Minutes of the Public Section of the Governing Body Meeting
held on Thursday 10 August 2017 at 2pm
in Function Room 2 at the Shay Stadium, Halifax

DRAFT MINUTES

Present
Dr Alan Brook AB Chair
Matt Walsh MW Chief Officer
David Longstaff DL Deputy Chair and Lay Member (Audit)
Lesley Stokey LS Head of Finance
Dr Steven Cleasby SC GP Member and Assistant Clinical Chair
Jackie Bird JB Registered Nurse
Dr Farrukh Javid FJ GP Member
John Mallalieu JM Lay Member (Finance and Performance)
Kate Smyth KS Lay Member (Patient and Public Involvement)
Dr Caroline Taylor CT GP Member
Dr Nigel Taylor NT GP Member
Paul Butcher PB (Director of Public Health, Calderdale Metropolitan Borough Council)

 Invitees
Penny Woodhead PW Head of Quality
Judith Salter JS Head of Corporate Affairs and Governance/Board Secretary

In attendance
Andrew O’Connor AOC Corporate and Governance Officer (Minutes)
Martin Pursey MP Head of Contracting and Procurement (item 8, min no. 43/17)
Debbie Graham DG Head of Service Improvement (item 10c, min no. 44/17)
Tim Shields TS Performance Manager (item 10c, min no. 44/17)
Rebekah Drury RD HR Manager (item 11, min no. 48/17)
Robert Gibson RG Risk, Health and Safety Manager (item 12, min no. 49/17)

Plus 4 members of the public.

35/17 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from Neil Smurthwaite (Chief Finance Officer and Deputy Chief Officer), Dr Majid Azeb (GP Member), Dr Helen Davies (GP Member), Robert Atkinson (Secondary Care Specialist) and Stuart Smith (Director of Adult and Children’s Services, Calderdale Metropolitan Borough Council).

36/17 DECLARATIONS OF INTEREST

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

NT declared that he had an interest in Item 8 (Procurement – Medicines Optimisation) as a member of the procurement’s evaluation panel. The Governing Body was advised that, whilst it was appropriate for NT to take part in discussions concerning the item, he should not participate in the decision making. Furthermore, that he would move his chair back from the table to signal his withdrawal from the item at that point in the meeting.
AB noted that declared conflicts of interest had been managed throughout the procurement process.

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.

37/17 MINUTES OF THE PUBLIC SECTION OF THE GOVERNING BODY MEETING HELD ON 8 JUNE 2017

DECISION:

The minutes of the public section of the Governing Body meeting were RECEIVED and ADOPTED as a correct record.

38/17 ACTIONS AND MATTERS ARISING

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

MW reported that a discussion concerning deconditioning had taken place at the A&E Delivery Board that week and that consideration was being given to the adoption of a seven day metric. Further work was noted to be taking place ahead of further discussions at the board’s next meeting.

Action 30/17 – Review of the Quality Committee Terms of Reference

PW reported that the review of Quality Committee’s Terms of Reference had not yet been completed. Further discussions were noted to be required and would take place before the next Governing Body meeting. It was confirmed that the issues to be discussed were not fundamental to the effective running of the committee.

Key Messages for Member Practices

AB confirmed that the agreed messages had been communicated to practices.

39/17 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

40/17 PATIENT STORY

SC explained that the CCG and Local Authority had started to develop the “Staying Well” programme four years earlier to address the impact that social isolation and loneliness have on physical and mental health and well-being. Amongst isolated or lonely patients there was reported to be a 60% increase in incidents of dementia and a 40% increase in incidents of depression, while the health of patients with long term conditions had been found to be approximately 50% worse. The programme was explained as being based around four locality hubs situated across Calderdale, providing a base for local activities and events.

SC explained that a patient who had attended the programme over a 12 month period had recently attended an annual review appearing completely transformed. The patient had identified the programme as being the principle factor underlying their improvement and had agreed to write about their involvement and ask others to do the same. The letters and stories received had subsequently been turned into a short film.
The Governing Body viewed a short film concerning the “Staying Well” programme. Following the film comments and questions were invited.

- PB reported that a University had undertaken an early evaluation of the scheme registering indicators of other improvements among participants.
- PB commented that “Staying Well” was both an excellent example of collaboration and partnership between the council and the CCG and of the way in which the system needed to operate with greater frequency in the future.
- PB confirmed that people could access the programme via self-referral, third sector groups and the formal health and social care system.

The Chair concluded the item noting how Patient Stories brought programmes and interventions to life and provided the Governing Body with valuable insight into their impacts in communities across Calderdale.

**DECISION:**

The Governing Body **RECEIVED** the Patient Story.

### 41/17 CHIEF OFFICER’S REPORT

MW in presenting the Chief Officer’s Report drew the following matters to the attention of the Governing Body.

**Right Care, Right time, Right Place**

The Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSCU), at its meeting on the 21st July 2017, had determined to refer the decision of the CCGs to the Secretary of State for Health. The grounds for the committee's decision were summarised in the Chief Officer’s Report and the CCG was noted to both acknowledge and respect the committee’s decision. The CCG had received the Full Business Case (FBC) developed by Calderdale and Huddersfield NHS Foundation Trust (CHFT) and work was underway in preparation for the matter to come to the Governing Body’s October meeting.

**Better Care Fund (BCF)**

Following the submission of Chief Officer’s Report, a discussion had taken place at the A&E Delivery Board (A&EDB) regarding the Improved Better Care Fund (IBCF), the alignment of Calderdale Council and Kirklees Council proposals and the challenges that were being faced in the system (A&E and delayed transfers of care). MW was pleased to note that the A&EDB was supportive of the proposals from Calderdale and that, as the Chair of A&EDB, he anticipated writing to both Health and Well Being Boards in the near future recommending both sets of the proposals to the CCGs and Local Authorities.

As the formal deadline for the final submission of the BCF Plan did not align with the Governing Body’s October meeting, it was recommended to the Governing Body that it delegate authority for approval of the plan to a small group of Governing Body members consisting of the Chair, Lay member (Finance and Performance), Chief Officer and Chief Finance Officer/Deputy Officer.

**DECISION:**

The Governing Body **DELEGATED 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 Chief Finance Officer/Deputy Officer.

**Healthier Calderdale after 10 year smoking ban**

PB in presenting this section of the Chief Officer’s Report explained that the nationwide smoking ban had resulted in a reduction in the number of smokers and the number of number of premature deaths attributed to smoking related illnesses in Calderdale. He emphasised that the ban attested to the impact that nationwide approaches can have on local health and demands on local health systems. He suggested that a similar impact might be achieved via the introduction of a nationwide minimum unit pricing on alcohol. MW replied that he was interested in the opportunities available to address this type of issue locally and regionally, through the Sustainability and Transformation Partnership (STP).

Comments and questions were invited.

**Changes to the Data Protection Legislation**

In response to a comment concerning anticipated changes to data protection legislation, JS confirmed that, in order to release specialist IG capacity, an IG administrator post would be created within the IG Team to provide support across the four CCGs.

There was a short discussion concerning the appropriate sharing of patient data. There was agreement that the underlying principle regarding the sharing of patient data should be one of patient consent.

**Art Therapies**

There was a short discussion concerning the CCG’s anticipated review of psychology services. There was a general agreement the planned review should be completed as scoped after which consideration could then be given to other services. The review was noted to be discussed at a future Clinical Development Forum (CDF).

**DECISION:**

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

**42/17 PATIENT AND PUBLIC ENGAGEMENT – ANNUAL STATEMENT OF INVOLVEMENT**

PW in presenting explained that the report provided an extensive overview of the engagement activity undertaken by the CCG during 2016-17. She went on to highlight the following:

- The breadth and depth of engagement activity that had taken place;
- The inclusion of engagement work undertaken by providers and voluntary and community organisations;
- The extent of the engagement work undertaken by Community Engagement Champions and the vital role the champions played in the CCG’s engagement activities;
- The ongoing development of Patient Stories during the year;
- The introduction of Patient Experience Groups which now played an important role at the start of any engagement work;
- The adoption of “Insight Reports” as part of standard practice;
- Planned engagement projects for 2017-2018;
The intention to revise the CCG’s Patient Engagement and Experience Strategy in response to revised NHS England guidance

Comments and questions were invited.

A discussion followed during which the quality of the report was recognised as was the outstanding performance of the engagement team. Approaches to further strengthening the involvement of Community Engagement Champions in the work of the CCG were raised. This included the Governing Body’s recognition of the need to continually support and develop this group. PW outlined for the Governing Body the support arrangements and activities already in place as well highlighting the champions’ success in engaging hard to reach and vulnerable groups.

**DECISION:**

The Governing Body **APPROVED** and **SIGNED OFF** the annual statement of involvement as an accurate account of the CCG’s activity during 2016-17 for publication.

**43/17 PROCUREMENT – MEDICINES MANAGEMENT OPTIMISATION**

MP in presenting the report drew the Governing Body’s attention to an error at 2.1 in the report. The figure of £125,000 per annum should have read £225,000 per annum. MP confirmed that the correct figure was used in the calculations presented in the remainder of the report.

MP explained that the paper outlined the process undertaken to procure a medicines optimisation service for the CCG. The following key points were then highlighted:

- the procurement had been undertaken according to the CCG’s normal procurement procedures;
- the CCG had received completed Invitation to Tender (ITT) documentation from six potential suppliers;
- an evaluation had been undertaken by a suitably qualified and experienced panel, details of which, including the process followed and scoring rationale, were set out from 2.5 onwards;
- a panel members’ conflict of interest had been raised prior to the start of the evaluation and was managed and mitigated via the two stage evaluation process;
- pre-moderation and moderated scoring had been produced as set out at 2.9;
- Bidder 5 had been excluded from the moderation process as their pre-moderation score did not meet the 50% benchmark;
- the value of the contract was noted to account for 40% of the weighted score and this was reflected in the moderated score;
- Bidder 3 was recommended as the preferred bidder having scored the highest overall raw and moderated scores;
- subject to Governing Body approval, successful and unsuccessful bidders would be notified of the CCG’s intentions with regard to the procurement;
- Unsuccessful bidders would receive debrief reports and any challenge to the CCG’s decision would need to be received during the 10 day stand still period.
Questions and comments were invited.

- That the CCG’s procurement procedure had been followed was recognised.
- In response to a question, MP confirmed that the two month period between stand still and service commencement had been made clear to potential suppliers from the outset and that the CCG had sought and received assurance concerning this.
- In response to a question, MP confirmed that the CCG was in a position to undertake the work that was required following decision by the Governing Body.

DECISION:

The Governing Body:

1. **NOTED** the process undertaken and **CONFIRMED** their confidence that a robust process had been followed for selecting the Medicines Optimisation Service which was in line with the CCG’s normal procurement rules.

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

**44/17 POLICY – CONTINUING HEALTHCARE (CHC) COMMISSIONING PRINCIPLES POLICY**

LS presented the report for Sarah Antemes, Head of Continuing Health Care. The report sought the approval of the draft Continuing Healthcare Commissioning Principles Policy as a new policy for the CCG. The Governing Body was advised that the policy was consistent with that which had been in operation in the Greater Huddersfield and North Kirklees CCG areas for a significant period of time. LS highlighted the following key points:

- the lack of an agreed policy meant there was no clear agreement in place concerning resource allocation in terms of individual packages of care;
- the policy was required to inform, guide and support the CCG’s Continuing Health Care (CHC) staff when undertaking discussions concerning packages of care with patients and their family;
- the policy would establish clear guidelines, ensure open, transparent conversations with patients and families, as well as ensuring consistent and fair decision making;
- the policy presented for approval had been reviewed by both the CCG’s Finance and Performance and Quality Committees.

Questions and comments were invited.

- That the policy had been robustly addressed by the committees.
- The introduction of an explicit policy was welcomed.
- Appendix C and D were noted to require transfer to Calderdale CCG templates.
DECISION:

The Governing Body:

1. **APPROVED** the Continuing Health Care Commissioning Principles Policy.

**45/17 FINANCE, CONTRACTING AND RECOVERY REPORT**

LS in presenting the report highlighted the following key messages:

- The CCG was forecasting to deliver its financial plan but was showing an unmitigated risk of £2.4m at Month 3, reflecting the level of uncertainty the CCG was experiencing in relation to QIPP (Quality, Improvement, Productivity and Prevention) delivery and potential overtrading on its contracts.
- The CCG’s contingency of £1.6m had been fully utilised to achieve the above.
- A risk matrix had been provided at 3.1, concerning the CCG’s QIPP target which showed a projected risk to the sum of £5.1m.
- At Month 2, the Calderdale and Huddersfield NHS Foundation Trust (CHFT) contract was showing a small underspend (£31k) but this was noted to include some estimates due to delays in the reporting of activity.
- The West Yorkshire & Harrogate (WY&H) Sustainability and Transformation Partnership (STP) had commissioned the York Health Economics Consortium to assist with the development of the STP Financial Strategy. Details of the intended working arrangement to take place across Kirklees and Calderdale were explained as set out at 1.1.
- The CCG had been successful in its bid to receive additional support from NHS England (NHSE) in the delivery of its QIPP savings as set out at 1.1.
- In reference to Appendix E, NHSE had announced that CCGs would not benefit from changes to the prices of Category M drugs and that the savings would be retained centrally to manage the risk across the whole health system. In the same letter, the shared responsibility of acute and mental health trusts in terms of managing financial risk across the system was reiterated including the requirement for providers to form a system risk reserve from Commissioning for Quality and Innovation (CQUIN) earnings.

Comments and questions were invited.

- A short decision took place concerning NHSE’s announcement concerning Category M drugs during which, whilst recognising that the additional funds would have been welcome, there was a general consensus that the decision was understandable. DL reported that that Audit Committee Chairs had challenged NHSE’s decision. NL reported that the potential Category M savings in Calderdale were in the region of £800k and that the Prescribing Support Service would prioritise the switch to generic brands from 17 July 2017. LS confirmed that the CCG had commenced completion of a return relating to the requirement for providers to form a risk reserve using local CQUIN earnings.
- MW reported that NS and Debbie Graham, Head of Service Improvement, had met with colleagues from the York Health Economics Consortium.

