td>
<td>a) To review A &amp; E data and bring back findings to next meeting.</td>
<td>TS</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) To check trend of patients referred for cancer treatment and bring back findings to next meeting.</td>
<td>TS</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td>277/17</td>
<td>a) To clarify how QUEST and its delivery will be reviewed in the future.</td>
<td>MP</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) To provide an update on SpaMedica activity at next meeting.</td>
<td>MP</td>
<td>In progress</td>
<td>27/07/17</td>
</tr>
<tr>
<td>RCRTRP</td>
<td>279/17</td>
<td>To send presentation slides to JM.</td>
<td>Jen Mulcahy</td>
<td>In progress</td>
<td>03/07/17</td>
</tr>
<tr>
<td>Key Messages</td>
<td>280/17</td>
<td>To inform the relevant admin support of F &amp; P items for referral to GB, SMT, LMC and CHFT Partnership Board.</td>
<td>ZA</td>
<td>In progress</td>
<td>03/07/17</td>
</tr>
<tr>
<td>AOB</td>
<td>282/17</td>
<td>a) To check the IG rules around the length of time a recording can be retained.</td>
<td>ZA</td>
<td>In progress</td>
<td>03/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) To seek advice on chairing arrangements.</td>
<td>NT</td>
<td>In progress</td>
<td>03/07/17</td>
</tr>
</tbody>
</table>
Minutes of the QUALITY COMMITTEE Meeting
held on 25 May 2017, 12:30pm
in Shibden Room at Calderdale CCG

FINAL MINUTES

Present
Dr Majid Azeb MA GP Governing Body Member, Chair
Emma Bownas EB Senior Quality Manager
Debbie Graham DG Head of Service Improvement
Gill Jones GJ Primary Care Quality and Improvement Manager
Kate Smyth KS PPI Governing Body Lay Member
(present for items 1, 2, 3, 4, 5, 7 and 8 only)
Dr Caroline Taylor CT GP Governing Body Member
Caron Walker CW Public Health Consultant, Calderdale Council
Penny Woodhead PW Head of Quality

In attendance
Jen Mulcahy JM Programme manager for Right Care, Right Time, Right place, Calderdale CCG (for item 4, min no. 287/17)
Sarah Antemes SA Head of Commissioning – Continuing Care, Calderdale CCG (for item 6, min no. 289/17)
Clare Wyke CWy Quality Improvement Lead – Patient Experience, Calderdale CCG (for item 8, min no. 291/17)
Helen Foster HF Medicines Management Lead, Calderdale CCG (for item 10, min no. 293/17)
Dr Nigel Taylor NT GP Governing Body member, Calderdale CCG (for item 10, min no. 293/17)
Shabana Bari SB Business Intelligence Analyst, Calderdale CCG (observing as part of induction to new role)
Dr Helen Davies HD GP Governing Body Member (observing as part of induction to new role, present for items 6, 9 and 10 only)
Georgina King GK Job Aide to Kate Smyth
(present for items 1, 2, 3, 4, 5, 7 and 8 only)
Dr Farruqh Javid FJ GP Governing Body Member (observing as part of induction to new role, present for items 6, 9 and 10 only)
Alison Waters AW Project Support Officer, Quality – Minute taker

283/17 APOLOGIES FOR ABSENCE

Action

Apologies were received from Louise Burrows (Quality Manager, Calderdale CCG), Debbie Robinson (Head of Primary Care Quality and Improvement, Calderdale CCG), Rhona Radley (Service Improvement Manager, Calderdale CCG) and Clare Smith (Infection Prevention and Control, Calderdale Council).

284/17 DECLARATIONS OF INTEREST

MA invited the Committee members to declare any interests relevant to items on the agenda.

MA and CT declared a direct professional interest in agenda item 7 – Primary Care Dashboard. This was because their GP practices were mentioned directly in the report.

MA advised that the item was for assurance and not decision; that the practices
had already been written to informing them of their position and had been
advised to review and discuss the data; and that it was not a material interest;
and as such he/she proposed that he and CT would take part in the whole item.

**DECISION:**

Agenda item 7; MA and CT to take part in the whole item.

The Register of Interests can be obtained from the CCG’s website
www.calderdaleccg.nhs.uk or from the CCG’s headquarters.

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**285/17 MINUTES OF THE Quality Committee meeting held on 27 April 2017**

Members of the Committee reviewed the minutes of the previous meeting and
agreed them as a correct record.

**DECISION:**

The minutes of the Quality Committee meeting were **RECEIVED** and **ADOPTED**
as a correct record.

**286/17 ACTIONS AND MATTERS ARISING**

The Action Log attached to the minutes of the meeting held on 27th April 2017
had been updated following the meeting. Members noted that all actions had
been completed.

**287/17 RIGHT CARE, RIGHT TIME, RIGHT PLACE UPDATE AND QUALITY IMPACT
ASSESSMENT REFRESH**

JM in presenting the report said that there were two parts to the paper: the first
part set out the proposed arrangements for the assurance of the Public Travel
Analysis; Quality and Safety Case for Change and Quality Impact Assessment.
JM explained that the Governing Body would be making a decision on the CHFT
Full Business Case at their July 2017 meeting, considering it in terms of whether
it supported the model that was consulted on, was affordable and improved the
financial sustainability of the system. She stated that the Governing Body would
rely on the assurance from its subordinate committees to help inform this
decision. The Quality committee will therefore receive the refresh of: the Public
Travel Analysis; the Benefits and Outcomes; and the Quality Impact
Assessment, at its June 2017 meeting for review and sign off.

The second part of the report recommended that a Quality and Safety Assurance
Panel should be established to ensure that the impact of the planned service line
changes was fully understood and would not compromise patient safety or
service quality. The purpose of the report was to gain approval for these two
proposals.

Comments and questions were invited. In discussion, the following was
concluded:

- The Quality and Safety Assurance Panel would look at the detail of the
  proposed changes and make quality and safety recommendations by service
  line.
- The focus of the Quality and Safety Assurance Panel would be on stage 2
  schemes.
- The Quality and Safety Assurance Panel model had been used by other
  Trusts successfully and had been advocated as part of the provider’s Cost
Improvement Programme process
- That the provider will be expecting the process to be managed in this way
- That the proposals were a sensible, proven way to manage the quality aspects of the Right Care, Right Time, Right Place programme.

DECISION:

The Committee AGREED the assurance arrangements for the Public Travel Analysis; Quality and Safety Case for Change and Quality Impact assessment and AGREED that a Quality and Safety Assurance Panel should be established.

288/17 QUALITY AND SAFETY REPORT AND DASHBOARD

The aim of the report was to provide assurance to the Committee on CCG and provider performance against quality and safety performance indicators, and to provide assurance on specific areas of quality and safety work.

EB in presenting the report highlighted the section on provider quality accounts, explaining that the CCG had received draft quality accounts from each of the main providers and had sent a stakeholder response back to them. The quality accounts would be publically available after 30th June 2017. She next explained that each CCG had been set a stretching target to reduce the number of E.coli infections as part of the CCG quality premium. The CCG was working with the Calderdale Council infection prevention and control team on how best to do this, and also with other CCGs. PW stated that the CCG would need to work with primary care providers as well to see how they could contribute to reducing the number of infections. EB added that the target was challenging and the initial aim for the CCG was to reduce the numbers of infections and introduce some processes to support this, within the available resources. CT and PW discussed how the Healthcare Associated Infections group would consider which actions could be undertaken which were specific to E.coli, and add these to infection prevention and control improvement plans.