**DECISION:**

The Governing Body **NOTED** the contents of the report.
PW in presenting the report highlighted the following:

- The CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) were scheduled to meet to discuss the timescales within which they were required to submit serious incident reports to CCG. The improving quality of the contents of the reports was welcomed as was CHFT seeking the input and assistance of the CCG with this matter.

- An Annual Complaints Report for 2016/17 had been provided. The CCG had seen an increase in the number of complaints received but these were at levels 1 and 2 (i.e.) lower level complaints. A number of the lessons learned during the year were set out at 3.4.3 and the Complaints Manager was noted to be developing working relationships with others complaints managers across the region.

- Practices in Calderdale were significantly above the 25% target in terms of accessing ongoing research studies and projects. 65% of GP practices had recruited patients to research studies during the year, compared to 19% during the previous year. Furthermore, 223 patients had taken part in research projects, compared to 82 during the previous year. The contribution of the GP Alliance to this improvement was noted.

- There had been recurrent breaches of mixed sex accommodation in the intensive care unit at CHFT. Root cause analysis and learning across the incidents that happened in February and during the summer of 2017 had been undertaken. The issue was explained to relate to whether patients were fit to return to a general ward. The Quality Team was reported to be working with CHFT on this issue.

- The Quality Committee was seeking assurances concerning discharge information and the timeliness of appointments in the context of the introduction of the Electronic Patient Records (EPR) system. The Quality Team was also planning a number of “go see” visits with CHFT to observe the impact of the system on clinical practices. An invitation was extended to Governing Body members.

Comments and questions were invited:

- In response to a question concerning the assurances that CHFT had provided about plans to improve the speed at which non-elective fractured neck of femur patients were transferred to surgery, PW confirmed that the matter continued to be a conversation at the Quality Board and with CHFT’s Medical Director. A number of reports had been received by the board setting out the required actions. The board had also asked for further performance data in addition to an analysis of any harm delays had caused. A Greater Huddersfield CCG Governing Body member had met with CHFT colleagues in July and would provide the board with an update in September. The EPR system was suggested to have had an impact in May.

- In response to a question concerning the level of Friends and Family Tests (FFTs) returned at both CHFT and the South West Yorkshire Foundation Partnership Trust (SWYFPT), PW confirmed that both organisations had patient experience groups looking at a range of metrics including the FFT. CHFT was explained to have undertaken to makes changes and was looking to learn from other organisations. The SWYPFT score was explained to be aggregated and was affected by this factor. PW suggested further conversations needed to take place with SWYFT on this topic.

- In response to a question concerning whether any evidence of improvement in quality resulting from the introduction of EPR had become apparent to date, PW advised that the reports received had focused on the resolution of issues arising from implementation. However, it was pointed out that the
Quality Board had posed a number of questions for consideration by CHFT’s Implementation Board. MW added that he had visited one of Medical Wards with CHFT’s Chief Officer and saw fantastic engagement with technology by staff. His view was that the hospital was going through the transformation that had been experienced by practices previously. AB noted that there were some components of EPR which would be advantageous to those in practices and hospitals which would be hugely useful when routinely available. PW suggested that clinicians from CHFT come to speak to the Governing Body at a future meeting.

- In response to a question, PW confirmed that slips, trips and falls reported were those which involved instances of serious harm. CHFT was explained to have a programme of work in place with a range of associated activities which was regularly reviewed by the Quality Board. While the issue would never entirely disappear, PW confirmed there were always efforts made to sustain and improve performance in this area, for example, joining up programmes between the CCG, hospitals, community health care and care homes.

**DECISION:**

The Governing Body **RECEIVED** the report and **NOTED** the actions being within in the dashboard.

**47/17 PERFORMANCE REPORT**

In presenting the report, TS highlighted the following issues:

- Following the Ambulance Response Programme, NHS England (NHSE) had announced the introduction of new ambulance response standards which would come into effect during September 2017.
- May 2017 had been a challenging period in terms of A&E performance. The Electronic Patient Record (EPR) system, and its impact on bed management and discharge planning, was suggested to have contributed to the deterioration. Performance levels in A&E had improved since May but remained below the constitutional standards.
- There had been breaches relating to diagnostic waiting times in March and April due to a peak in referrals for MRI and ultrasound scans. An improvement plan had been developed and shared with NHS Improvement (NHSI). The position was anticipated to be recovered by June 2017.
- There had been breaches concerning the two week wait for patients referred urgently with suspected cancer. This had been linked to EPR and its impact on booking capacity. An action plan to address this issue was in place.

Comments and questions were invited:

- NP advised that the Cancer Network in July had its first in-depth look at the cancer related breaches. He assured the Governing Body that this process should help drive improvements in this area.

DG in presenting an update on transfers of care reminded the Governing Body of the work that had been undertaken to date. This included achieving sustained improved performance in relation to reportable delays. It also included the recognition of a need to address a larger cohort of patients who were staying in hospital longer than was required. In response, a narrative concerning deconditioning had been developed, partners engaged and, working with A&E Delivery Board, a Transfer of Care Plan delivered 12 months prior to NHSE deadlines. This advanced position had enabled the CCG to make a strong case regarding the targeting of Better Care Fund funding.
DG said that, as part of addressing the delays in transfers of care, a dashboard had been developed. The dashboard had supported real changes and improvements in service delivery. However, it was said to have its limitations and was not designed to monitor performance. Consequently, a new dashboard had been developed to provide more accurate performance data for Calderdale. The new figures emerging described an improving picture for the area. For example, data showed that the number of people delayed in hospital had reduced from 107 in September 2016 to 40 in July 2017 and that, from a static admission rate, pre-EPR, the number of people discharged each month had gone from its lowest level in May 2016, when 132 people were discharged, to its highest rate in May 2017, when 194 people were discharged. It was noted that these figures were supported by data that showed that the length of stay in hospital and numbers of people delayed for over 50 days was now in line with figures from 2015. DG concluded that the new revised dashboard provided both a more accurate account of performance relating transfers of care and proposed that a deep dive report be brought to the next Governing Body meeting.

Comments and questions were invited.

- MW commented that the CCG’s sponsorship of this work was important and that the new performance data emerging was beginning to validate the hard work that has taken place. He also added that care should be taken with regard to the making of any decisions regarding schemes that were actually having a positive an impact until the data was fully understood.
- PW suggested that, following October’s Governing Body meeting, the Safeguarding Adults Board receive information for its assurance.
- PW advised that she would be speaking to the Regional Director of Nursing regarding the CCG looking at the issue from a safeguarding perspective.
- DG confirmed that the data was beginning to confirm that Calderdale and Kirklees were performing at similar levels.
- AB suggested that the converse issue of premature discharge be taken in account, possibly triangulating discharge data with rates of readmission, and that attention needed to be given to a GP action element in the EPR system that was being used to recommend actions following discharge but without arrangements having being put in place.

**DECISION:**

The Governing Body:

1. **NOTED** the contents of the report
2. **CONSIDERED** the updated Delayed Transfer of Care (DTOC)

**48/17 WORKFORCE REPORT**

RD presented the workforce report for the second half of the 2016/17 financial year in order to provide the Governing Body with assurance and the opportunity ask any questions. She went on to highlight the following points:

- Figures concerning staff turnover were noted to be set out at 2.2.2. RD explained the CCG’s relatively small workforce resulted in any turnover having a significant impact on overall percentages. There had been three leavers in the second half of the financial year and the CCG was satisfied that this represented a normal and healthy level of staff turnover.
- Figures concerning sickness absence were noted to be set out at 2.3.2. Levels of absence were reported to have been high for some time, rising over the six month period before beginning to reduce. This was attributed to
a number of instances of long term sickness which were being carefully and closely managed.

- Feedback from staff forum concerning the organisational support in place at the CCG, including management support, the employee assistance programme and occupational health support, indicated that these had helped staff to return to work sooner.
- Levels of sickness absence had now fallen and data for June 2017 showed absence at 3.89%.
- Key highlights in the CCG’s workforce health and wellbeing activity were noted to be set out at 2.4.2.
- SMT were reported to be satisfied that the correct actions were being undertaken to address sickness absence levels at the CCG.

Comments and questions were invited.

- PB welcomed the development of joint working between the CCG and the Local Authority, informing the Governing Body that the Calderdale area overall had slightly higher levels of sickness absence than other areas. RD said she would raise this issue with the network group for discussion.
- MW suggested that it could be potentially useful for the CCG to begin benchmarking itself against other public sector organisations. RD agreed.
- In response to a comment concerning raising the profile of the Employee Assistance Programme, RD confirmed that the CCG had a number of actions in place to publicise the programme amongst CCG staff.
- JM advised the Governing Body that it should not overlook the quality of work on staff Health and Well Being at the CCG which was outstanding.
- MW recognised the energy, drive and commitment of the CCG’s staff forum in contributing to this agenda.
- In response to a question, RD explained that the information concerning statutory and mandatory training was being verified and would be brought to a future meeting.
- JS advised that, while the final evaluation was not yet available, anecdotal staff feedback on the Coaching Conversations Programme appeared to be very positive.

DECISION:

The Governing Body RECEIVED and NOTED the contents of the report.

49/17 RISK MANAGEMENT – HIGH LEVEL RISK LOG AND REPORT, CYCLE 2 2017/18

RG in presenting the high level risk report highlighted the following points:

- At the end of risk cycle two, the risk register contained 27 open risks
- There were two critical risks scoring 20 as detailed at 2.6 with further information supplied at Appendix 3.
- Two critical risks had been closed during risk cycle two. Risk 829 had been closed and reopened with a lower scoring, while Risk 988 had been closed altogether.
- There were five serious risks scoring between 15 and 16 as detailed at 2.10 in the report. Following the end of the financial year, two serious risks had been closed and reopened with new risk identification numbers.
- The Commissioning Primary Medical Service Committee (CPMSC) had met and agreed the process for the reporting of risks relating to its remit and would commence receipt of reports relating to risks scoring 15 and above from its next meeting in October.
Comments and question were invited.

- MW suggested that risk 709 be considered during the next risk cycle in light of discussions concerning transfers of care.
- RG confirmed that all risks are reviewed during each review cycle including those that are closed and reopened at the start of the new financial year.
- In response to comment concerning Risk 515, MP explained that the risk rating had remained as there were ongoing challenges which, whilst changing, needed be managed and mitigated month-on-month.

DECISION:

The Governing Body **CONFIRMED** that it was assured that the High Level Risk Register represented 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 by Quality and Finance & Performance Committees at their meetings on the 27 July 2017.

50/17 AUDIT COMMITTEE ANNUAL REPORT

JS explained that the report provided a summary of the committee’s activities during the year as well as assurance concerning its overall effective and compliance. She went to highlight the following:

- The responsibility of the committee was to maintain an overview of the adequacy and effectiveness of the CCG’s systems of internal control and risk management.
- The committee’s membership had been consistent throughout the year ensuring continuity.
- The committee had met six times during 2016/17.
- A summary of the committee’s activities during the year was noted to be set at 4.0 in the report.
- As part of reviewing its own effectives in 2016/17, the committee had taken a number of actions to amend it terms of reference and stream line its annual work plan to reduce duplication and release capacity. This had facilitated the reduction in the frequency of meetings.
- The importance of CCG’s working relationship with external and internal auditors was highlighted as was the appointment of KMPG during the year as the CCG’s external auditors.
The work of staff across the organisation which had resulted in the Head of Internal Audit Opinion of ‘Significant Assurance’ was noted.

DL added that the CCG was working through recent amendments to conflicts of interest guidance and that he would be attending an Audit Chairs National Meeting in October 2017.

Comments and questions were invited:

- PW asked that the report be updated to include the outcome of the internal audit of the CCG’s Safeguarding arrangements. JM asked that the membership cited be amended with regard to his role during 2016/17.
- MW asked that JS consider how the Governing Body might be informed of the outcomes of internal audit reviews.
DECISION:
The Governing Body RECEIVED the Audit Committee Annual Report 2016-17.

COMMITTEE MINUTES

a) The Minutes of the Finance and Performance Committee held on 27 April 2017, 25 May 2017 and 29 June 2017

NT explained that three sets of minutes were being received by the Governing Body as the committee’s meeting on the 25 May 2017 had been inquorate and, as such, had delayed the committee’s approval of the minutes of the committee meeting held on the 27 April 2017 and there submission to the Governing Body.

He advised that Governing Body that the committee were undertaking significant and robust discussions concerning the CCG’s financial risks. Furthermore, that the committee had not been content to accept the £2.4m gap as an unmitigated risk and had tasked the relevant recovery groups within the CCG with the task of identifying how this gap could be reduced.

DECISION:
The Governing Body RECEIVED the minutes of the Finance and Performance Committee.

b) The Minutes of the Quality Committee held on 25 May 2017 and 29 June 2017

DECISION:
The Governing Body RECEIVED the minutes of the Quality Committee.

c) The Minutes of the Commissioning Primary Medical Services Committee held on 2 February 2017.

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

KEY MESSAGES FOR MEMBER PRACTICES

DECISION:
- Transfer of Care – Deep Dive

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
12th October 2017, 2pm
The Shay Stadium, Halifax
### Risk Management Report (Cycle 2 2017/18)

<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>Risk Management Report (Cycle 2 2017/18)</td>
<td>49/17</td>
<td>Risk 709 to be considered during risk cycle 3 in context of the outcome of work being carried out on Transfer of Care</td>
<td>RG</td>
<td>Complete</td>
<td>12.10.2017</td>
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### Key Messages for Members Practices

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<tbody>
<tr>
<td>Key Messages for Members Practices</td>
<td>52/17</td>
<td>Transfer of Care – an update on the detailed work that has been carried out</td>
<td>DG</td>
<td>Report will follow the Governing Body meeting on 12 October.</td>
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AGM WELCOME AND INTRODUCTIONS  
AB welcomed everyone in attendance to the CCG’s Annual General Meeting. He introduced the CCG as an organisation, setting out its makeup, membership and purpose.

PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS  
AB presented the CCG’s Annual Report 2016/17 taking the opportunity to thank the CCG’s staff for their hard work and commitment during the year and partners across the system for their support and contributions.

It was acknowledged that, whilst the year had been dominated by necessary changes to hospital and community services, there had been a great deal of other work that had taken place at the CCG which deserved recognition.

The CCG’s priorities for 2016/17 were explained to include the following:

- Transform the way that healthcare is provided for local people
- Sustain quality and keep people safe
- Ensure system resilience
- Ensure a clear focus on financial recovery
- Invest time in partnership working

AB went on to speak about each priority highlighting the work undertaken during the year and progress made.

Concerning transformation, whilst recognising there were many other examples in the Annual report, AB focused on the work that had been undertaken with
Member Practices and care homes. In terms of work with member practices, the outcomes of the annual commissioning engagement scheme were set out. These included improvements in quality, safety and patient experience; a reduction in unwarranted variation between practices; a contribution towards Quality Innovation Productivity and Prevention (QIPP) delivery across the system and support for the shift from unplanned to planned care. The contributions of the CCG’s Practice Commissioning Leads and its five Commissioning Teams were then highlighted, including the outcomes of projects that had undertaken during the year.

With regard to care homes, AB introduced the work that had taken place to develop a shared vision for the future care home provision in Calderdale. The vision was described as being for care homes to be integral parts of communities providing access to different types of care and support in partnership with many different people, young and old. A short video followed which explained more about the vision and the work that had taken place.

The meeting was also provided with an update about Right Care, Right Time, Right Place programme activity including next steps.

In relation to sustaining quality and keeping people safe, the expanding safeguarding agenda was set out followed by examples of the work that had taken place during the year. This included closer working with GP practices; development of a GP safeguarding network; significant input into the Calderdale Safeguarding Board and the development and implementation of policies and guidance for CCG and primary care staff. The Safeguarding Team were also noted to have received favourable feedback from NHS England and continued to work closely with colleagues on a local, national and regional basis.

With regard to ensuring system resilience, the Accident and Emergency Delivery Board was explained to have the lead role in proactively responding to the sustained pressure on Calderdale’s urgent care system. The role and makeup of the board was as explained as was the work undertaken at its monthly meeting. This included reviews of system performance and identification of mitigating actions; driving the identification of system risk and response; development of pilots and initiatives in response to system need and seeking assurance from regional networks and programmes. The board was also noted to be developing a view of its “common purpose” to drive future planning and operated to ensure that meetings provided the opportunity for partners to come together to build relationships and nurture innovation.

Regarding financial recovery, AB explained that the CCG had worked with partners to develop a financial recovery plan which the Head of Finance would expand upon later in the meeting.

In terms of investing time in partnership working, AB advised that the CCG was committed to partnership working across a number of footprints. The strategic importance of primary care was recognised in relation plans to transform the local system including the delivery of Care Closer to Home and the CCG’s hospital change programme. Whilst noting the centrality of general practice to the CCG’s plan, they were explained to provide a clear signal about the importance of working across the spectrum of primary care providers and other stakeholders and the CCG’s intention to strengthen links between primary care, community pharmacy, community health services, acute care, social care and the third sector. Highlights of the CCG’s partnership work during the year were shared followed by a short video providing further information concerning a partnership scheme which had been developed with the aim of reducing falls in Calderdale’s Upper Valley.
LS was invited to present the CCG’s Annual Accounts for 2016/17.

The CCG was confirmed to have delivered its statutory financial duties in 2016/17 in challenging financial circumstances. Significant cost pressures arising in acute health care and prescribing costs had required the CCG to utilise £3.7m of its brought forward surplus. As a consequence, the delivered surplus was reported to be £3.7m less than the NHS expected level. The CCG’s failure to deliver the financial plan was explained to mean that the CCG was now in “financial recovery” and that this had impacted on the organisation’s eligibility to receive Quality Premium Payments which could have reached a potential maximum of £1m.

LS then explained how the CCG’s budgets of £312 million was invested to improve local health care during the financial year. This was followed by an analysis of acute spending totalling £158m.

Looking to the future, the 2017/18 financial plan was highlighted to be extremely challenging. The CCG was explained to be in receipt of the lowest level of growth and, as such, higher levels of savings would need to be made. The CCG was explained as planning to utilise £3.1m of it brought forward surplus but would, in addition, have to deliver £11.5m in savings to achieve the planned financial position. This was highlighted to equate to approximately 4% of the CCG’s total programme resource. The plan was also explained to assume the CCG would meet NHS planning requirements and investments. The CCG’s financial recovery plan was explained to focus on the following 5 key areas:

- Eliminating waste
- Ensuring services
- Ensuring services perform as expected
- Transactional work
- New models of funding and financial flows
- Stopping things

56/17 PATIENT AND PUBLIC ENGAGEMENT: ANNUAL STATEMENT OF INVOLVEMENT

PW presented the CCG Patient and Public Engagement: Annual Statement of Involvement.

The statement was explained to provide an overview of the engagement work the CCG had undertaken with partners and communities over the previous 12 months. Furthermore, that it demonstrated the CCG’s commitment to patient and public engagement; provided assurances that the CCG had met its legal obligations and ensured that the requirements of its Patient and Public Engagement and Experience Strategy had been met. Whilst there were legal and statutory requirements for the CCG to undertake engagement activities, PW emphasised that, for the CCG, as an organisation, its commitment to engagement came from an understanding of the valuable impact that the information provided by people could have on reshaping and improving local health services.

The new approaches to engagement adopted in 2016/17 were shared. A system of collecting Patient Stories had been introduced. These were said to be helping to inspire the CCG to learn, make changes and excel. A Patient Experience Group had also been established to help shape and improve patients’ experience via networking and relationship development, collaboration with providers and the setting, monitoring and delivery of patient experience priorities.
Insight Reports had also been adopted as part of standard practice at the CCG to ensure that the views shared by people were continually used to support service improvements.

PW went on to speak about Engagement Champions. The champions were explained to be people working in the voluntary and community sector who been trained to engage with local people concerning health services at a grassroots level. There were 65 champions at the time of the meeting, working across 48 different organisations with the scheme continuing to grow. A short film followed featuring champions engaging with people from a South Asian background concerning care home provision in Calderdale.

An overview of some of the engagement activities undertaken by the CCG in 2016/17 was provided. Key achievements were noted to include engagement work concerning Right Care, Right Time, Right Place and Care Homes.

Looking to the future, planned engagement work for 2017-18 was summarised, including reference to meetings of the Travel and Transport Reference Group, activity relating to “it’s everyone’s NHS – and we’re not going to waste it” and a pain management survey.

PW concluded by talking about work that had taken place to support people in having a voice. Working in partnership with Voluntary Action Calderdale (VAC) training had been developed for individuals and support organisations. Two training courses had been delivered during the year in Calderdale with 20 people completing the training while, across Calderdale, Kirklees, Wakefield and Barnsley, 80 people had taken part via nine sessions. A short video followed featuring the experiences of an adult with learning difficulties who had benefited from the initiative.

57/17 LOOKING TO THE FUTURE

Looking to the future, MW spoke about the CCG’s purpose. He recognised the statutory requirement for the CCG to work with partners to provide NHS services of appropriate quality and value and the CCG’s commitments to this. However, he then went on to describe a broader, more fundamental purpose, one which involved the organisation’s commitment to creating a conversation about the need for change. The conservation was described as one that would invite people to participate in a dialogue; that would prompt consideration of opportunities to alter the relationships between people and services; that would support people to better understand the ways in which they could reduce their risks of ill health and have greater control; that would helped people to better understand how they could best access care and that, when care was needed, would ensure it would be delivered in the right way and give people the best possible chance of the best possible outcomes.

Recognising that the future of the NHS was ultimately a political decision, MW spoke about the things that the CCG and local system had within its control. These included the relationships it created, the words it chose to use and the choices and decisions it opted to make. He went on to talk about one of the CCGs’ decision which concerned responding to the negative impact that delays in transfers of care were having on people in local hospitals. He explained that previously a significant number of people, every day experienced a delay in transfer of care from hospital and that evidence strongly indicated that this additional time in hospital was causing harm through deconditioning. For older people, this time was noted to particularly important. A short film was played entitled “The Last 1000 Days” which provided further insight into the impact of delays in transfers of care on older people. Following this MW spoke about the
actions that were required to create change before setting out what had been done to address the issue and the outcomes. The latter were noted to include a significant decrease in the number of people stuck in hospital on a daily basis; a reduction in harm through deconditioning and the creation of additional bed capacity. While recognising the progress made to date, further work was recognised as needing to take place.

MW concluded by thanking staff, partners and stakeholders across the system, with special mention of Hillary Thomson and Soo Nevison, Local Voluntary and Community Sector colleagues. He also thanked local people for the vital contribution they had made to the CCG’s engagement and consultation work throughout the year.

58/17 QUESTIONS FROM THE PUBLIC

25 questions were noted to have been received from Jenny Shepard. AB explained that responding to each question would exceed the time allotted for the item and an agreement had been reached to provide answers to two questions selected by Jenny and that the remainder would be responded to in writing. The following questions were answered:

Q: What proportion of its commissioning budget did Calderdale CCG spend on the so-called independent sector in 2016-17, including private companies and Voluntary and community sector organisations? How does this compare with the national average?

A: AB responded that the CCG commissioned services from a wide range of organisations based on their capability and capacity to deliver the required service. In accordance with the NHS Procurement, patient choice and competition regulations (no.2) 2013, the CCG did not discriminate in relation to the ownership status of the organisation.

Q: Calderdale CCG says that one of its responses to its “financial challenge” is stopping things. What things is Calderdale CCG stopping or considering stopping? On what basis? How are the public involved in these considerations and decisions?

A: AB responded that the CCG faced a significant financial challenge in 2017/18 and was planning to deliver savings of £11.5m. He went on to explain that the CCG was focussing on five key areas in its financial recovery plans including: eliminating waste, ensuring services perform as expected, transactional work, new models of funding and financial flows, stopping things. He said that stopping things was the last option, which the CCG would only consider after the other four options had been explored and that the CCG was keen to work with the wider system to look at how prevention could support achievement of the aims. He went on to say that the CCG had not yet approved stopping anything but areas which were being considered at the CCG and across many areas in country were said to include, for example, gluten free prescribing. He concluded that the CCG had an agreed patient and public engagement and experience strategy that described its approach to the involvement of the public and that this would extend to ‘stopping things’.

A question had been submitted by Jenny Tierney and was answered as follows:

Q: I’ve heard from a reliable source to say there will be no Hospital in Huddersfield! Is this true?
A: AB responded that the proposals would mean that there was a hospital on the Acre Mills (Huddersfield) Site and a hospital on the Calderdale Royal Hospital (CRH) (Halifax) site. He explained that the hospital on the Huddersfield site would deal with planned care, such as day case operations, and the hospital on the Halifax site would deal with Emergencies and more complex operations. He also explained that Outpatients would continue on both sites and that Urgent Care Centres were proposed for both Huddersfield and Halifax sites.

A question had been submitted by Jackie Murphy and was answered as follows:

Q: I would like to know what your plans are to cope with extra influx of patients from Huddersfield as you are planning to close HRI.

A: AB responded that the proposals intended to change the way that people received treatment, not close services. He explained that the proposed provision of an Urgent Care Centre on both the Acre Mills and CRH sites meant that 54% of patients would continue to receive treatment at the site they currently attend with the remaining activity split between CRH and HRI. Planned care activity would be located at the Huddersfield Acre Mills Site, involving a movement of activity with patients from Halifax attending the Huddersfield hospital. Unplanned care activity would be located at the Halifax CRH site, involve a movement of activity with patients from Huddersfield going to Halifax. The reconfiguration of activity was explained to mean that fewer beds would be required in Huddersfield. One of the reasons for this, he noted, was that a lot of planned operations did not require an overnight stay. He went on to explain that more beds would be required in Halifax to accommodate the additional unplanned activity. One of the reasons for this was noted to be that the Emergency Centre was located at the Halifax site. The detailed explanation of activity, beds and site capacity was confirmed as being set out in the Calderdale and Huddersfield NHS Foundation Trust’s (CHFT) (the hospitals’) Full Business Case.

A further question was taken from the floor asking whether the plans for hospital and community health services had taken account of local development plans that could potentially see 17,000 new homes built in the Calderdale area.

AB answered that demographic changes were taken into account as standard when considering and planning health service delivery.

AB thanked people for their attendance and the meeting ended.
## Executive Summary

**Please include a brief summary of the purpose of the report**

This report sets out the supporting information to enable the Governing Body to consider and decide whether to indicate to NHS England that you are supportive or not of Calderdale and Huddersfield NHS Foundation Trust (CHFT)’s FBC.

### Previous consideration

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Meeting Date</th>
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<tr>
<td>Not applicable</td>
<td>37T</td>
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### Recommendation(s)

Following consideration on the basis of evidence and judgement and the significant contribution to improved clinical care and improved outcomes for our population the CCGs consider that the FBC is in line with the model on which we consulted.

Following consideration on the basis of: evidence and judgement; the significant contribution to improved clinical care; improved outcomes for our population; and on the basis of the joint system working outlined in section 8.3, the CCGs consider that the FBC is affordable to Commissioners and that the FBC does improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care.

Should the Governing Body agree with this assessment, it is recommended that it should indicate to NHSE that it is supportive of CHFT’s Full Business Case.

### Decision

☑️ Assurance

☐ Discussion

☐ Other 37T

### Implications

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>An Equality and Health Inequality Impact Assessment has been completed in relation to these proposals. This has concluded that there is no indication of the proposed changes being discriminatory</th>
</tr>
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<tbody>
<tr>
<td>Public / Patient / Other Engagement</td>
<td>Formal Consultation on these proposals finished in June 2016</td>
</tr>
<tr>
<td>Resources / Finance implications (including Staffing/Workforce considerations)</td>
<td>There are significant financial implications associated with the proposals. These have been outlined in Section 8 of the report.</td>
</tr>
<tr>
<td>Strategic Objectives (which of the CCG objectives does this relate to)</td>
<td>All Risk 821</td>
</tr>
<tr>
<td>Legal / Constitutional Implications</td>
<td>None</td>
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</table>
1. Purpose of the Report
This report sets out the supporting information to enable the Governing Body to consider and decide whether to indicate to NHS England that you are supportive or not of Calderdale and Huddersfield NHS Foundation Trust (CHFT)’s FBC.

2.0 Background
The Governing Bodies of Calderdale CCG and Greater Huddersfield CCG have previously agreed that there is a compelling case for changing the way that local health services are provided and that if the local system is unable to redesign and transform services in a way that drives up quality then patients will experience poorer outcomes as a result. You have agreed that making no change is unlikely to be in the best interests of patients and have already made a number of decisions to support the sustainability of services.