EB presented the quality and safety dashboard to the Committee, highlighting areas of enhanced surveillance for each provider. In discussing Calderdale and Huddersfield NHS Foundation Trust (CHFT), EB highlighted the high level of qualified nurse vacancies. PW explained that she had requested a full staffing report to come to the CHFT Clinical Quality Board. The Committee agreed that they had some concerns around the impact of IR35 rules on staffing levels.

The Committee also wished for further assurance from the Trust on two week waits and on the impact of the implementation of the electronic patient record (EPR) system. DG added that the CCG’s Chief Officer had escalated concerns about these to the A&E Delivery Board. She stated that there was a need to ask primary care clinicians to report all incidences of issues caused by the implementation of the EPR.

DG explained that the A&E Delivery Board had discussed CQUINS in more detail and also wished to increase their monitoring of quality aspects of A&E provision. To this end, the Board would receive a quarterly update on CQUINS and any other relevant quality information from the Quality Manager.

In discussion, the following was concluded:
- Future updates on E.coli infection rates would be received by the Committee via the quality and safety report and / or the quarterly infection prevention and control report.
- Assurance was needed on the implementation of the electronic patient...
record system and its impact on patient safety and quality
- Assurance was needed on the process for dealing with two week wait breaches.

DECISION:

The Committee RECEIVED and NOTED the report and were ASSURED on the quality and safety work being undertaken by the CCG. The Committee REQUESTED further assurance on particular areas of provider work.

ACTION:

1) DG to arrange for a communication to primary care clinicians, asking them to report all incidents relating to the implementation of the electronic patient record system  
2) PW to raise the impact of the Electronic Patient Record system implementation at the CHFT Clinical Quality Board  
3) The Committee to receive an update on incidents resulting from the EPR at a future meeting.

289/17 TRANSFORMING CARE UPDATE

SA in presenting the report said that the report provided an update on the work of the transforming care programme across Calderdale, Kirklees, Wakefield and Barnsley. The report included a programme highlight which included key objectives, milestones and progress made. The report was brought to the Committee to provide them with assurance on the progress being made in transforming care for people with learning disabilities across Calderdale, Kirklees, Wakefield and Barnsley.

DG left the meeting at this point (1:47pm).

SA also briefly explained the progress made in provision for Calderdale residents with learning disabilities currently in hospital beds. She added that processes were far more robust now as the Care and Treatment Review process was embedded for people in hospital and people at risk of hospital admission. However, further work was required to embed it for people earlier in the process.

KS and GK left the meeting at this point (1:50pm).

Members learned that the transforming care programme plan was on trajectory currently and that there were no big risks to flag to the Committee. SA highlighted following problems with recruiting clinicians, that a Senior Advanced Medical Practitioner had been recruited who would work across the patch.

In discussion, the following was concluded:
- The transforming care programme was on track in Calderdale, Kirklees, Wakefield and Barnsley
- There were no significant risks of concern
- The Committee was assured about the progress made and planned.

DECISION:

The Committee RECEIVED and NOTED the report and were ASSURED on the progress made.
GJ in presenting the report said that the quarter 4 data in the report showed no change in the high level indicators compared to quarter 3. She added that the data for outliers was from 2014-15, and that the team was hoping to receive more up to date data in July 2017. Members also noted that the data used to inform the measures in the dashboard were all updated at different times, so it made it very hard to get an overall picture of a practice at a moment in time.

GJ stated that Medicines Management colleagues had contacted the practices which were outliers in Ezetimibe prescribing, asking them to review the patients which had been prescribed this drug.

Comments and questions were invited. MA asked about what a review entailed and GJ explained that a review of a practice by the primary care quality and improvement team involved considering which indicators were classed as outliers, and understanding what was behind them, when the data was from, and talking to the practice about them. If concerns were highlighted during the review, the Quality Committee would be updated. MA added that the Care Quality Commission (CQC) have all the practice data when the visit a practice to inspect it.

MA declared an interest at this point, as his practice had recently been reviewed by the CQC and was waiting for the report to be sent to them.

PW explained that the CQC were changing the methodology that they used and that the inspections were driven by data and any local concerns which had been flagged.

PW asked what was done about Friends and Family Test reporting breaches and GJ stated that NHS England sends the practice a letter about the breach, and the CCG is informed of this. Martin Pursey flags any breaches in the contract report. The CCG team also contacts the practice to remind them of their obligation to report and the deadlines and discusses any issues.

CW and PW raised the issue of where information could be shared, for example to be included in the Calderdale Joint Strategic Needs Assessment, and the Committee agreed that it would be helpful for the council to access this information.

In discussion, the following was concluded:

- The data from the NHS web tool used to inform the dashboard was useful information, but should not be used as a starting point for identifying concerns, as other data and soft intelligence was often more up to date.
- The local council could use the data to help inform the Joint Strategic Needs Assessment.
- The Committee were assured that the review process conducted by the Primary Care Quality and Improvement team was sufficient to identify and deal with any concerns.

**DECISION:**

The Committee **RECEIVED** and **NOTED** the report.
findings of the NHS National Staff Survey undertaken in 2016. The report also included responses from the CCG's main providers (Calderdale and Huddersfield NHS Foundation Trust (CHFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and Yorkshire Ambulance Service (YAS)) to the results of the survey and the actions they were taking. The report was being brought to the Committee for assurance that staff experience was being monitored and acted upon.

Comments and questions were invited. CW highlighted that CHFT had a statistically significant positive change in the percentage of staff who had attended work when they were not well. Members asked about this and CW stated that the Patient Experience Group would find out more at their next meeting, and identify the learning that could be taken from it. EB added that the SWYPFT staff survey results had been discussed at the last SWYPFT Clinical Quality Board. Members of the Quality Board had been pleased that improvement actions undertaken by SWYPFT following the 2015 staff survey results had resulted in improvements in the 2016 staff survey results, i.e. the actions had been effective in improving staff experience. The learning from this would also be identified at the Patient Experience Group.

MA asked about indicator KF2 for CHFT ‘staff satisfaction with the quality of work and care they were able to deliver’. The result from this indicator was below average. MA asked which survey questions had contributed to this indicator and CW explained that she would need to look at the survey data in more detail. PW added that the results correlated with the Friends and Family Test staff satisfaction results. EB added that data in the CCG’s quality and safety dashboard showed different results. CW suggested that this could be due to the dashboard using more up to date data than the national staff survey report. PW commented that it would be interesting to see which areas CHFT chose to focus on when the staff survey report came to the CHFT Clinical Quality Board.

In discussion, the following was concluded:
- Results were generally positive
- The Committee felt assured about the results and the actions being taken in response to them.

DECISION:

The Committee RECEIVED and NOTED the report and were ASSURED that staff experience was being monitored and acted upon by the CCG’s main providers.

292/17 REVIEW OF QUALITY COMMITTEE WORKPLAN 2017-18

The Committee reviewed the work plan for 2017-18 and agreed the following amendment:

1) That the quarterly Equality and Diversity update would come to the next meeting in June 2017.

DECISION:

The Committee RECEIVED and NOTED the workplan and AGREED an amendment, as described above.
ACTION:

1) AW to update the workplan.

293/17  MEDICINES OPTIMISATION SERVICE SPECIFICATION

The meeting was not quorate for this item as the Lay Member was not present. Therefore no decision could be made. The Chair sought advice from the Corporate Governance Manager and proposed that the Committee discuss the paper; record the salient points; brief an alternative lay member outside the meeting as no Lay Member was available to attend the meeting; and make a decision at that point. The Committee members agreed to proceed in this way.

HF and NT in presenting the report said that they had brought the updated draft service specification for the existing external medicines optimisation service to the Quality Committee for review and approval as the existing contract ended on 31st October 2017. HF explained that the Key Performance Indicators in the original service specification had been changed in November 2016, as part of the annual contract review, and that since then a number of very minor amendments had been made. There were no changes to how the service would run in the new draft service specification.

Comments and questions were invited. MA clarified that the Committee was being asked to quality assure the service specification. PW asked if all the relevant heads of service had given positive assurance that they were happy with the specification. HF assured the Committee that they had and that no concerns had been raised.

In discussion, the following was concluded:
- There were no significant changes to the service specification
- The Committee were assured about the quality of the service specification
- The Committee members present were happy to approve the service specification, subject to the lay member’s approval.

Members agreed that HF could present the service specification and the points made in the discussion to an alternative lay member. MA stated that he could be contacted if the lay member wished to discuss the issues further.

DECISION:

The Committee was not able to make a decision on the service specification as it was not quorate.

ACTION:

1) HF to present the draft specification and the Committee’s discussions and conclusions to the lay member for decision.

Post meeting note: following consultation with the Corporate Governance Manager it was agreed to approve the service specification in principle and ratify the decision at the next Quality Committee meeting on 29th June 2017.

294/17  MINUTES TO RECEIVE

DECISION:

The Committee RECEIVED and NOTED:
- South West Yorkshire Partnership NHS Foundation Trust Clinical Quality
**ANY OTHER BUSINESS**

None raised.

**MATTERS TO REFER TO THE GOVERNING BODY OR PRIMARY MEDICAL SERVICES COMMITTEE**

The Committee agreed the following referrals:

- Governing Body - an update on care homes to the private section of the meeting
- Primary Medical Services Committee - the Primary Care dashboard.

**DECISION:**

The Committee **AGREED** referrals to Governing Body and Primary Medical Services Committee.

**DATE AND TIME OF THE NEXT MEETING:**

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

**Quality Committee Meeting**
29 June 2017, 12:30pm to 2:30pm
Shibden room, Calderdale CCG
## Quality Committee Meeting 25 May 2017 – Action Sheet

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
</tr>
</thead>
</table>
| Quality and Safety Report and Dashboard          | 288/17     | a) DG to arrange for a communication to primary care clinicians, asking them to report all incidents relating to the implementation of the electronic patient record system  
          |             | b) PW to raise the impact of the Electronic Patient Record system implementation at the CHFT Clinical Quality Board  
          |             | c) The Committee to receive an update on incidents resulting from the EPR at a future meeting.                                                                                                               | DG   | Completed      | Notified of completion on 26-6-17  
          |             |                                                                         | PW   | Completed      | Raised at CHFT CQB meeting on 6/6/17.  
          |             |                                                                         | PW   | Not yet due    | Incident report going to CHFT CQB meeting on 12/7/17.  
          |             |                                                                         |      |                | QC will receive update at 27/7/17 meeting. |
| Review of Quality Committee Workplan 2017-18     | 292/17     | a) AW to update the workplan.                                                                                                                                  | AW   | Completed      | 29-5-2017               |
| Medicines Optimisation Service Specification     | 293/17     | a) HF to present the draft specification and the Committee’s discussions and conclusions to the lay member for decision.                                                                                       | HF   | Completed      | 26-5-2017               |
Minutes of the QUALITY COMMITTEE Meeting
held on 29 June 2017, 12:30pm
In Shibden Room at Calderdale CCG

FINAL MINUTES

<table>
<thead>
<tr>
<th>Present</th>
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<tbody>
<tr>
<td>Dr Majid Azeb</td>
<td>MA</td>
<td>GP Governing Body Member, Chair</td>
</tr>
<tr>
<td>Louise Burrows</td>
<td>LB</td>
<td>Quality Manager</td>
</tr>
<tr>
<td>Debbie Graham</td>
<td>DG</td>
<td>Head of Service Improvement</td>
</tr>
<tr>
<td>Ben Leaman</td>
<td>BL</td>
<td>Public Health Consultant, Calderdale Council</td>
</tr>
<tr>
<td>(representing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caron Walker)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhona Radley</td>
<td>RR</td>
<td>Senior Service Improvement Manager</td>
</tr>
<tr>
<td>Debbie Robinson</td>
<td>DR</td>
<td>Head of Primary Care Quality and Improvement</td>
</tr>
<tr>
<td>Kate Smyth</td>
<td>KS</td>
<td>PPI Governing Body Lay Member</td>
</tr>
<tr>
<td>Dr Caroline Taylor</td>
<td>CT</td>
<td>GP Governing Body Member</td>
</tr>
<tr>
<td>Penny Woodhead</td>
<td>PW</td>
<td>Head of Quality</td>
</tr>
<tr>
<td>Helen Davis</td>
<td>HD</td>
<td>GP Governing Body Member</td>
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<table>
<thead>
<tr>
<th>In attendance</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Bottomley</td>
<td>AB</td>
<td>Programme Manager, Calderdale CCG, (for item 5, min no. 303/17)</td>
</tr>
<tr>
<td>Dr Nigel Taylor</td>
<td>NT</td>
<td>GP Governing Body member, Calderdale CCG (for item 4, min no. 302/17)</td>
</tr>
<tr>
<td>Jen Mulcahy</td>
<td>JM</td>
<td>Programme Manager for Right Care, Right Time, Right place, Calderdale CCG (for item 6, min no. 304/17)</td>
</tr>
<tr>
<td>Clare Wyke</td>
<td>CWy</td>
<td>Quality Improvement Lead – Patient Experience, Calderdale CCG (for item 8, min no. 306/17)</td>
</tr>
<tr>
<td>Janet Smart</td>
<td>JS</td>
<td>Complaints Manager, Calderdale CCG (for item 9, min no. 307/17)</td>
</tr>
<tr>
<td>Stella Johnson</td>
<td>SJ</td>
<td>Research Manager, West Yorkshire Research and Development (for item 10, min no. 308/17)</td>
</tr>
<tr>
<td>Georgina King</td>
<td>GK</td>
<td>Job Aide to Kate Smyth</td>
</tr>
<tr>
<td>Alison Waters</td>
<td>AW</td>
<td>Project Support Officer, Quality – Minute taker</td>
</tr>
</tbody>
</table>

298/17 APOLOGIES FOR ABSENCE

Apologies were received from Caron Walker (CWa) (Public Health Consultant, Calderdale Council) and Debbie Graham (DG) (Head of Service Improvement, Calderdale CCG).

299/17 DECLARATIONS OF INTEREST

MA invited the Committee members to declare any interests relevant to items on the agenda.

MA and CT declared an indirect financial interest in agenda item 4, minute no. 302/17 - ‘Improved Access in Primary Care Service Specification’. This was because the pilot would be commissioned from Pennine GP Alliance and MA and CT may be from member practices that will form part of the pilot and therefore funding my flow to those practices. Also MA and CT have the ability to influence content of the specification in their favour; however this was only marginal, as the main content of the specification is mandated by NHS England.
MA advised that GPs should be in the meeting as they brought expertise and valuable input and MA had been the clinical lead on the work so would provide additional expertise and input. Also, the main content of the specification was mandated by NHS England and part of the GP Five Year View, which required improved access to primary medical services. The decision being made today did not relate to funding. The Governing Body had approved the overall funding in a meeting in public and had managed the conflicts of interest at this point (see minutes of the Governing Body meeting held on 10 April 2017). As such MA proposed that he and CT would take part in the discussion but would not take part in the decision.