The Governing Bodies have agreed:
- The clinical model of care, on which the redesign and transformation of services would be based.
- That consultation with the public on this model and where these services should be located had finished, and that the feedback had identified: areas that should be addressed; and concerns regarding implementation.
- That the relationship between changes to hospital and changes to community services is such, that confidence in the delivery of Care Closer to home is a decisive factor in the development of the proposals.
- That these areas and concerns should be addressed through exploration of implementation in a Full Business Case (FBC).
- Their response to the Joint Health Overview and Scrutiny Committee (JHOSC) questions in relation to the consultation.

3.0 Introduction
On Thursday 3 August 2017 the Board of Calderdale and Huddersfield NHS Foundation Trust (CHFT) approved the organisation’s Full Business Case (FBC) in relation to proposed changes to its hospital services in Calderdale and Greater Huddersfield. This decision enabled CHFT to submit the FBC to its regulator, NHS Improvement, for its assessment.

It is not the role of the CCGs’ Governing Bodies to approve CHFT’s FBC. Instead, the role of the Governing Body is to indicate to NHS England whether you are supportive of the FBC. In this regard, the CCGs are asked separately to consider CHFT’s FBC on the basis of evidence and judgement in relation to three questions:
1. Is the FBC in line with the model on which we consulted?
2. Is the FBC affordable to Commissioners?
3. Does the FBC improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care?

The CCGs have been supported in their assessment of these considerations through an associated suite of documents and the assurance that has been undertaken. The associated suite of documents that has been produced is:
- Refresh of the Benefits and Outcomes in line with any updated clinical standards and any changes to the proposed model.
- Activity modelling for Community Services.
- Refresh of Integrated Quality Impact Assessment across hospital and community services.
- Refresh of the Public Travel Analysis.
When the Governing Bodies were making their decisions about whether to proceed to consultation they relied, in part, on the assurance that had been undertaken by subordinate committees to assure individual elements of the Pre-Consultation Business Case. In line with these previous assurance arrangements, the refresh of: the Benefits and Outcomes; and the Quality Impact Assessment, have been assured by the CCGs’ Quality Committees. The Activity modelling for Community has been assured by the CCGs’ Finance and Performance Committees. The Public Travel Analysis has been provided to the Travel and Transport Working Group as outlined in Section 5.1.

The area and concerns that the Governing Bodies agreed in October, 2016 should be addressed through exploration of implementation in a FBC, together with the nature and extent of the assurance that has been undertaken is set out below.

4.0 Deliberation recommendations
At their meeting in October, 2016, the Governing Bodies considered: The independent report of findings from consultation and the key findings in relation to each of the service areas; The Equality and Health Inequalities Impact Assessment and; the recommendations from the Joint Health Overview and Scrutiny Committee (JHOSC). Following this consideration, the Governing Bodies agreed the areas and concerns which could be addressed through further development of a FBC. These areas are listed below.

For ease of reference, the section of the report where the CCGs’ response is provided, is noted in brackets in each of the areas.

4.1 Emergency Care
Travel, Workforce and Ambulance Service were mentioned in a number of service areas and were of particular concern around Emergency Care.
(Responses in Sections: 5.1, 5.4 and 5.5.1)

4.2 Travel
Set up a travel and transport group.
Undertake a comprehensive up to date travel analysis.
(Response in Sections 5.1)

4.3 Workforce and Estate
Develop specific detail to identify the workforce and estates requirements to enable Calderdale Royal Hospital to operate as the emergency centre.
(Response in Sections 5.3 and 5.4)

4.4 Ambulance Service
Develop specific detail to identify the future implications for the commissioning of emergency ambulance services.
(Response in Section 5.5.1)

4.5 Urgent Care
Progress the urgent care proposals.
Undertake further work on feasibility and affordability.
Develop the Staffing model and detailed Workforce plans.
(Response in Section 5.5.2)

4.6 Care Closer to Home
Continue to develop and improve Care Closer to Home.
Provide more therapies and services in the local community.
Take action now on the services that can be provided out of hospital.
(Response in Section 5.5.3)
4.7 Maternity Care
The current model for hospital based maternity services stays the same.
Improve the current service in line with consultation findings and the CQC report of findings.
Identify the expansion of community provision in line with the national maternity review.
(Response in Section 5.5.4)

4.8 Planned Care
Progress changes to planned care taking into account surgical consultant feedback.
Ensure risk assessments and escalation policies and procedures are in place.
Set up a travel and transport group and better communicate the model to the public.
(Response in Sections 5.2 and 5.5.5)

4.9 Paediatric Care
Progress the paediatric proposals.
(Response in Section 5.5.6)
Develop specific detail in response to the needs of children within the emergency and urgent care pathway.
Provide clarity about the arrangements required to transfer sick children quickly from the Urgent care Centre to the emergency Centre.
Support parents now through effective communication plans and campaigns.
Consider the findings from the consultation as part of the future commissioning of NHS 111 to improve the service.

5.0 Progress on Governing Bodies’ recommendations.
This section of the report sets out the progress regarding the Governing Bodies’ recommendations in relation to the findings from consultation and deliberation as set out in Section 4.
There are four common themes within these recommendations (Travel and Transport; Clinical Safety and Capacity; Estate; and Workforce) and the progress in relation to these has been set out first. Progress in relation to the remaining recommendations, which are not included in the common themes set out above, follows the update on the common themes. Where the work has been completed by CHFT, a summary is provided and the complete response can be found in CHFT’s Full Business Case

5.1 Travel and Transport
Travel and Transport Working Group
A Travel and Transport Working Group has been established and an Independent Chair has been appointed. The role of the group is: To advise, inform and provide expert input on transport and access matters. The group will:
- Review suggestions for improvements to existing access and travel arrangements identified during public consultation and make recommendations.
- Identify the potential implications of the proposed changes in relation to Access, Travel, Parking, and Public Transport, taking account of the timing and potential impact of the sequencing of the movement of services into community and the proposed improvements to the A629.
- Review and take account of the relevant findings from the Equality and Health Inequality Impact Assessment as part of any recommendations.
- Review the existing and updated Patient travel analyses.
The group will only consider the additional implications of the option on which the CCGs consulted.
The group comprises Representatives from:

- West Yorkshire Combined Authority (WYCA)
- Council Highways & Transport
- Healthwatch
- Upper Calder Valley Sustainable Transport
- Calderdale and Huddersfield Foundation Trust
- Calderdale and Greater Huddersfield Clinical Commissioning Groups.
- North Bank Forum - Public Voice Interface

Members – who attend as required

- MYHT
- SWYPFT
- Kirklees CCG

The Travel and Transport Working Group met for the first time in May and has met on seven occasions to date. The Group will produce a report of findings which will identify action that could be taken to address and mitigate the implications of the proposed changes.

In addition to agreeing its Terms of Reference and work plan, the Working Group has considered information in relation to: the WYCA Transport Strategy; the A629 upgrade (both Halifax and Huddersfield); Primary Care in both Calderdale and Greater Huddersfield; Patient Transport Services, Shuttle Bus and existing CHFT transport methods; Care Closer to Home for Calderdale; an update from Yorkshire Ambulance Service and; Public and Private Travel times by postal district.

The Working Group has also established a Reference Group, independently managed and co-ordinated by North Bank Forum. North Bank Forum are now members of the Travel and Transport Working Group and provide the Public Voice Interface.

The Reference Group will provide the Working Group with access to a range of input and feedback. The Demographic information from the membership, both in relation to themselves and the profile of the groups that they could reach through their networks has been collated and analysed. This has confirmed that there is adequate representation from geographical locations and protected groups in line with our Equality duties.

The intention is that there would not be one designated person to sit on the Travel & Transport Working Group. The Reference Group members have identified their preferred approaches as to how the interface with the Travel & Transport Working Group could work, and, additionally, individuals may be invited to meetings to provide advice and guidance on an ad hoc basis as requested by the Chair.

**Updated Travel Analysis**

The previous Patient Travel Analysis was produced by Jacobs Engineering and formed part of the Pre Consultation Business Case. A revised analysis has been produced and comprises an overall report looking at the impact on travel and an appendix which provides average journey times by Postal District.

The analysis that was commissioned assumed that Dewsbury District Hospital (DDH) would be closed to blue light ambulances. This is the same assumption as was made in the Pre-Consultation Business Case and CHFT’s five year plan. MYHT have advised that this assumption is incorrect. Dewsbury District Hospital will continue to have an emergency department (A&E) which will be open 24 hours a day, seven days a week. The plans include changes to the way that specialist and inpatient care is provided to ensure people are seen more quickly by a clinician with the right skills. Patients who are more seriously ill and need very specialist care which is likely to mean they have to stay in hospital will be taken directly to
Pinderfields if they call a 999 ambulance. The paramedics will decide which is the best hospital for their needs. If a person comes to DDH and the clinical team find they need inpatient care they will be stabilised and transferred to Pinderfields.

In effect this means that there is no longer an either/or situation in relation to DDH as some blue light patients will be taken there (based on protocols agreed with YAS) but some will be diverted to other hospitals. Also, some of the patients who present, who are not conveyed there by ambulance, may need to be taken by blue light ambulance from DDH to another hospital.

The changed assumption in relation to Dewsbury results in the inclusion of a higher number of patients’ data.

The analysis has been produced using CHFT, MYHT and YAS data to model the same two scenarios:

- A single Emergency Centre at CRH without HRI and DDH
- A single Emergency site at HRI without CRH and DDH

The breakdown by Postal Sector shows:

- The Actual time taken;
- The average time for the journey by Public Transport and;
- The average time taken by private car.

There are some limitations to Postal Sector Breakdown and these are set out in Appendix A. Acknowledging these limitations, the Postal Sector analysis does provide average journey times by postal district for travel by private car and public transport. The report has been provided to the Travel and Transport Working Group to inform its work.

5.2 Clinical Safety and Capacity

5.2.1 Clinical Safety - Delivery of Quality and Safety and improved Outcomes

In order to identify any changes to the Quality and Safety implications of the proposals, CHFT has refreshed the Quality Impact Assessment as a component of the work they have done on the FBC. To identify any changes to the Benefits and Outcomes that we expect, the Quality and Safety Case for change has been refreshed to take account of: the updated position in relation to CHFT’s performance; Clinical Consensus on the provision of Paediatric Urgent Care; and updates to the in-hospital clinical standards.

Both the Quality and Safety Case for change and the QIA have been approved by the CCGs’ Quality Committees. The refresh of the Quality and Safety Case for Change has confirmed that the Benefits and Outcomes that we expect from the proposed changes remain the same.

In considering the refresh of the QIA, the CCGs’ Quality Committees have agreed that, as each of the service line changes are developed in greater detail, a further Quality Impact Assessment should be produced. The committees have agreed to adopt the ‘star chamber process’ as detailed in the National Quality Board report ‘Quality Impact assess Provider Cost Improvements plans’ March 2013, to consider the service line QIAs as plans are taken forward into implementation. This is a formal process developed by the National Quality Board to analyse the potential risks and consequences of service transformation and transition. The programme will refer to this as the Quality and Safety Assurance panel.

The panel will consider all the service line changes in line with the implementation time line. The scope of changes considered by the panel will include the transfer of services into community settings and the movement of services between hospital and community sites.

The Quality and Safety Assurance Panel will be convened to scrutinise the Quality Impact Assessment (QIA) carried out by CHFT on each of the proposed service line changes. The process is designed to provide a forum for timely, open and constructive challenge to identify potential risks and consequences of proposed changes. In accordance with NQB guidance, the
process will be clinically led and involve clinical and director representatives from the CCGs and CHFT. As and when required the panel would involve external experts in this process, dependent upon the areas being discussed.

The process will be designed to peer review and critique the service line QIAs by means of open and constructive challenge, to establish that there is sufficient assurance that the planned service line changes would not compromise patient safety or service quality and to make recommendations to the Governing Bodies/Trust Board.

The panel would undertake a detailed and rigorous confirm and challenge process. It may identify additional assurance requirements on specific aspects of the QIA, service line changes and process for future monitoring. It will consider quality and safety from the perspectives set out below:

- **Clinical Effectiveness**
- **Patient Safety and System impact**
- **Patient Experience, Equality & Diversity.** This will include consideration of the recommendations from the Travel and Transport Working Group

This separate and continuing quality assurance process will enable the CCGs to ensure that as the planned service line changes are introduced there is a full understanding of:

- their impact in relation to patient safety and service quality;
- their alignment with the overall Programme QIA;
- their contribution to the overall benefits and outcomes as identified in the Quality and Safety Case for Change; and

- their compliance with the clinical model and agreed standards.

Additionally, the CCGs have been in conversation with the Clinical Senate regarding their recommendation that further work was required to understand the ability of the model to deliver the standards proposed. The Clinical Senate has confirmed that the detail referred to cannot be developed until the individual service line detail has been produced and the CCGs have agreed that we will work with them as part of the Quality Assurance panel described above.

### 5.2.2 Capacity:

One of the elements supporting the provision of assurance in relation to capacity is the delivery of capacity in the Community to reduce the demand on the hospital services. The movement of activity from Hospital to Community is planned to be achieved through the delivery of the service changes in line with the CCGs’ Care Closer to Home Programmes and System Recovery Plans.

When the Pre-Consultation Business Case (PCBC) was completed in December, 2015, one of the assumptions made in the modelling of future capacity and activity was that delivery of commissioners’ QIPP would realise a 6% reduction in non-elective medical admissions per annum for five years.

As part of the production of the FBC, CHFT have refreshed and updated the key planning assumptions previously used in the Trust's five year Strategic Plan. As part of that update, the first two years of the CCGs’ 6% QIPP delivery have been incorporated into the starting baseline. Accordingly, the assumption in relation to the CCGs’ QIPP has been changed. The revised assumption is that the CCGs’ QIPP schemes will deliver a 18% reduction in non-elective medical admissions over a period of five years.

In support of the CCGs’ delivery of a 18% reduction over five years, an internal working group was established to review the CCGs’ plans. Its work was supported and assured by the NHS Transformation Unit which was commissioned to review the CCGs’ plans and to focus on five questions:
1) Given the health system current baseline position and the current evidence available in the UK and internationally, is the range of proposed secondary care activity reduction targets (in-patient admissions) over a five year period a realistic assumption or an aspirational target.