**DECISION:**

Agenda item 4; minute no. 302/17; MA and CT to take part in the discussion but would not take part in the decision.

The Register of Interests can be obtained from the CCG’s website or from the CCG’s headquarters.

The Register of Interests can be obtained from the CCG’s website www.calderdaleccg.nhs.uk or from the CCG’s headquarters.

**300/17 MINUTES OF THE Quality Committee meeting held on 25 May 2017**

MA noted that the Corporate and Governance Manager had approved the wording of item 293/17 relating to the discussion on the Medicines Optimisation Service Specification.

Members of the Committee reviewed the minutes of the previous meeting and agreed them as a correct record.

**DECISION:**

The minutes of the Quality Committee meeting were RECEIVED and ADOPTED as a correct record.

*Post meeting note: The numbering of the 25 May 2017 minutes was updated after the meeting to continue with the numbering of the previous minutes. The Corporate and Governance Manager is reviewing how minutes are numbered across the CCG and a consistent process across all meetings will be agreed and introduced later in the year.*

**301/17 ACTIONS AND MATTERS ARISING**

The Action Log attached to the minutes of the meeting held on 25th May 2017 had been updated following the meeting. Members noted that all actions had been completed.

**288/17a Quality and Safety Report and Dashboard**

DG to arrange for a communication to primary care clinicians, asking them to report all incidents relating to the implementation of the electronic patient record system.

Update – AW confirmed on behalf of DG that this action had been completed. Close action.
The Committee to receive an update on incidents resulting from the EPR at a future meeting. Update – PW explained that she would receive a detailed update from Calderdale and Huddersfield NHS Foundation Trust on 12 July 2017 and would provide this Committee with further details at the next meeting.

Matters Arising

1) Ratification of the decision to approve the draft Medicines Optimisation service specification at the meeting held on 25 May 2017

The Committee AGREED to ratify the decision and APPROVE the draft Medicines Optimisation service specification.

2) Electronic Patient Record implementation

PW confirmed that the implementation of the Electronic Patient Record (EPR) had been discussed at the last Calderdale and Huddersfield NHS Foundation Trust (CHFT) Clinical Quality Board meeting on 6 June 2017. She added that a more detailed updated would be provided to the next CHFT Clinical Quality Board meeting on 12 July 2017.

302/17 IMPROVED ACCESS IN PRIMARY CARE SERVICE SPECIFICATION

KS chaired the meeting for this item as MA and CT had declared indirect financial interests in this item (see minute 299/17 for details).

DR presented the draft service specification for improved access in primary care to the Committee for approval. In presenting the report, she said that the main content of the service specification was from NHS England, and that the CCG was mandated to introduce extended GP services by April 2018.

DR explained that equality information would be collected in the pilot phase to support the development of a full Equality Impact Assessment for further rollout of the service. A Quality Impact Assessment would also be developed during the pilot phase.

KS commented that the section on engagement was good and it was clear what issues were being addressed by the new service. MA stated that further to the discussions on the draft specification that he had been involved in earlier in June, it was important to make aims such as ‘Reduce unplanned admissions’ realistic and attach Key Performance Indicators (KPIs) to them so they could be measured and recorded, and the impact of the new provision assessed.

PW asked if the 60% population coverage of the scheme was a nationally mandated level and DR responded that it was what the CCG could afford. The funding for the scheme would double in 2019-20 and the aim was for the coverage to be 100% then. PS asked whether 60% coverage was acceptable to NHS England and DR explained that the draft scheme had been submitted to NHS England in December 2016 and no comments had been received back about the coverage. BL asked about how the 60% coverage was chosen, and whether health inequalities were being considered. DR explained that the aim was to focus on practices with the most patient dissatisfaction in terms of access. However, the IT systems required that the pilot scheme be implemented in areas where practices used the same IT system.
The Committee then discussed the amount of extra capacity that the CCG had been requested to commission by NHS England (30 minutes extra per 1000 population) and asked how this number had been arrived at. No information or evidence for this calculation had been made available to CCGs by NHS England. CT felt that this was an achievable amount for practices and DR commented that this amount had been used in previous schemes such as Directed Enhanced Services (DES).

Members discussed the definition of an ‘appropriate professional’ providing the extra capacity (section 3.2 of the service specification, bullet point 8) and the Committee agreed that ‘as a minimum’ should be removed and the definition should state ‘including a GP’.

PW asked about how learning would be identified and shared as part of the pilot scheme. DR explained that the specification included a section on sharing information with the CCG and West Yorkshire Urgent Care to identify and share learning to feed into the integrated urgent care model which was being developed. PW asked that the specification include more detail about how the CCG would identify and manage the learning. MA added that the integrated urgent care model service specification would be agreed in March 2018, so learning would be needed in December 2017. The Committee suggested that the specification should be amended to include an audit being carried out in December 2017 to find the learning from the pilot.

The Committee discussed how the impact of the scheme would be assessed and DR explained that the next national patient experience of primary care survey would take place in July 2018, and this would show the impact. Members agreed that A&E attendance would not be a good indicator of impact as a number of schemes could affect this, so it would be impossible to attribute a reduction in attendance to any particular scheme.

At this point MA and CT pushed their chairs back and did not take part in the discussion.

DECISION:
The Committee APPROVED the service specification subject to updating bullet point 8 in section 3.2 of the service specification from ‘Provide access to a range of appropriate professionals including, as a minimum GP’s.’ to ‘Provide access to a range of appropriate professionals including a GP.’

ACTIONS:

a) DR to update bullet point eight in section 3.2 of the service specification from ‘Provide access to a range of appropriate professionals including, as a minimum GP’s.’ to ‘Provide access to a range of appropriate professionals including a GP.’

b) DR to consider adding appropriate KPIs and an audit to identify learning to the service specification.

MA and CT re-joined the meeting at the end of this item.

303/17 IMPROVING OUTCOMES IN ELECTIVE CARE – NEW THRESHOLDS

AB and NT presented the report to the Committee for approval. The report explained that the CCG had been identified by the Commissioning for Value packs as an outlier for particular areas of care, particularly musculo-skeletal. Activity had been reviewed and thresholds for care for certain conditions had
been developed, including for hallux valgus, with the aim of improving outcomes for patients. The report set out criteria for clinicians referring patients with hallux valgus to secondary care and included a requirement for patients to have been seen, assessed and treated by podiatry services and conservative measures having been trialled for 12 weeks and failed.

AB explained that the ‘management of adult hallux valgus’ paper had been reviewed by the Commissioning Development Forum (CDF) the previous week and a number of amendments had been made, including adding the sentence ‘These criteria will be vigorously observed unless a patient can demonstrate genuine exceptionality, in which case an individual funding request must be followed.’; changes to patient outcomes; and removing references to patient satisfaction.

The Committee supported the changes requested by the CDF and approved the thresholds for hallux valgus. The Committee also agreed that the statement ‘These criteria will be vigorously observed unless a patient can demonstrate genuine exceptionality, in which case an individual funding request must be followed.’ could be added retrospectively to the approved thresholds for treatment for carpal tunnel, dupuytrens contracture, spinal injections, tonsillitis, grommets, and acupuncture.

DECISION:

The Committee APPROVED the thresholds for the management of adult hallux valgus. The Committee also AGREED that the statement ‘These criteria will be vigorously observed unless a patient can demonstrate genuine exceptionality, in which case an individual funding request must be followed.’ could be added retrospectively to the approved thresholds for treatment for carpal tunnel, dupuytrens contracture, spinal injections, tonsillitis, grommets, and acupuncture.

304/17 RIGHT CARE, RIGHT TIME, RIGHT PLACE – QUALITY IMPACT ASSESSMENT AND HOSPITAL STANDARDS

JM presented the refreshed Quality and Safety Case for Change and the refreshed Quality Impact Assessment (QIA) for the Right Care, Right Time, Right Place programme to the Committee for approval, and provided an update on the travel and transport analysis. She explained that the Quality and Safety Case for change had been refreshed since it had been presented to the Governing Body in January 2017, including updates on paediatrics, standards for children and young people’s emergency care, the five year view for maternity, the changing performance of Calderdale and Huddersfield NHS Foundation Trust (CHFT), and the quality and safety, workforce and performance challenges.

PW requested that further information be included about the workforce challenges facing the Trust, including the spend on agency staff; the agency cap target; and the vacancies in specialities. She added that quality was variable at the Trust, with some metrics improving and others worsening over the past two years, and that the need for quality improvement work remained.

JM next explained that the Quality Impact Assessment had been refreshed by CHFT and converted to the CCG format, which would make it easier to check. PW added that the QIA was a high level document but that each programme of service change would have its own QIA and the Quality and Safety Assurance Panel would consider individual service changes and the detail of these, including how risks would be mitigated, metrics for tracking impacts and outcomes etc. The Assurance Panel process would be tested at Greater Huddersfield CCG on the rehabilitation update paper that the GHCCG Quality
and Safety Committee had received at their meeting on 28 June 2017.

Members discussed the travel and transport update and KS said that the travel group she had attended earlier in the month had been positive. MA asked if JM was aware that the council was conducting an opinion survey on people’s views of the new road layout, and asked how the Travel and Transport Working Group would receive the survey results. JM stated that she had not been informed about the survey and that she would ask her highways and councillor colleagues on the group about it.

**DECISION:**

The Committee **APPROVED** the refreshed Quality and Safety Case for Change and the refreshed Quality Impact Assessment and **RECEIVED** the update on the public travel analysis.

**ACTION:**

a) JM to add further detail to the workforce challenges section of the Quality and Safety Case for Change, then send it to PW and MA for approval.

b) JM to ask highways and councillor colleagues on the Travel and Transport Group about the council’s public opinion survey of the new road layout.

**305/17 QUALITY AND SAFETY REPORT AND DASHBOARD**

The aim of the report was to provide assurance to the Committee on CCG and provider performance against quality and safety performance indicators, and to provide assurance on specific areas of quality and safety work.

LB in presenting the report and dashboard highlighted the section on Freedom To Speak Up (FTSU) Guardians. She explained that the FTSU guardians were required for hospital trusts following the Francis review into failings at Mid-Staffordshire. South West Yorkshire Partnership Foundation Trust (SWYPFT) had six FTSU guardians and Calderdale and Huddersfield NHS Foundation Trust (CHFT) had one. Conversations were ongoing at to what the guardians would be doing and LB agreed to chase CHFT for more details on the role of their guardian and provide an update at the next meeting.

LB also highlighted the section on the Learning Disabilities Mortality Review Programme (LeDeR) update, explaining that this was potentially a huge new area of work for the CCG. Members noted that the process for conducting reviews had been delegated to CCGs from 1 April 2017 by NHS England and that formal handover for Calderdale and Kirklees took place on 12 June 2017. As at 21 June 2017, there had been 14 deaths notified across Calderdale and Kirklees. Work on the reviews was underway. PW commented that some learning had already been identified from the reviews and it was important to continue to identify lessons. She added that there were not enough reviewers in the CCG.

BL highlighted the difference between adults and children and the challenges involved in doing reviews on children with learning disabilities who had died, e.g. due to the length of time taken to conduct a Child Death Overview Panel.

MA asked if the A&E Delivery Board included primary care information in their dashboard. DR stated that she was waiting to hear the details and would update the Committee next month.
DECISION:
The Committee RECEIVED and NOTED the report and were ASSURED on the quality and safety work being undertaken by the CCG.

ACTION:

a) LB to contact CHFT about their Freedom to Speak up Guardian and get more details about the role etc. 

b) DR to find out whether A&E Delivery Board include primary care information in their dashboard and update the Committee next month.

306/17 PATIENT EXPERIENCE UPDATE QUARTER 1 2017-18

CWy presented the patient experience update for quarter 1 2017-18 to the Committee for assurance. The report included information on the implementation of patient stories across Calderdale, Greater Huddersfield and North Kirklees CCGs; the Patient Experience Group including providers; the Complaints and PALS Professional Network; patient experience improvement projects such as posture and mobility services patient engagement and experience work; and national patient surveys.

PW asked about the Patient Experience Group and highlighted the importance of acting on the experience information that is shared. CWy commented that the group had good representation from Calderdale, Greater Huddersfield, North Kirklees and Wakefield CCGs and from the four main provider organisations. Feedback from the meeting was positive with all parties agreeing that the conversation was helpful for them. She added that when providers were invited to attend, they were also invited to bring relevant colleagues with them to talk about particular areas of healthcare in more detail. The group was moving strongly towards working on patient experience improvement projects.

DECISION:
The Committee RECEIVED and were ASSURED by the update provided.

307/17 COMPLAINTS ANNUAL REPORT 2016-17

JS presented the Complaints Annual Report 2016-17 to the Committee for assurance. In presenting the report she said that the CCG had directly received 132 enquiries, concerns and complaints throughout the year. Of these, 32 were level 3 or 4 complaints, requiring a written response. JS stated that one of the figures in section 7.4 was incorrect and that she would send the correct version of the report to AW for the record. In explaining the action taken and learning from complaints section of the report, JS noted that some of the actions and learning was described in a general manner to prevent cases from being identifiable. JS also highlighted to the Committee that a new complaints group of complaints manager from Calderdale, Kirklees and Wakefield would meet quarterly to share good practice, ensure a consistent approach across the area and share learning with each other. The six-monthly complaints updates received by the Committee would include updates on this group.

KS asked if complaints were equality monitored and JS confirmed that they were, and that all equality monitoring was handled by the CCG’s specialist equality team.

MA asked if patient complaints regarding GP practices were included in the statistics in the report as most were directed to the practice or to NHS England.
JS explained that if the patient complained to the CCG about the GP practice, then that was included in the numbers in the report. But if a patient complained directly to the practice or to NHS England then it was not. DR added that her team was working on getting complaints information from GP practices.

Members next discussed what information they wished to refer to the Governing Body and agreed that it was important to highlight the number of complaints received by the CCG about providers, and that the CCG was assured that providers handled the complaints appropriately. PW and JS agreed to discuss the Governing Body referral in more detail outside the meeting.

PW requested that future reports include details of how the CCG is assured on how providers handle complaints, for example assurance that all GP practices submit information on complaints as they are required to. LB would support JS in collating this information.

**DECISION:**

The Committee **RECEIVED** and were **ASSURED** by the Complaints Annual Report for 2016-17.

**ACTION:**

a) JS to send AW updated report with correct figure at section 7.3.  
   b) PW and JS to discuss what information should be referred to Governing Body outside of the Committee meeting. 
   c) LB and JS to discuss assurance on provider complaints handling for future complaints reports.

**308/17 RESEARCH UPDATE**

SJ provided the Committee with the Research Annual report for 2016-17 to assure them that the CCG was fulfilling its statutory requirements relating to research. The report included information on research development; research governance and management; research engagement and knowledge transfer.