2) If the scale of secondary care activity change is considered aspirational in this area, to what extent are the proposed changes in line with the commissioning of emerging new care models across the whole system and in particular urgent care models.

3) To what extent do the current plans and proposed change interventions focus on the right areas to deliver the scale of change expected and do the two CCGs have the appropriate commissioning and contracting approaches to deliver this change.

4) Is the approach to delivery of the proposed commissioning changes in line with best evidence available or, considering UK and International evidence on the key enablers that might improve the impact of the plans, are there areas of the approach that have significant gaps or could be developed further.

5) What are the key recommendations on what additional focus or work is required across the system to improve the plans of the two CCG’s.

The final version of the report was received in July, 2017. The key findings from the report are:

- To achieve 18% over 5 years is a challenging target. Taking on board demographic changes across the CCG, this target rises to a 23% reduction given the natural 1% growth pa. This equates to 3.5% to 4.5% per annum.

- This is a realistic assumption and is potentially achievable. However, few UK Health Systems have achieved this and it would require the CCGs to achieve the best in Class Upper Quartile position. Greater Huddersfield CCG achieved a reduction of 1.7% over the last five years. Calderdale CCG saw an increase of 0.9% over the last five years, but achieved a reduction of 2.3% in 2016/17.

- The CCGs’ proposed schemes are aligned to the approaches being pursued in many other health communities and international evidence.

- There are too many individual schemes and there would be benefit in joining up some schemes; the balance between schemes which improve planned care and those which improve unplanned care, needs to be adjusted so that more emphasis is placed on schemes which improve unplanned care and are focussed on the large areas of both activity and resource change.

- A contractual framework should be developed that aligns contract levers to encourage multi provider working in the form of a delivery vehicle or joint venture. This framework should be underpinned by a financial model where all providers involved have payment mechanism aligned to the delivery of the commissioning plans’ outcomes both in activity and financial changes.

- Information in relation to national, international and local examples of schemes which have delivered significant capacity in community and/or benefited from a different contracting framework and underpinning financial model are provided.

- Recommendations in relation to key enablers around organisation and skills to support the delivery of the change are included.

The CCGs’ Finance and Performance Committees have agreed that the progression of the recommendations in the NHS Transformation Unit’s report will be overseen by the CCGs’ revised governance arrangements for joint transformation and service improvement.

5.3 Estate

This work has been undertaken by CHFT and is included in their Full Business Case. In summary: During the past six months the Trust has obtained further external estates advice that has confirmed that whilst the CRH site is constrained it is of sufficient size to be able to
accommodate the additional new build and clinical capacity to deliver the service model for unplanned and emergency services at Calderdale Royal Hospital. A Feasibility Cost Model of the expected build costs for the preferred option has been provided and this has been used in the Full Business Case.

5.4 Workforce
This work has been undertaken by CHFT and is included in their Full Business Case. In Summary, the Trust has developed a workforce strategy (copy available on CHFT website) and updated the workforce plan that was used in public consultation. Changes in the national and local workforce context have been used to test the assumptions previously used to profile the future staff groups and numbers employed by the Trust. The Trust's updated ten year workforce plan (2017 – 2027) takes account of the above factors and is based on the assessed impact of the following on the workforce profile and numbers employed.

a) service reconfiguration and redesign to optimise the effectiveness and productivity of the workforce;

b) recruitment and retention to reduce agency spend;

c) recruiting new professional groups;

d) job evaluation approaches to ensure clinically qualified staff can work to the ‘top of their licence’;

e) optimising the availability, utilisation and productivity of the entire workforce creating more time to care.

The ten year workforce plan generates a total planned reduction in whole time equivalent staff employed by the Trust of 479 (this is fewer than the planned reduction of 964 which was included in CHFT’s Five Year Plan). No redundancy costs have been included in the business case since ‘business as usual’ turnover of staff will be sufficient to achieve this reduction without the need for redundancies.

5.5 Deliberation findings by Service Area not covered by the common themes.

5.5.1. Emergency Care
The impact on the Yorkshire Ambulance service (YAS) in relation to these proposed changes will be dealt with as part of the existing commissioning process for Ambulance Services. YAS have been fully apprised of the plans in respect of the changes in the CCGs’ commissioning intentions as a result of the outcome of our proposed reconfiguration plans. The CCGs’ would provide notice of any impending changes as early as possible and at the very least 12 months before the intended change. Following the notice, YAS will complete their ‘Reconfiguration Impact Assessment’ and this will be considered together with any other information regarding proposed changes to services.

5.5.2. Urgent Care and Paediatrics
A Clinical workshop comprising representatives from both CCGs and CHFT has developed additional detail in relation to Urgent Care Centres and Paediatrics. The output from that workshop, providing greater clarity on the proposals is included at Appendix B.

In summary, the workshop has confirmed that the model on which we consulted in relation to Urgent Care, will be the model which would be delivered: it will, medically led, will operate 24 hours a day, seven days a week and will operate on both sites in the same way.

5.5.3. Care Closer to Home (CC2H)
Both CCGs are already delivering revised services in Community. These have delivered improved integration across a number of pathways & between providers, supporting the CCGs’ ambitions of providing care closer to home & reducing hospital admissions / activity. The models of community care are continuing to develop with further integration between community & social care provision, to deliver seamless coordinated care, supporting the CCGs’ to maximise the available capacity within the community services.
Full implementation of Calderdale’s CC2H is planned for April 2019. Work is underway with Calderdale Council to finalise an integrated model of care which will underpin the development of further services and their implementation.

The Kirklees CC2H community service has been operational for 2 years – the CCG are currently mapping through the current position of their delivery model against the timeline & implementation plan (the contract was awarded for 5+2yrs) that the provider submitted. New models of integrated provision are being further developed to support ongoing service reconfiguration for 2018/19 and 2019/20.

The delivery of both CCGs’ Care Close to Home models of care, together with the recommendations in the NHS Transformation Unit’s report will be overseen by the CCGs’ revised governance arrangements for joint transformation and service improvement. Further reports will be provided to Governing Bodies through these arrangements.

5.5.4. Maternity Care

The feedback from consultation and the findings from the CQC have been combined by CHFT and a plan to improve the current service has been produced. The combined plan has also been provided to the West Yorkshire and Harrogate Health and Care partnership. The findings from the National Maternity review have been included in the update to the Clinical Standards which have then fed into the refresh of the Quality and Safety Case for Change and the refresh of the Quality Impact Assessment – as described above.

5.5.5. Planned Care

As part of the CHFT’s refresh of the hospital activity and bed modelling, account has been taken of the surgical consultant feedback and the feedback from consultation regarding the safety of complex surgery on the Planned Care site. With support from NHSI, CHFT has reviewed and updated the hospital activity and bed modelling assumptions previously used during public consultation, to reflect this feedback.

This has resulted in a change to the mix of activity at both the Planned and Emergency sites. The revised activity at both sites would be:

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Acre Mill</th>
<th>CRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCBC</td>
<td>721,060</td>
<td>290,800</td>
<td>430,260</td>
</tr>
<tr>
<td>FBC</td>
<td>721,060</td>
<td>290,569</td>
<td>430,491</td>
</tr>
</tbody>
</table>

Whilst the volume of activity at each site is very similar to the previous modelling, the change in the type of activity at each site, particularly in relation to surgery, where 83% of activity is day-case\(^1\), has resulted in a revised bed distribution across the two sites. This is shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Acre Mill</th>
<th>CRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCBC</td>
<td>732</td>
<td>120</td>
<td>612</td>
</tr>
<tr>
<td>FBC</td>
<td>738</td>
<td>64 (-56)</td>
<td>674 (+62)</td>
</tr>
</tbody>
</table>

Whilst the activity has not changed, there is a reduction of 56 beds at Acre Mill. This is largely related to the removal of 25 beds that would have been used for rehabilitation (it is now assumed that Rehabilitation following treatment will be delivered in a community setting); 21 step down beds have moved to CRH so that patients are not moved between sites following their procedure; and 10 beds have moved to CRH due to surgical complexity. In addition to these 31 beds, there is also an increase of a further 31 beds at CRH to reflect the revised activity.

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\(^1\) In 1998 this was 67%. In 2013 was 78% (Kings Fund 2015)
assumptions in relation to the CCGs’ ambition (Pace & Scale) on the reduction of Non-Elective admissions and the corresponding ability to create capacity in community. The revised assumption is that there will be a reduction of 18% over 5 years (previously 30% over five years). This is covered in more detail in the earlier parts of this report in relation to Capacity and Care Closer to Home.

5.5.6. Paediatric Care
The information in relation to paediatric care is included in the response above in relation to urgent care, with the addition that the findings from consultation (including those in relation to paediatric care) will be fed into the future commissioning of the 111 service.

6. Equalities and Health Inequalities Duties.
The report to Governing Bodies in October, 2016, outlined the findings and conclusions from the Equalities and Health Inequalities Impact Assessment. The progress and arrangements in relation to the Travel and Transport Working Group and the Quality Assurance Process are designed to ensure that these findings and recommendations are taken forward and that the CCGs’ continuing duty in relation to equalities is met.

7. Is the FBC in line with model on which we consulted?
The CCGs have reviewed the model of care that is described within the FBC in the context of the model that was the subject of consultation and the areas of concern that the Governing Bodies agreed were to be addressed as part of the FBC. The progress and assurance in relation to that review are set out earlier in this report.

In summary, the CCGs’ progress in relation to the Governing Bodies’ recommendations has identified that:
- Travel and Transport recommendations have been addressed and there is an ongoing independent process to identify mitigation of the implications.
- The refresh of the Quality and Safety Case for change and the Quality Impact Assessment to take account of the updated position in relation to: CHFT’s performance; clinical consensus on the provision of Paediatric Urgent Care; and the most up to date clinical standards has addressed the recommendation in relation to Clinical Safety.
- The revised assumptions in relation to the pace and scale of delivery of community capacity from the CCGs’ Care Closer to Home programmes and the assurance from the NHS Manchester Transformation Unit have addressed the recommendations in relation to Capacity.
- The continuing process to consider individual service line changes as they are proposed provides assurance that any future changes to the transfer of services into community settings and the movement of services between hospital and community sites will also be compliant with the clinical model and agreed standards.
- Delivery of and compliance with the CCGs’ continuing equality duties will be addressed through the work of the Travel and Transport group and the continuing process to consider individual service line changes.
- Estate and Workforce have been addressed by CHFT in their FBC.
- Individual Service line recommendations have been addressed, particularly in relation to the further detail requested in relation to Paediatric Urgent Care and the change in clinical assumptions regarding Planned care based on feedback from surgical consultants, and the reassessment of clinical risk.
- The changes in clinical assumptions have not made a material difference in the amount of activity that will take place at either the Planned Care site or the Emergency Care site.
• That the changes in bed numbers (across sites and in total) are predicated primarily upon the reassessment of clinical risk in relation to planned care and the revised assumptions regarding Community Services (the move of Rehabilitation to Community and the pace of delivery in relation to CC2H).

The findings from the review of progress in relation to the Governing Bodies’ recommendations is that the FBC is in line with the model on which the CCGs consulted.

In addition to the above, a further clinical workshop with representation from both CCGs and CHFT is taking place on 4th October to enable the CCGs’ Chairs and clinical representatives to provide additional assurance to Governing Bodies that this test has been fully and properly addressed.

8.0 Is the FBC affordable to Commissioners? Does the FBC improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care?
The Finance and Performance Committee has discussed in detail the financial assumptions of the FBC and in its recommendation to the Governing Body for the two areas: CCG affordability and system financial sustainability.
The FBC has been shared publicly by Calderdale & Huddersfield NHS Foundation Trust.

8.1 The Key financial aspects of the CHFT FBC
The governing body should take note of the following key FBC financial aspects:
• A proposed three year construction commencing in 2019/20
• Capital cost of build for the new model of £297m the majority of which is funded through PFI. Retaining the current model would require HRI to be replaced in 10 years time at a cost of circa £379m.
• Estimated annual savings for the Trust are £18m from the site re-configuration
• The Trust returns to surplus in year 8 of the plan, financial year 2024/25
• It incorporates the CCG aspiration of a 6% annual reduction in NEL admissions
CCG financial plans have been shared with the trust as part of the development of the FBC, including our level of assumption around QIPP savings and activity levels.

8.2 Financial risk in current plans
As part of discussions and analysis of the FBC some risks were highlighted:
• The FBC identifies a significant cost improvement program of work to return to a financial surplus position, particularly in the first few years of the plan
• After completion the CIP assumption is on average 2% per annum
• CCG savings requirements over future years are significant and the FBC assumes any additional saving requirements will reduce costs at the same rate as income reduction.
• System financial risk, the annual gap shown within the FBC in 2017/18 is £11.5m growing to £18.5m in 2021/22.
• West Yorkshire wide programs of work.
The CCG and system partners recognise these risks and are working together to develop joint recovery plans to address this outstanding gap and further updates will be provided to the Finance & Performance Committee and Governing Body as appropriate.

8.3 Does the FBC improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care.
The Finance and Performance Committee has considered the risks and benefits of the FBC and recognises the significant contribution it makes to improved clinical care, improved outcomes for our population and financial sustainability. Therefore CCG affordability and achievement of system financial sustainability is dependent upon wider joint working outside of the FBC
including delivery of joint system recovery plan as committed to by all partners. On this basis the Committee recommends that the Governing Body supports the FBC.

9. **External Governance**

9.1 **Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC)**

Following submission to JHOSC of the CCGs’ response to their recommendations, the CCGs and JHOSC entered a period of reconciliation. At the conclusion of reconciliation, the CCGs and CHFT provided an updated response to all of JHOSC’s recommendations in a report that was submitted to its July Meeting.

At that conclusion of that meeting, the JHOSC resolved unanimously that they accepted that maintaining the status quo was not an option and understood the clinical quality and safety case for change. The JHOSC also accepted that delivering services across two sites was a contributory factor in CHFT’s workforce challenges and confirmed that it had expressed no opinion about the location of the planned hospital or the unplanned hospital.

The JHOSC also set a number of serious concerns in relation to: the ability of the CCGs’ to deliver CC2H at the pace and scale that would be required; financial considerations regarding overall sustainability and PFI; The staffing of Urgent Care Centres; Travel and Transport and Parking; capacity of the CRH site; and the revised bed distribution across the two sites.

The JHOSC resolved by a vote of five votes to three 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.

The full wording of the JHOSC resolution is attached at Appendix C.

Following the resolution, JHOSC referred the proposals to the Secretary of State for Health.

9.2 **NHS England (NHSE)**

Following the October, 2016 meeting of the Governing Bodies, their agreed response was forwarded to NHSE. NHSE has confirmed that the three areas identified for further work and consideration as part of the consultation had been addressed through the consultation.

Subsequent to the Governing Bodies’ decision, NHSE announced that from 1 April, local NHS organisations will have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go to consultation:

1. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
2. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The consultation for these proposals had already finished when these new conditions were announced, but the CCGs recognise that compliance with this test is one which they would want to meet. The revised number of beds proposed by this programme is based on conditions 1 and 3 of the new test. In relation to condition 1, the information set out at Section 5.2.2 confirms that a 18% reduction in Non-Elective medical admissions over a period of five years is achievable, but
requires the CCGs to achieve best in class performance; join up proposed community schemes and put in place revised contracting arrangements.

In relation to condition 3, CHFT’s FBC outlines the assumptions that have been made in its modelling regard more efficient use of beds through, for example, reduced length of stay. Following the Governing Bodies’ decision to indicate whether they are supportive or not of the FBC, NHSE will progress to the next stage in their governance process.

9.3 External Governance – Next Steps
The three external governance processes (The referral to the Secretary of State by JHOSC, the further assurance by NHSE and the assessment that is being undertaken by NHSI in relation to the submission from CHFT) will progress in parallel to each other. The CCGs will be providing information to support each of these processes as requested. The CCGs’ Governing Bodies will be updated as this further work progresses. The timetable for determination of these processes has not yet been established.

10. Overall Context of these proposals.
10.1 The Governing Bodies of Calderdale CCG and Greater Huddersfield CCG have previously agreed that there is a compelling case for changing the way that local health services are provided and that change is required to drive up quality and improve outcomes for patients.

The proposed future arrangements for hospital and community health services are a key enabler in the broader redesign and transformation of services across Calderdale and Greater Huddersfield. Together with the CCGs’ Care closer to home programmes and Primary Care Strategies they provide the plan for the delivery of the CCGs’ ambition for their populations and are an integral part of the Sustainability and Transformation Plans (STPs) for both Calderdale and Kirklees and the overall West Yorkshire STP.

11. Conclusions
The areas and concerns which the Governing Bodies agreed could be addressed through further development of a FBC, have been addressed or the CCGs have confidence that arrangements are in place by which they will be addressed.

This conclusion is based on the evidence provided above, supported by judgement in relation to: the Quality Assurance arrangements which have been put in place; the processes which are ongoing in relation to Travel and Transport; and the governance in relation to the delivery of the reduction of 18% Non-Elective admissions and Commissioning of services from YAS.

12. Recommendation
Following consideration on the basis of evidence and judgement and the significant contribution to improved clinical care and improved outcomes for our population the CCGs consider that the FBC is in line with the model on which we consulted.

Following consideration on the basis of: evidence and judgement; the significant contribution to improved clinical care; improved outcomes for our population; and on the basis of the joint system working outlined in section 8.3, the CCGs consider that the FBC is affordable to Commissioners and that the FBC does improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care.

Should the Governing Body agree with this assessment, it is recommended that it should indicate to NHSE that it is supportive of CHFT’s Full Business Case.
APPENDICES
Appendix A  Public and Private Travel Analysis.
Appendix B  Clinical Workshop Urgent Care and Paediatrics
Appendix C  Resolution of the Joint Health Overview and Scrutiny Committee
Public and Private Travel Analysis - limitations to Postal Sector Breakdown.

The results are rounded to the nearest five minutes (so 7:29 would become 5 minutes and 7:31 would become 10 minutes).

a) The analysis assumes that people go to their nearest hospital (even if they think they would be going to CHFT/HRI/DDH) which also reduces the average.

b) Whilst the analysis provides an indication of the total volume of people affected. It overestimates through inclusion of data in relation to attendances at DDH.

c) The total volume of people affected is further overestimated in that it does not subtract 54% in line with the rationale that this would be the volume of patients who would attend an Urgent Care Centre at the site where they currently attend.

d) We cannot provide the split in the percentage of people who would travel by public transport versus the percentage who would travel by private car.

e) We cannot provide meaningful data on the number of visitors to hospital or any reliable assumptions on the starting point for their journey.

f) The data used includes MYHT data which impacts on the volume of people affected and their average journey time.

Acknowledging the limitations described above, the Postal Sector analysis does provide average journey times by postal district for travel by private car and public transport. The report has been provided to the Travel and Transport Working Group to inform its work.
A further Clinical Workshop with representation from both CCGs and CHFT took place in April 2017.

The purpose of the workshop was to provide greater clarity on the Urgent Care proposals, particularly in relation to Paediatrics.

**Urgent Care Centre Principles**

There needs to be extensive / comprehensive marketing campaign telling people what the “offer” is at each site with clear examples of types of conditions that should or should not be taken to a UCC.

Patients should be encouraged to phone 111 for any urgent needs to obtain the best advice about where they should attend (this may not be a hospital site at all). There will be direct booking of appointments in the UCC by 111.

The urgent care offer at Calderdale and Huddersfield UCCs must be essentially the same.

The UCC will provide clinical triage for all “walk-in” patients and redirection if appropriate.

Patients only access the Emergency department via clinical triage, via ambulance (triaged) or referred from either UCC. Patients with life-threatening illness and injury will be taken by ambulance directly to the Emergency Department (or to a specialist emergency / trauma centre).

The GP OOH service will be co-located with the UCC on both sites and will run 24/7.

**Urgent Care Centre Staffing**

The UCC is medically led by a Doctor who is a “generalist” i.e. qualified to deal with the full spectrum of urgent care illness / injury for adults and children. There will be a 24/7 rota where this Doctor is clinically responsible for patients within the UCC although may not physically be in the dept. 24/7.

Diagnostic facilities (including Point of Care and X-Ray) to support triage and decision making will be available.

There will be 24/7 presence of ENP (s) to deal with minor injuries and ANP (s) to deal with minor illness. These will be supervised by the “generalist” Doctor. They will be capable of autonomous clinical decision making and trained in advanced life support.

There will be readily available access 24/7 (either via video technology or adjacent ED) to A&E middle grade or consultant clinical advice if patient requires specialist A&E clinical skills.

**Children**

The Paediatric Emergency Centre (part of the Emergency centre at Calderdale) will have staff and facilities that conform to the RCPCH guidelines and will clearly be marketed as the place to take children who are very unwell or likely to need specialist treatment.

Parents of unwell / injured children should be firstly advised to phone 111 to obtain best advice as to where their child should be seen. Parents of children who are more seriously ill or have serious injury would be advised to phone 999.

Protocols will be in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care is directed to the specialist Paediatric Emergency Department (paediatric surgery and acute inpatient medical care will be co-located with the Emergency Department).

Children over 5 yrs. of age can generally be seen in a UCC for minor illness or injury.

Children who are more seriously ill, have serious injury or are under 5 years old will be quickly triaged, stabilised and, if necessary, transported to the PEC.

The Urgent care centres will be able to treat the following:
<table>
<thead>
<tr>
<th>Minor Injuries</th>
<th>Minor Illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bites/stings</td>
<td>Allergy (including anaphylaxis)</td>
</tr>
<tr>
<td>Burns and scalds</td>
<td>Dermatological conditions</td>
</tr>
<tr>
<td>Contusion/abrasion</td>
<td>ENT conditions</td>
</tr>
<tr>
<td>Diagnosis not classifiable</td>
<td>Infectious disease</td>
</tr>
<tr>
<td>Dislocation/fracture/joint injury/amputation</td>
<td>Local infection</td>
</tr>
<tr>
<td>Electric shock</td>
<td>Ophthalmological conditions</td>
</tr>
<tr>
<td>Facio-maxillary conditions</td>
<td>Psychiatric conditions</td>
</tr>
<tr>
<td>Foreign body</td>
<td>Social problem (includes chronic alcoholism and homelessness)</td>
</tr>
<tr>
<td>Head injury</td>
<td>Soft tissue inflammation</td>
</tr>
<tr>
<td>Laceration</td>
<td></td>
</tr>
<tr>
<td>Muscle/tendon injury</td>
<td></td>
</tr>
<tr>
<td>Nerve injury</td>
<td></td>
</tr>
<tr>
<td>Sprain/ligament injury</td>
<td></td>
</tr>
</tbody>
</table>
At the conclusion of their July 2017 meeting, the JHOSC resolved unanimously that:

1. ‘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 significant concerns are:

- The Joint Committee agreed that it would make a decision on referral to the Secretary of State in the knowledge of the content of the Full Business Case, as discussed at the mediation session in January 2017. The Joint Committee has not been given sufficient time to consider the Full Business Case in line with agreed timescales. The report presented to the Joint Committee at this meeting from CHFT and the CCGs does not adequately address the concerns of the Joint Committee expressed through their recommendations. This is inadequate consultation with the Joint Committee.

- The hospital reconfiguration proposals are dependent on reducing demand on hospital services through “care closer to home”. Although some reduction in unplanned admissions to hospitals has been reported, the Joint Committee is not assured that the proposal for “care closer to home” are sufficiently robust to deliver the reductions in demand on hospital services at a sufficient scale to allow the number of beds in the two hospitals to be reduced by more than one hundred. The Joint Committee is not convinced that an 18% reduction in unplanned admissions is achievable given the advice from NHS Transformation Unit is that few UK health systems have achieved such an improvement and that the Trust is currently only achieving an annual reduction of 2%.

- The Joint Committee has not received sufficient information to be assured that the proposals are financially sustainable. Although the latest proposals reported to the Joint Committee indicate that the CHFT will achieve a surplus after 2024/5, no information has been provided that explains how this is to be achieved.

- The Joint Committee is concerned that the capital development is to be funded through PFI, particularly when no detail about this has been made available to the Joint Committee. The Joint Committee is disappointed that support for the proposals has not been forthcoming from the Treasury or other national Government sources especially in the light of the PFI arrangement that is already in place in Calderdale and Greater Huddersfield.

- The CCGs have not consulted on primary care. However, the Joint Committee has heard evidence that General Practice has an important part to play in reducing demand on hospitals. The consultation document says, “Both CCGs are planning improvements to in-hours and out of hours GP services to reduce the need for patients to attend hospital when they have an urgent care need.” The Joint Committee is not assured that progress in introducing these improvements will be fast enough or substantial enough to have a significant effect on demand at the hospitals, particularly given the scale of the workforce crisis in General Practice.

- The Joint Committee has recommended that better outcomes are embedded across the whole health and social care system and wants to be satisfied that there is sufficient capacity to serve the diverse populations and address the health inequalities that exist.
across both areas. The Joint Committee is not satisfied that this has been satisfactorily addressed.

- The Joint Committee is concerned to learn that there will not be a doctor present at the proposed Urgent Care Centres all the time. This is not consistent with the statement in the Consultation Document that “[the Urgent Care Centre] would be open 24/7 staffed by highly experienced doctors and nurses who have trained and worked in emergency care over many years.”

- The Joint Committee has heard about the reductions in travel time that will result from improvements to the A629 and that ambulance services will be commissioned to achieve the same service standards as currently when new arrangements are implemented. However, the Public Transport Analysis refresh is not complete and the Travel and Transport Group has not reported. Consequently, the Joint Committee still has concerns that the hospital reconfiguration proposals will have a detrimental effect on patients making their own way to hospital and for their visitors.

- The report prepared for the Joint Committee states that 600 car parking spaces will be provided at Calderdale Royal Hospital and that external estates advice is that the site at Calderdale Royal Hospital is of sufficient size to be able to accommodate the additional new build and clinical capacity necessary. Until the Joint Committee receives more detail about this, it cannot be assured about the capacity of Calderdale Royal Hospital to provide a service to a significantly larger number of patients, particularly given the proposed increase in beds at Calderdale Royal Hospital from 612 to 676.

- The reasons for the proposed further reduction in beds from 120 to 64 at the new hospital in Huddersfield have not been adequately described and so the Joint Committee cannot be assured that there will be sufficient capacity in Huddersfield. This change is so significant in size that the Joint Committee does not consider that the public have been properly consulted on this aspect of the proposals.

The JHOSC resolved by a vote of five votes to three

2. The Joint Committee decides 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.
<table>
<thead>
<tr>
<th>Name of Meeting</th>
<th>Governing Body</th>
<th>Meeting Date</th>
<th>12 October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Report</td>
<td>Chief Officer’s Report</td>
<td>Agenda Item No.</td>
<td>7</td>
</tr>
<tr>
<td>Report Author</td>
<td>Matt Walsh, Chief Officer</td>
<td>Public / Private Item</td>
<td>Public</td>
</tr>
<tr>
<td>GB / Clinical Lead</td>
<td>-</td>
<td>Responsible Officer</td>
<td>Matt Walsh</td>
</tr>
</tbody>
</table>

**Executive Summary**

Please include a brief summary of the purpose of the report

This report updates the Governing Body on current pertinent issues.

| Previous consideration | Name of meeting | N/A | Meeting Date | 37T
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<tbody>
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<td>Name of meeting</td>
<td>N/A</td>
<td>Meeting Date</td>
<td>37T</td>
<td></td>
</tr>
</tbody>
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**Recommendation (s)**

It is recommended that the Governing Body receive and note the content of the report.