In presenting the report SJ highlighted that it had been a busy year, particularly for research development. National metrics for research were being exceeded and the team had been involved with the development of over 35 research studies totally over £20 million; were part of successfully securing over £12 million of funding. Members noted that over the past year, 65% of GP practices had recruited patients to research studies, compared with 19% the previous year; and 223 patients had taken part in research projects over the past year, compared to 82 the year before.

The Committee learned that the service had supported knowledge transfer by conducting a very successful workshop on cancer and palliative care. It had been very well attended and clinicians were able to feed back on their findings. The local knowledge gained from the research would contribute to the Sustainability and Transformation Partnership (STP).

In considering particular studies, members were pleased to note that the Campaign to Reduce Opioid Prescribing (CROP) study had hoped to achieve a plateau in the prescribing of opioids for non-cancer patients, but had actually achieved a reduction of 3% across the study area, with a reduction of 1% in Calderdale, which was very positive. MA asked if this saving had been captured in the QIPP scheme and SJ commented that the head of the research and development team had met with the CCG’s medicines management lead the
previous day about other drugs, so may have discussed it.

PW praised the research and development function for the service they provided to the CCG, and acknowledged the GP alliance’s role in encouraging practices to get involved in research.

HD asked how much influence the CCG has on the types of research done and SJ explained that much of it was national and funded nationally, but if the CCG had particular topics it wished to address, the team could arrange meetings with the appropriate academics to discuss it further. PW added that the research and development team look at each CCG’s strategic priorities and try to match them with relevant studies.

PW stated that the report highlights would be included in the next Quality and Safety report to Governing Body.

**DECISION:**

The Committee RECEIVED and were ASSURED by the research Annual Report for 2016-17.

**309/17 EQUALITY AND DIVERSITY QUARTERLY UPDATE REPORT**

PW presented the quarterly update report to the Committee for assurance. The report briefly explained that progress continued against the CCG’s two equality objectives, and that the Equality Delivery System (EDS2) was completed in quarter 4 2016-17. A full report on the EDS2 delivery with recommendations for the future would be provided to the next meeting of the Committee. PW commented that this would help the organisation to set future quality objectives.

**DECISION:**

The Committee RECEIVED and were ASSURED by the equality and diversity quarterly update.

**310/17 INFECTION PREVENTION AND CONTROL ANNUAL REPORT FOR 2016-17 AND HCAI IMPROVEMENT PLAN FOR 2017-18**

This item was discussed as the first main item of the meeting after the Actions and Matters Arising.

BL and CS in presenting the report said that due to capacity issues the report was a quarterly update, rather than the Annual Report for 2016-17. They added that the Annual Report would be brought to the July meeting of the Committee. Members also learned that the Health Care Associated Infection (HCAI) Improvement Plan for 2017-18 was currently in draft form (again due to capacity issues) and would also be brought to the July meeting of the Committee.

The quarterly update report was brought to the Committee for assurance and included information on cases of Clostridium difficile (Codify) infection; Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia; Methicillin susceptible Staphylococcus aureus (MSSA) bacteraemia; E.coli infections; and Norovirus across Yorkshire and the Humber.

CS first updated the Committee on outbreaks of infection in Calderdale, explaining that there had been five outbreaks of gastroenteritis in the last quarter. The electronic system for sharing results from the laboratory in Leeds was still not working and the infection prevention and control team had found it
Members then learned that there had been two new cases of MRSA in the community and arbitration was needed to decide which organisation one of the cases would be attributed to. A third party was thought to be the source of the infection. CS stated that there had been seven cases of C.diff in both April and May 2017. CT added that she worked in a community setting where it was suspected that for two cases of C.diff, the patients had contracted the infection in hospital, but it had only been identified once the patients were in the community. BL, CT and LB agreed to discuss this outside of the meeting. CS next explained that NHS England had introduced new targets for E.coli infection numbers and that these would be addressed in the HCAI Improvement Plan for 2017-18.

PW raised the issue of the avian and pandemic flu management plan. She explained that NHS England had requested local health systems to devise plans together, and this was in progress, but had currently stopped with Calderdale and Huddersfield NHS Foundation Trust. The NHS England deadline for submitting the plan had passed, and liaison with the Trust was needed to get a plan agreed. The Committee requested that Caron Walker provide an update to the next meeting.

PW raised the issue of information governance at Calderdale Council and stated that CW had written to her to explain that the council could not upload infection information to the national database by the required deadline. PW had written back and asked why the issue had not been raised before. PW did not know the scope of the issue. CS updated the Committee, explaining that there had been progress and the toolkit had been uploaded and a provisional score given.

In discussion, the following was concluded:

- Low infection prevention and control staff capacity was a risk for Calderdale and for the wider area. A conversation was needed with NHS England on workforce planning, their actions, opportunities etc.
- Laboratory issues in Leeds were a concern. The Committee agreed that BL would get an update from CWa on her conversations with the lab; and that CWa and PW would discuss where to escalate this issue to.

DECISION:

The Committee RECEIVED and were ASSURED by the infection prevention and control work undertaken.

ACTIONS:

- a) BL, CT and LB to discuss two cases of C.diff infection in the community which may have started on a hospital ward
- b) CWa to provide an update to the July meeting on the agreement of a local health system plan for avian and pandemic flu management
- c) CWa and PW to discuss escalation of Leeds laboratory results sharing software issues.

CS left at the conclusion of this item (12:53pm).
REVIEW OF QUALITY COMMITTEE WORK PLAN 2017-18

The Committee reviewed the work plan for 2017-18 and agreed the following amendments:

1) Add Recovery – Care Education Treatment Reviews to the work plan for July 2017.
2) Add Community Rehabilitation Pathway to the work plan for July 2017.

DECISION:

The Committee RECEIVED and NOTED the work plan and AGREED amendments, as described above.

ACTION:

a) AW to update the work plan.

MINUTES TO RECEIVE

The Committee RECEIVED and NOTED:

a) Medicines Advisory Group minutes of 16 March 2017
b) Patient and Public Engagement Group minutes of 13 March 2017
c) Cancer Network DRAFT minutes of 25 May 2017 (PW confirmed that these minutes were received in draft form due to the timing of the meetings.)

ANY OTHER BUSINESS

None rose.

MATTERS TO REFER TO THE GOVERNING BODY OR PRIMARY MEDICAL SERVICES COMMITTEE

The Committee agreed the following referrals:
- Governing Body – research update, complaints update.
- Primary Medical Services Committee – no referrals.

DECISION:

The Committee AGREED referrals to Governing Body.

DATE AND TIME OF THE NEXT MEETING:

The Committee NOTED that the next meeting would take place as follows:

Quality Committee Meeting
27 July 2017, 12:30pm to 2:30pm
Shibden room, Calderdale CCG
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
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<tbody>
<tr>
<td>Quality and Safety Report and Dashboard</td>
<td>288/17</td>
<td>c) The Committee to receive an update on incidents resulting from the EPR at a future meeting.</td>
<td>PW</td>
<td>In progress</td>
<td>Incident report going to CHFT CQB meeting on 12/7/17. QC will receive report at August meeting.</td>
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<tr>
<td>Improved Access in Primary Care Service Specification</td>
<td>302/17</td>
<td>a) DR to update bullet point eight in section 3.2 of the service specification from ‘Provide access to a range of appropriate professionals including, as a minimum GP’s.’ to ‘Provide access to a range of appropriate professionals including a GP.’ b) DR to consider adding appropriate KPIs and an audit to identify learning to the service specification.</td>
<td>DR</td>
<td>Complete</td>
<td>July 2017</td>
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<td>Right Care, Right Time, Right Place Quality Impact Assessment and Hospital Standards</td>
<td>304/17</td>
<td>a) JM to add further detail to the workforce challenges section of the Quality and Safety Case for Change, then send it to PW and MA for approval. b) JM to ask highways and councillor colleagues on the Travel and Transport Group about the council’s public opinion survey of the new road layout.</td>
<td>JM</td>
<td>Complete</td>
<td>July 2017</td>
</tr>
<tr>
<td>Quality and Safety Report and Dashboard</td>
<td>305/17</td>
<td>a) LB to contact CHFT about their Freedom to Speak up Guardian and get more details about the role etc. b) DR to find out whether A&amp;E Delivery Board include primary care information in their dashboard and update the Committee next month.</td>
<td>LB</td>
<td>On agenda</td>
<td>July 2017</td>
</tr>
<tr>
<td>Complaints Annual Report 2016-17</td>
<td>307/17</td>
<td>a) JS to send AW updated report with correct figures at section 7.3. b) PW and JS to discuss what information should be referred to Governing Body outside of the Committee meeting. c) LB and JS to discuss assurance on provider complaints handling for future complaints reports.</td>
<td>JS</td>
<td>Complete</td>
<td>July 2017</td>
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<td>PW / JS</td>
<td>Not yet due</td>
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<td>LB / JS</td>
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| Infection Prevention and Control Annual report for 2016-17 and HCAI Improvement Plan for 2017-18 | 310/17     | a) BL, CS and LB to discuss two cases of C.diff infection in the community which may had started on a hospital ward  
   b) CWa to provide an update to the July meeting on the agreement of a local health system plan for avian and pandemic flu management  
   c) CWa and PW to discuss escalation of Leeds laboratory results sharing software issues. | BL / CT / LB    | Complete       | July 2017                 |
| Review of Quality Committee Work Plan for 2017-18                             | 311/17     | a) AW to update the work plan.                                                                                           | AW             | Complete       | July 2017                 |
Minutes of the Public Section of the
Commissioning Primary Medical Services Committee Meeting
Held on Thursday, 2nd February, 2017, 2pm to 4:30pm
at the Elise Whiteley Innovation Centre, Halifax

FINAL Minutes

Present

John Mallalieu (JM) Lay Advisor to the Governing Body (Chair of the Committee)
Matt Walsh (MW) Chief Officer
Neil Smurthwaite (NS) Chief Finance Officer/Deputy Chief Officer
Kate Smyth (KS) Lay Member - Patient and Public Involvement (Deputy Chair of the Committee)
Jackie Bird (JB) Governing Body Registered Nurse
Dr Alan Brook (AB) Governing Body GP Member
Dr Caroline Taylor (CT) Governing Body GP Member

In attendance:

Neil Coulter (NC) Contracts Manager, NHSE West Yorkshire Area Team
Martin Pursey Head of Contacting & Procurement (Agenda item 6)
Debbie Robinson (DR) Head of Primary Care Quality & Improvement – (Agenda Item 7)
Tracey Robson (TR) Primary Care Quality & Improvement Project Officer (Minutes)
Judith Salter (JS) Corporate & Governance Manager (Agenda Item 8)

WELCOME & INTRODUCTIONS

01/17 APOLOGIES FOR ABSENCE

Apologies were received from Rajesh Phatak, Governing Body Secondary Care Specialist, Helen Wright, Director of Healthwatch Calderdale and Councillor Tim Swift, Representative of the Calderdale Health and Wellbeing Board.

02/17 DECLARATIONS OF INTEREST

JM invited the Committee members to declare any interests relevant to items on the agenda.

AB and CT declared a direct financial interest in agenda item 6 “Alternative Provider Medical Services Contract”, this was because the options outlined in the paper could impact on AB’s and CT’s practice, either in financial terms or in increased pressure on capacity.

KS declared an indirect non-financial personal interest; this was because she was a patient at a neighbouring practice. It was noted that the materiality of the conflict was low.
DECISION:

JM advised that the expertise of both GPs, along with their clinical input into the discussion was beneficial to the Committee and the Committee agreed and as such were invited to stay in the meeting to participate in the discussion but not take part in the deliberation prior to the decision nor in the decision itself. They were therefore asked to absent themselves from the meeting table at the relevant point in proceedings. And it as agreed that KS would stay in the meeting to inform the discussion and participate in the decision.

JM indicated that he would maintain the decisions on the way the conflict was managed during the meeting but he would ask AB and/or CT to withdraw from the discussion at any point if he felt it appropriate to do so.

AB and CT also declared a direct financial interest in agenda item 7 “Proposal for reinvestment of PMS Premium funding” because the contract in question covered the whole of the Calderdale population and as a consequence of the options that were to be discussed; the financial impact could be positive or negative.

In reminding the Committee that the decisions regarding the funding and timing of the reinvestment had been made at the previous meeting where the management of the conflict had been actioned, the conflicts of interest for AB and CT were noted and it was agreed that they would stay and participate fully in discussion

DECISION

Agenda item 6; AB & CT would take part in the discussion but not the decision and KS would take part in the whole item.

Agenda Item 7; acknowledging the decision had been made at the previous meeting, AB & CT; would take part in the discussion

The Register of Interests can be obtained from the CCGs website or from the CCGs Headquarters.

MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 2nd DECEMBER, 2016

DECISION

That the minutes of the meeting held on 2nd December, 2016 were RECEIVED and APPROVED as a correct record.

ACTIONS AND MATTERS ARISING

Min. 20.16 Alternative Provider Medical Services (APMS) Contract

MP reported that the mandate issued by the Committee in October
2016 to extend the current contract with Meadow Dale Group Practice to March 2019 had been fulfilled and the contract had been agreed in principle; he provided reassurance that robust performance management would be maintained throughout the extension period and advised that all services would continue to be provided from all three sites, operating hours would remain the same and an improved financial deal based on growth had been secured. MW thanked MP and acknowledged the positive outcome.

**Min. 21/16.3 PMS Equitable Funding Review**

MP advised that the relevant practices had been notified of the Committee’s decision to reduce their PMS Premium funding in line with original pace of change, two responses had been received and assurance was given that the CCG would formally address the concerns raised in writing.

All actions were noted as complete.

**04/17 QUESTIONS FROM THE PUBLIC**

There were no questions from the public.

**05/17 ALTERNATIVE PROVIDER MEDICAL SERVICES CONTRACT**

JM reminded the Committee of the conflicts of interest which were noted at the start of the meeting.

In presenting his report, MP provided the Committee with information in relation to the current performance and future commissioning options in respect of the Park and Calder Alternative Provider Medical Services (APMS) contract for after 30th September 2018.

He advised the Committee that the purpose of the discussion was to help the Committee reach a decision on the recommendation in the paper, to provide detail of the process used by the CCG to reach recommendations and to provide assurance to the Committee about the depth and breadth of the performance review undertaken in relation to the current provider.

The Committee was reminded about the three options under consideration and the recommendation from the CCG to an extension of the current contract to March 2019 (Option 3b and 2b).

- **List Dispersal;** on expiration of the contract, patients would be directed to re-register at another local GP practice.

- **Re-procurement of the service;** in line with NHSE guidance (May 2016) the CCG would decide what services to procure whilst ensuring their actions are demonstrably fair and transparent.

- **Extension of current contract arrangements;** this option is
consistent with the CCG procurement policy and is predicated on the provider demonstrating acceptable performance of service and a service that provides value for money.