**Decision**

☐ Assurance ☒ Discussion ☐ Other 37T

**Implications**

<table>
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<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>None identified.</th>
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<tr>
<td>Public / Patient / Other Engagement</td>
<td>The CCG is committed to working with public, staff, patients, partners and other stakeholders to improve health care services.</td>
</tr>
<tr>
<td>Resources / Finance implications (including Staffing/Workforce considerations)</td>
<td>None identified.</td>
</tr>
<tr>
<td>Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)</td>
<td>All</td>
</tr>
<tr>
<td>Risk (include link to risks)</td>
<td>None identified</td>
</tr>
<tr>
<td>Legal / Constitutional Implications</td>
<td>None identified</td>
</tr>
<tr>
<td>Conflicts of Interest (include detail of any identified/potential conflicts)</td>
<td>Any conflicts of interest will be managed in line with the CCG’s Conflict of Interest Policy</td>
</tr>
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</table>

1. Veterans Award
1.1 Calderdale CCG has achieved the Silver Award for the Armed Forces Employee Recognition Scheme. This national award recognises what an organisation does to support employment or services for the armed forces and veteran community. The CCG has identified an Armed Forces Covenant Lead who proactively engages in the Armed Forces Covenant meetings led by Calderdale Metropolitan Borough Council. To date we have encouraged GP practices to become more aware of the needs of veterans by encouraging take up of NHS England’s E-Learning package locally to promote the care available to veterans and also to record this in their clinical systems. Securing this award demonstrates to the people of Calderdale and West Yorkshire that Calderdale CCG is proactively working for those who have served our country.

2. **Sport England**

2.1 The Calderdale system has submitted a bid to become a Sport England delivery pilot, and has been successful in moving to a stage in the process where a panel will visit Calderdale on Tuesday 3rd October to discuss the bid with leaders. The aims of the bid are:

- Shape service transformation related to the health and social care sector via development of neighbourhood hubs linked to our voluntary community anchors. This transformation work will form part of our programme of integration by 2020 linking citizen voice, design and active engagement to create new forms of health and social care delivery.

- To be the most active borough and tackling inactivity is an absolute priority. Under the Active Calderdale umbrella, we will galvanise local action to create a social movement supporting our communities to be more resilient and physically active.

- The built environment will be shaped to support people being active making the most of our beautiful local natural assets. Publicly owned facilities will promote activity and positive activity choices will be the easiest/default for people. We will work with local businesses and workplaces to support physical activity and the wellbeing of employees.

- We will promote the amazing array of benefits physical activity gives us and ensure the transport infrastructure supports and encourages active travel. We will use physical activity to transform communities taking on the challenge of stubborn inequalities and make the economic case for investing in physical activity, and reap wider outcomes.

- We want to explore the application of outcomes based accountability through both service delivery and overall population outcomes with Sport England.

- At the neighbourhood level we expect to use participatory budgeting to encourage community connections, grow new forms of action on activity and support existing business and voluntary offers. Outcomes will be determined by the community and will be communicated back to communities.

2. **NHS e-Referral Service: Paper Switch-Off Programme**

2.1 A national programme has been established to oversee the delivery of e-RS paper switch-off by October 2018. The programme will help Trusts meet the conditions of the NHS Standard Contract where, from 1 October 2018, providers:
need not accept (and will not be paid for any Activity resulting from) Referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service.”

The programme will also help Trusts meet the requirements of the national CQUIN (Commissioning for Quality and Innovation) target for e-RS in 2017/18.

2.2 Calderdale and Huddersfield NHS Foundation Trust (CHFT) has been selected by NHS Improvement to go live with paperless GP referrals by 1 January 2018 – chosen partly because of the high level of e-RS usage within CHFT.

2.3 A small LMC (Local Medical Committee) subgroup will meet Thursday 5 October at Calderdale CCG to discuss GMC and BMA input behind practices no longer issuing paper referrals from GP practices from 1 January 2018. ‘Early Adopter’ practices have been liaising with the Relationship Team to establish in-house practices for moving Suspected Cancer/2WW (two week wait) referrals from the fax machine and onto the national e-Referral Service.

2.4 Full timescale for implementation of the Suspected Cancer/2WW referral process is as follows:

**Phase 1: 2 - 31 October – 2WW Pilot**
CHFT adds 2WW onto e-RS from 2 October for the following pilot practices:

- Hebdon Bridge Group Practices: Valley Medical Centre, Grange Dene Medical Centre, Luddenden Foot Medical Centre
- Caritas: Mixenden Stones Surgery, Shelf Health Centre, Woodside Surgery
- Station Road Surgery
- Todmorden Health Centre
- Plane Trees Surgery

**Phase 2: 1 November – 2WW switch-on**
The Relationship Team continue to liaise with the remainder of Calderdale CCG member practices to send 2WW referrals via e-RS to CHFT.

**Phase 3: 30 November – fax machines**
CHFT will disable the fax machines for receipt of 2WW referrals.

**Phase 4: 1 January 2018 – Routine/Urgent Referrals**
If CHFT receive a faxed referral from a member practice of Calderdale CCG, it will not be processed and will instead be returned to the practice for the referral to be made via the e-Referral Service.

3. **Winter Plan**

3.1 Calderdale and Greater Huddersfield Accident & Emergency Delivery Board (A&EDB) have refreshed the local system’s Winter Plan and Surge and Escalation Plan. The Surge and Escalation Plan describes agreed operational processes through which the system will escalate and de-escalate activities to deal with increases in system pressure throughout the year.

3.2 The Winter Plan confirms additional specific arrangements related to the winter period; for example dealing with periods of extreme cold weather and ensuring business continuity plans are fit for purpose. The work also includes the development of winter communications plans.
3.3 The Plans agreed by the A&EDB are currently going through governance arrangements in each of the partner organisations. This work supports on-call arrangements in place within Calderdale and Greater Huddersfield CCGs and also work with external partners as part of emergency preparedness.

4. **PPE&E Strategy**

4.1 Calderdale CCG has a ‘Public and Patient Engagement and Experience Strategy’ in place for 2015-18. This strategy describes the organisation’s approach to public engagement and patient experience and the relevant legislation and guidance. This strategy is published on the CCG’s website.

4.2 Following the publication of guidance and legislation from NHS England, it was necessary to refresh the current strategy to ensure it is up to date. The new legislation and guidance is set out below:

- **‘Patient and public participation in commissioning health and care’ and ‘Involving people in their own health and care’: statutory guidance for CCGs and NHS England:** The two sets of guidance, and a wealth of web based resources and best practice, together supersede the original ‘Transforming Participation in Health and Care’ guidance, which was published in 2013.

- **Annual reporting on the legal duty to involve patients and the public in commissioning:** building on existing best practice in reporting, this strategy will help to ensure that annual reports meet the needs of patients and the public, CCGs, NHS England staff and relevant stakeholders.

- **Engaging Local People:** This document was published in September 2016 and is for teams developing Health and Care Partnerships and the organisations which form part of them.

4.3 In relation to patient experience we have recognised that there was strong assurance that what the CCG was hearing mirrored what providers were also reporting; without exception. As a result we concluded that it was appropriate to shift the focus to patient experience improvement work rather than data gathering and assurance. This framework is set out in the strategy.

4.4 In addition following a CCG workshop on co-production with the Mental Health Innovation Hub, the hub co-designed a set of principles for co-production, which were agreed by all partners. Following the refresh we have now also included these principles in the strategy.

4.5 **It is recommended that:**

The Governing Body acknowledges the new legislation and accepts the changes made to the current strategy. If Governing Body members wish to receive the refreshed document prior to publication it can be circulated after this meeting.

Subject to agreement by the Governing Body, the refreshed strategy will be published two weeks after this meeting.
5.0 Managing Conflicts of Interest

5.1 On 16 June 2017, NHS England issued revised statutory guidance for Clinical Commissioning Groups (CCGs) on the management of conflicts of interest. This revised guidance takes into account the new cross system requirements.

5.2 Key changes introduced are:

- **Registers of interest** - CCGs must satisfy themselves, as a minimum on an annual basis, that their registers of interest are accurate and up to date. Only decision-making staff are required to be included on the publicised register.

- **Gifts from suppliers or contracts** - gifts of low value (up to £6) can now be accepted.

- **Gifts from other sources** - gifts of under £50 can be accepted from non-suppliers and contractors. These do not need to be declared. Gifts of over £50 can only be accepted on behalf of the organisation.

- **Hospitality** – meals and refreshment - hospitality under £25 does not need to be declared. Anything between £25 and £75 can be accepted but must be declared. Anything over £75 should be refused until senior approval is given.

- **New care models** - a new annex has been included to provide further advice in this developing area.

5.3 The guidance can be found at: www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

5.4 The CCG has updated its policy for the Management of Conflicts of Interest to take account of the new requirements. A copy of the revised policy, which was approved by the Audit Committee on the 21st September 2017, can be found on the CCG’s website: https://www.calderdaleccg.nhs.uk/wp-content/uploads/2016/06/005-Conflicts-of-Interest-Policy-FINAL-revised-03-Oct-2017-1.pdf

6 Equality Delivery System (EDS2) and Equality Objectives

6.1 The Equality Delivery System (EDS2) for the NHS is a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for individuals and groups protected by the Equality Act 2010, and to support them in meeting the Public Sector Equality Duty (PSED). The principal aims of the EDS2 are to embed equality into business practices and foster a culture of transparency and accountability in the CCG. It supports the CCG to review current equality performance and identify future priorities and actions, including the development of new Equality Objectives.

6.2 A new model for delivery of the EDS2 was developed in 2016/17 with input from Community Voices, the voluntary, community and social enterprise sector (VCSE) and local healthcare providers. An assessment panel was established with membership from Community Voices and the VCSE sector, representing a range of protected characteristics. The CCG was assessed by the grading panel against a prescribed set of goals and outcomes. A report detailing the results and recommendations is available on the CCG website.

6.3 The comments and recommendations made by the grading panel and the assessment of workforce related performance have been used to inform a new set of Equality Objectives and
actions for the CCG in 2017. The following proposed headline objectives have been drafted by the Equality Steering Group and will run for four years. Subject to approval by each organisation, it is anticipated that the same high level objectives will be shared across Calderdale, Greater Huddersfield and North Kirklees CCGs.

6.3.1 Improve access to GP Practices for specific equality groups (the groups will be agreed during an SMT development session)

6.3.2 Improve engagement with specific equality groups (the groups will be agreed during an SMT development session)

6.3.3 Improve governance processes for equality

6.4 It is recommended that the Governing Body:

Agrees the high level objectives in relation to Equality Delivery System (EDS2) and Equality Objectives.

7. NHS Charging Regulations (Amendment)

7.1 There is growing concern about the potential impact of the new Charging Regulations for Overseas visitors upon the ability of particularly vulnerable people to access services, and some concern about the additional bureaucratic burden being placed upon health service providers as a consequence of these regulations. I though it worthwhile to bring the matter to the attention of the governing body.

7.2 Not everyone is entitled to free NHS hospital treatment in England. This guidance explains what should happen when an overseas visitor needs NHS treatment provided by an NHS hospital in England. New guidance has been produced which is intended for staff at relevant NHS bodies, including clinicians, senior managers and clerks, and in particular staff with a responsibility to identify and charge overseas visitors. The Department of Health strongly recommends that relevant NHS bodies have a designated person/s – hereafter referred to as an Overseas Visitor Manager (OVM) – to oversee the implementation of the Charging Regulations. All staff, including clinicians and managers, have a responsibility to ensure that the charging rules work effectively.

7.3 DH believes that the success of the charging rules also depends on NHS staff being aware and supportive of the role of the OVM. The OVM should be given the authority to ensure that the charging rules can be properly implemented in all departments.

I have reproduced the following from the guidance, which is available in full at:


3. The NHS is a residency-based healthcare system and eligibility for free NHS hospital care is based on the concept of “ordinary residence”. An overseas visitor is any person who is not “ordinarily resident” in the UK. A person will be “ordinarily resident” in the UK when that residence is lawful, adopted voluntary, and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration. Nationals of countries outside the European Economic Area (EEA) must also have indefinite leave to remain in the UK in order to be “ordinarily resident” here. A person who is “ordinarily resident” in the UK must not be charged for NHS hospital services.
4. The Charging Regulations place a legal obligation on NHS trusts, NHS foundation trusts and local authorities in the exercise of public health functions in England (referred to as ‘relevant NHS bodies’), to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges. From 23 October 2017 this legal obligation will also apply to any provider of NHS-funded community and secondary care including non-NHS organisations, at which point the term will change to ‘relevant body’.

5. When charges apply, a relevant NHS body must make and recover charges from the person liable to pay for the NHS services provided to the overseas visitor. From 23 October 2017 relevant bodies (which will then include non-NHS organisations providing NHS funded secondary care) will be required to recover these charges in full in advance of providing them, unless doing so would prevent or delay the provision of immediately necessary or urgent services.

I have appended a table which outlines the changes consequent to the 2017 amendment.
<table>
<thead>
<tr>
<th>Regulation 3A(1)(a)</th>
<th>Person is being treated in accordance with the treatment of any condition to which this paragraph applies, or is being treated as an outpatient. The treatment is provided free of charge.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 3A(1)(b)</td>
<td>Person is being treated with the consent of the person to whom this paragraph applies, or is being treated as an outpatient. The treatment is provided free of charge.</td>
</tr>
<tr>
<td>Regulation 3A(1)(c)</td>
<td>Person is being treated in accordance with the treatment of any condition to which this paragraph applies, or is being treated as an outpatient. The treatment is provided free of charge.</td>
</tr>
</tbody>
</table>

Situation 2: Expanding the role of healthcare providers in accordance with the Regulations coming into force.

Situation prior to 2017 Amendment Regulations coming into force.

Situation subsequent to 2017 Amendment Regulations coming into force.

Situation before and after the 2017 Amendment Regulations coming into force.

Chargeable visits apply to overseas visitors and whether on examination from an overseas visitor (their consistent category) when a patient's NHS record (their consistent NHS record) will not be received to record an overseas visitor in an overseas visitor's NHS record. From August 2017, when the patient has in an overseas visitor's NHS record, where the patient has been an overseas visitor, whether on examination from an overseas visitor (their consistent category) when a patient's NHS record (their consistent NHS record) will not be received to record an overseas visitor in an overseas visitor's NHS record.