In the discussion, the following issues were covered:-

- The process was agreed to have been robust however the paper would have benefitted from more clarity and granularity in relation to contract performance.
- The misalignment in CQC, Patent Satisfaction and KPI data
- The history of contract management and the need to establish control of contracts.
- The ability to compare practices on a like for like basis with other GP services across Calderdale.
- Assurance in relation to the current contract issues being addressed and improved and timelier contract reporting going forward.
- How to better assess the quality of contracts to assist with decision making process going forward
- The Committee asked to be given the opportunity to gain a better understanding of the different types of contracts e.g. APMS/PMS/GMS.
- The need to consider other ways of mitigating provider risk.

A more detailed discussion was had about the recommended options.

At 3:10pm both AB and CT moved their chairs back from the table and did not participate in the conversation any further prior to the Committee moving into its deliberation and decision.

Following further discussion the Committee determined unanimously to support the implementation of Option 3b and 2b to extend the current contact to 31st March 2019 and to commence mobilisation in October 2017, subject to the provision of satisfactory evidence in both provider and contract performance to the June 2017 Committee meeting.

Proposed next steps

- Provide satisfactory evidence of contract performance of provider improvement in quality indicators to June Committee.  
- A future discussion on the quality of the decision making process and the ability to compare like for like to be included in work plan
- Procurement process/approach to be included in work plan for future agenda.

JM asked the Committee to note the content of the report and to consider the preferred options and asked the Committee if they were comfortable with the recommendation.

DECISION:
The Committee

1. NOTED the paper and its associated risks
2. APPROVED the implementation of Option 3b to extend the current contact to 31st March 2019 subject to evidenced performance improvement in its quality indicators
3. APPROVED the implementation of Option 2b to include a mobilisation period of 6 months, commencing September 2017 to allow the alignment of two APMS contract procurements to run concurrently
4. NOTED the action to provide evidence of improved performance to the Committee meeting in June 2017

06/17 PROPOSAL FOR REINVESTMENT OF PMS PREMIUM FUNDING

DR informed the Committee about the national requirement to undertake a review of local PMS agreements working towards more equitable funding arrangement for Primary Medical services contract types and reminded the Committee of its decision to proceed with the option to remove the PMS Premium funding from the 5 PMS Practices in Calderdale following the review process. The Committee had made its decision regarding the funding removal at its previous meeting on 1st December, 2016.

The paper provided three proposals in relation to the option for investment of the PMS premium funding which will be released in Calderdale during the financial year 2017/18 and equated to approximately £218k.

1. **Incentive Scheme to improve Access.** Funding would be used to develop a one year incentive scheme for Calderdale practices which would aim to reduce variation in the offer to patients via the delivery of agreed standards for access which would apply to all practices taking part.

2. **Contingency against increased referral activity.** This related to the request and decision of the Committee at its December meeting to ring fence a contingency fund of £57,491 to mitigate the risk of a potential increase in referral activity as a consequence of the removal of 50% of premium funding from April 2017.

3. **GP Practices serving atypical populations.** Proposed development of a deprivation payment scheme for practices. NHS England have recently released guidance relating to identifying practices with atypical populations, this guidance followed discussions that had already taken place at both an earlier Committee and the Local Medical Committee. The proposal suggested that officers of the CCG work through guidance and undertake the necessary analysis. DR asked that it be noted that, due to the lack of clarity in the guidance, the outcome of this could not be taken into account in considering investment in 2017/18. The work within the proposal would take time and would be available for consideration in investment decisions for 2018/19
A more detailed discussion was had about each of the options and the following issues raised:-

- The PMS premium ring fenced monies were discussed and assurance was given that the monies would be reinvested in Primary Care unless the risk materialises. A decision on this would be made mid-year.
- The CCG would adhere to its principles. If the Committee makes a wrong decision, they would learn from it.
- Questions in relation to potential perceived disparity of the incentive scheme to improve access were raised. Assurance was given that the scheme would be a standard offer to all practices and would be in line with the vision that had been agreed for Calderdale Primary Medical Services, which practices had signed up to. It is a practice based, in-house access scheme aimed at reducing variation.
- It was recognised that in light of the new guidance, there was work to be done in establishing atypical populations.

At 3:30pm JM asked the Committee to note the content of the report and to consider the options and the Chair asked the Committee if they were comfortable with the proposals. The Committee indicated they were.

Proposed Next Steps:-

- Provide reinvestment of PMS Premium funds update to October 2017 meeting
- Recognise the potential for provision of a six month review of ring fenced contingency fund should it not be required – hospital data would be used to assess whether there had been any increases
- Note that the incentive scheme monies are non-recurrent

DECISION

The Committee

1. NOTED the paper and its associated risks
2. APPROVED the implementation of an Incentive Scheme to Improve access to be completed by 31st March, 2017.
3. RECOGNISED the requirement for the provision of a six monthly review should the ring fenced contingency fund of £57,491.00 not be required
4. NOTED the Incentive Scheme monies are non-recurrent
5. AGREED to receive PMS premium funds update in October, 2017
6. AGREED to support the atypical analysis by CCG officers

07/17 PROPOSED REVISIONS FOR TERMS OF REFERENCE

In presenting the draft Terms of Reference (ToR) JS advised that the sub-Committees of the Governing Body were required to review their
ToR on an annual basis to ensure they accurately reflected any statutory or national guidance, the governance arrangements of the CCG and the roles and responsibilities of the Committee.

The amendments were presented, reviewed and debated.

DECISION:

The amended Terms of Reference were received and subject to agreed amendments approval was given for submission to Governing Body on 6th April 2016.

DATE AND TIME OF NEXT MEETING

The Committee NOTED that the next meeting would take place as follows:

Thursday, 13th April 2017, 4pm – 5.30pm at the Elsie Whitely Innovation Centre, Hopwood Lane, Halifax.
## Commissioning Primary Medical Services Committee Meeting 2\textsuperscript{nd} February, 2017 – Action Sheet

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>Minute No.</th>
<th>Action required</th>
<th>Lead</th>
<th>Current Status</th>
<th>Comments/Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMS Contract</td>
<td>05/17</td>
<td>Investigate contract and quality learning/development opportunities for Committee via PCC Park &amp; Calder Community Practice: present provider and contract performance review report to June 2017 Committee. Extension of contract is subject to satisfactory performance.</td>
<td>Debbie Robinson</td>
<td>In progress</td>
<td>13\textsuperscript{th} April 2017</td>
</tr>
<tr>
<td>05/17 a)</td>
<td></td>
<td></td>
<td>Martin Pursey</td>
<td>On today’s agenda</td>
<td>1\textsuperscript{st} June 2017</td>
</tr>
<tr>
<td>Proposal for reinvestment of PMS Premium Funding</td>
<td>06/17</td>
<td>Note that the incentive scheme monies are non-recurrent</td>
<td>Debbie Robinson</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>06/17 a)</td>
<td></td>
<td>PMS Reinvestment of Premium funding – Incentive Scheme to improve Access; provide update report</td>
<td>Debbie Robinson</td>
<td>Not due yet</td>
<td>5\textsuperscript{th} October, 2017</td>
</tr>
<tr>
<td>06/17 b)</td>
<td></td>
<td>Recognise potential for provision of six month review of ring fenced contingency fund should it not be realised (hospital data would be used to assess whether there had been any increases)</td>
<td>Debbie Robinson</td>
<td>Not due yet</td>
<td>5\textsuperscript{th} October, 2017</td>
</tr>
<tr>
<td>Proposed revisions to ToR</td>
<td>07/17</td>
<td>Update ToR with agreed amendments and submit to Governing Body on 6th April 2016</td>
<td>Judith Salter</td>
<td>Completed</td>
<td>Completed</td>
</tr>
</tbody>
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