Chargeable visits apply to overseas visitors when the patient has been an overseas visitor, whether on examination from an overseas visitor's NHS record, where the patient has been an overseas visitor, whether on examination from an overseas visitor's NHS record. From August 2017, when the patient has been an overseas visitor, whether on examination from an overseas visitor's NHS record, where the patient has been an overseas visitor, whether on examination from an overseas visitor's NHS record.
<table>
<thead>
<tr>
<th>Service</th>
<th>Exception, where family planning services are provided by a provider other than the NHS, to be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Trust</td>
<td>An organisation other than in NHS Trusts of NHS registered providers of primary care services that are provided by GPs or hospitals to patients.</td>
</tr>
<tr>
<td>CIC</td>
<td>Palliative care services provided by a palliative care charity or other service provider.</td>
</tr>
<tr>
<td>Person’s interests</td>
<td>By other NHS Trust.</td>
</tr>
<tr>
<td>UK registered ships</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Overseas visitors working in the UK and the NHS absorbs the cost.</td>
<td>UK, the employer is not liable for the cost of treatment</td>
</tr>
<tr>
<td>The employer is the owner of the ship on which they are employed or employed on ships registered outside the UK.</td>
<td>Overseas visitors working on ships registered outside the UK is working in any capacity, or a ship registered in the UK is an overseas visitor.</td>
</tr>
<tr>
<td>From 21 August 2017, the employer of an overseas visitor</td>
<td></td>
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</tbody>
</table>

| | Examples: Persons dependent, which includes family members, and support family members and dependents as defined by the asylum seeker. | Regulations 4(3)(d) and 4(3)(e) |
| | Refugee, asylum seeker or supported family member, or family member who is employed on ships registered outside the UK. | |
| | The Department of Health has made amendments to this. | |

5-7 and Table 5-2-2 for more information. | Ordinary resident person for the duration of their visa. | |
| Apply under the charging regulations. Please see paradigm. | Secondary care services are exempt from change. | |
| These charging courses of treatment that are underway on | | |
Executive Summary

Please include a brief summary of the purpose of the report

This report provides an overall review of the Safeguarding Adults and Safeguarding Children’s work undertaken within and on behalf of the CCG from April 2016 to March 2017.

A contextual background from both a national and local perspective has been provided including changes to processes for Safeguarding, as well as horizon scanning for imminent future changes sets the scene for the safeguarding work being undertaken.

The report details the achievements for the reporting period and the work priorities for the coming year. Overall the report provides assurance that the CCG is engaged and supporting work to Safeguard Adults at risk of abuse and neglect and Safeguarding Children that forms part of its responsibilities.

Recommendation(s)

It is recommended that the Governing Body:
1) Receives and notes the contents of report;
2) Makes any further comments or recommendations as appropriate;
3) Confirms that it is assured that the CCG is fulfilling its responsibilities as a statutory partner and engaging in safeguarding work and activity.

Implications

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

None Noted

Public / Patient / Other Engagement

The report provides assurance of the engagement with local partners for safeguarding work and activity

Resources / Finance implications (including Staffing/Workforce considerations)

None identified

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

Ensure services we commission are safe

Risks

None identified

Legal / Constitutional

The duties and functions

Conflicts of Interest
| Implications | in relation to safeguarding for CCGs are articulated within NHS England Safeguarding Accountability & Assurance Framework (June 2015) | (include detail of any identified/potential conflicts) | None |
1. Introduction

1.1 This report summarises the safeguarding activity in NHS Calderdale Clinical Commissioning Group (CCG) from 1st April 2016 to the 31st March 2017. As an NHS organisation and principal commissioner of local health services, the CCG has specific responsibilities and duties in respect of safeguarding children (including looked after children) and adults at risk of abuse.

2. Detail

2.1 The purpose of the joint report is to assure the Governing Body and members of the public that the NHS Calderdale Clinical Commissioning Group (CCG) is fulfilling its statutory duties in relation to safeguarding and children looked after in Calderdale; it takes account of and provides information about national and local safeguarding influences and how statutory requirements are being assured.

3. Next Steps

3.1 It is requested that the Governing Body review the report and make any comments or ask for clarifications.

3.2 The CCG is assured that that it is fulfilling its statutory responsibilities and is engaged and working in partnership to safeguarding adults at risk and children within Calderdale.

4. Implications

4.1 Public / Patient / Other Engagement

The report provides assurance of the engagement with local partners for safeguarding work and activity

4.2 Legal / Constitutional Implications

The duties and functions in relation to safeguarding for CCGs are articulated within NHS England Safeguarding Accountability & Assurance Framework (June 2015)


5. Recommendations

It is recommended that the Governing Body:

1) Receives and notes the contents of report;

2) Makes any further comments or recommendations as appropriate;

3) Confirms that it is assured that the CCG is fulfilling its responsibilities as a statutory partner and engaging in safeguarding work and activity

6. Appendices

Appendix 1 Safeguarding Adults at Risk and Children’s Annual Report 2016-17
Safeguarding Annual Report 2016-17

**Version Number:** 3

**Name of Author:** Luke Turnbull Designated Nurse Safeguarding Adults & Gill Poyser-Young Designated Nurse Safeguarding Children

**Date of the Report:** 1st April 2016 to 31st March 2017

**Name of Responsible Director/ Assistant Director:** Penny Woodhead – Head of Quality

**Date of the Board/ Committee Meeting:** 12th October 2017

**Date of Previous Submission to the Board/ Committee:** 13th October 2016
Acknowledgment

NHS Calderdale Clinical Commissioning Group (CCG) would like to take this opportunity to thank its partner agencies in working collaboratively in ensuring the agenda for both children’s and adults safeguarding is meeting its statutory responsibilities in safeguarding vulnerable people in Calderdale between 2016/2017.

NHS Calderdale CCG would like to thank both the Children's and Adults Safeguarding Boards in driving its responsibility across Calderdale.

NHS Calderdale CCG would finally like to thank NHS England, the Yorkshire and Humber Safeguarding Network and other regional and national partners in helping drive the safeguarding priorities across Calderdale CCG’s and Local Authorities to enable us all to learn lessons, share knowledge, skills and expertise for assurance purposes.

Declaration

The authors assert that NHS Calderdale CCG Safeguarding Annual Report has not been published before and is a true record of the work that has been undertaken during 2016/2017. NHS Calderdale CCG is not responsible for the content of the external links included in this report.
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Luke Turnbull & Gill Poyser-Young Designated Nurses Safeguarding Calderdale CCG
Combined Adults at Risk and Children's Safeguarding Annual Report 2016/17
1.0 EXECUTIVE SUMMARY

This is the Clinical Commissioning Group’s (CCG) second combined safeguarding annual report (separate safeguarding reports for children and adult safeguarding were written prior to this). It outlines the responsibilities of the CCG in respect to safeguarding adults, children and Mental Capacity Act (MCA) implementation. The report covers the period of 1st April 2016 to the 31st March 2017 and provides both the national and local context to safeguarding developments. It outlines how the CCG is meeting its statutory requirements and responses to local challenges and an expanding agenda.

1.1 Internal governance for reporting safeguarding children’s and adults national and local developments and key priorities has continued throughout the previous year. This report provides a summary overview of safeguarding and compliments the regular reports submitted to Quality Committee. It contains some core data but not a full range. Further information on local safeguarding data can be found on the Safeguarding Boards Website and in the Calderdale JSNA.

All NHS organisations have a statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. CCGs are required to provide an annual report on Safeguarding Children that links to the Children Act (2004) Section 11 requirements and present these to the CCG Board. NHS bodies are statutory members of the Local Safeguarding Children’s Boards under Section 13 of the 2004 Act. The local coordination of Safeguarding Adults at risk was strengthened with the introduction of The Care Act (2014) in April 2015, which put Safeguarding Adults Boards on a statutory footing.

1.2 CCGs are statutorily responsible for ensuring that the organisations from which they commission services have safe and effective systems that safeguards adults and children at risk of abuse, neglect or exploitation. This includes specific responsibilities for children looked after (CLA) and Care Leavers (CL) and for supporting the Child Death Overview process including sudden unexpected death in childhood. The Child Death Overview Panel (CDOP) annual report is available on request for information and through the Safeguarding Board Website. The Children’s Looked After report is submitted separate to the Safeguarding annual report to the CCG Quality Committee by the Designated Doctor and Nurse for Children Looked After.

1.3 CCGs are responsible for securing and employing the expertise of Designated Safeguarding Professionals on behalf of the local health system. These statutory roles undertake a whole health economy perspective. It is crucial that Designated Safeguarding Professionals play an integral role in all parts of the commissioning cycle, from procurement to quality assurance if services are to be commissioned that support adults and children at risk of abuse or neglect, as well as effectively safeguard their wellbeing. Additionally CCGs are responsible for securing the expertise of Designated Professionals for Children Looked After.

1.4 The Designated Nurse role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child and adult protection. Designated Nurses are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the LSCB/SAB and the Health and Wellbeing Board.

1.5 The CCG has continued to make a significant contribution to the work of Calderdale Safeguarding Boards (Local Safeguarding Children’s Board (LSCB) and Calderdale Safeguarding Adults Board (CSAB)) and to the Corporate Parenting Panel (CPP). The Health and Wellbeing Board with responsibility for safeguarding has Executive CCG representation.
Key achievements 2016-17

- **NHSE conducted an audit** of all CCG safeguarding teams in North of England. (see section 3.2)
- **Internal audit** of safeguarding - Calderdale CCG provided significant assurance, and all actions are complete. (see section 3.2)
- **Merger of back office functions of the Boards** - this has significantly improved the functioning and development of the CSAB. (see section 5.2)
- **CCG Policies reviewed** Safeguarding, MCA / DoLS, Domestic Abuse and Prevent policies have been reviewed and updated.
- **Applications for Deprivation of Liberty made** to the Court of Protection. 2016-17 saw the CCG make its first applications to the Court of Protection. All applications have been accepted without the need for revision. One significant case in the Court of Protection has concluded with the court praising the involvement of the CCG (see section 5.9.1)
- **Improved safeguarding training compliance across the CCG** (see section 3.3)
- **Development of safeguarding pages of CCG internet and intranet** (see section 4.2)
- **Bi-monthly safeguarding newsletter for primary care staff** (see section 4.2.4)
- **All GP practices have a Safeguarding Lead** (see section 4.2.1)
- **CSAB development of a high level performance scorecard** and increased focus by the CSAB on gaining system safeguarding assurance. (see section 5.2.1)

This annual report has provided an insight into local developments and initiatives pertaining to safeguarding that have taken place during the last twelve months. In doing so it aims to provide assurance to the Governing Body that the CCG is fully committed to ensuring they meet their statutory duties and responsibilities for safeguarding children and adults at risk of harm.
2.0 BACKGROUND AND PURPOSE

This report summarises the safeguarding activity in NHS Calderdale Clinical Commissioning Group (CCG) from 1st April 2016 to the 31st March 2017. As an NHS organisation and principal commissioner of local health services, the CCG has specific responsibilities and duties in respect of safeguarding children (including looked after children) and adults at risk of abuse.

Over recent years, safeguarding has grown and changed. The safeguarding team at CCGC lead on the following areas which are now considered to be under the safeguarding umbrella:

- Safeguarding Adults at Risk
- Safeguarding Children
- Prevent
- Human Trafficking and Modern Day Slavery
- Domestic Abuse
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Children Looked After
- Forced Marriage
- Female Genital Mutilation
- Child Sexual Exploitation

The purpose of the joint report is to assure the Governing Body and members of the public that the NHS Calderdale Clinical Commissioning Group (CCG) is fulfilling its statutory duties in relation to safeguarding and children looked after in Calderdale; it takes account of and provides information about national and local safeguarding influences and how statutory requirements are being assured.

Although the report does include information regarding Children Looked After, a separate report has been authored under the current commissioning arrangements about how the health needs of this cohort of children and young people have been met and presented to the CCG Quality Committee prior to submission to the joint CCG and Local Authority performance monitoring meeting and then presented to the Corporate Parenting Panel.

3.0 GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The duties and functions in relation to safeguarding for CCGs are articulated within NHS England Safeguarding Accountability & Assurance Framework (June 2015)


The CCG receives assurance from its safeguarding team through quarterly reports to Quality Committee and through Annual Reports to the Governing Body.

NHS Calderdale CCG has fulfilled its requirement to secure the expertise of designated professionals, who provide strategic guidance and advice in their respective roles for safeguarding adults, children, looked after children and child death. The incumbent professionals have relevant and appropriate skills and knowledge to support the CCG in commissioning and assuring safe and effective services for CCGC residents. The Named GP role has yet to be appointed to since it became vacant in January 2017, despite recruitment initiatives.

The CCG are also required to have a Designated Doctor for Safeguarding Children in place and for Calderdale this is Pamela Ohadike who is commissioned through Calderdale and
Huddersfield NHS Foundation Trust. The Paediatrician for Sudden Unexpected Infant Childhood Deaths (SUDIC) is Dr Eilean Crosby who is also commissioned through CHFT.

The Calderdale Children Safeguarding Board (CSCB) and the Calderdale Safeguarding Adult Board (CSAB) also have responsibilities to receive assurance from all partners including Calderdale CCG that arrangements are in place to safeguard children and adults at risk.

Calderdale CCG and the Local Authority are jointly responsible for commissioning the ‘Children Looked After’ Health Service which is delivered by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The CCG is required to have in place a Designated Doctor, Dr Liz Higgs and Nurse, Hannah Smith, for Children Looked After to assist them in fulfilling their responsibilities for the health needs of Children Looked After.

3.1 The Shared CCG Safeguarding Team

The safeguarding team is hosted by Greater Huddersfield CCG and sits under the leadership of the Head of Quality.

Whilst each member of the team undertakes work on behalf of one or two CCGs, the shared nature of the team allows for joint working, sharing of best practice and cover for leave.

As well as undertaking the work described in this report the Designated Nurses are accountable to NHS England. They all work on a regional and national basis as well as directly for the CCGs, this work includes providing safeguarding supervision for other safeguarding specialists in the region.

3.2 Audits

The table below summarises the outcomes of the audits that the CCG safeguarding team have been involved in, in 2016-17:

<table>
<thead>
<tr>
<th>Audit</th>
<th>Scrutiny</th>
<th>Assessment &amp; Areas for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework – self assessment audit Completed May 2016 and NHSE visit July 2016</td>
<td>NHS England and reported via CCG Quality Committee &amp; Governing Body</td>
<td>The majority of domains were RAG rated Green. Just 3 out of 28 areas were assessed as having a RAG rating of Amber. There were no areas RAG rated as red. Minor amendments to policies required - whistleblowing, acceptable standards of behaviour and managing allegations about staff. Now complete. An action plan was put in place and has been completed</td>
</tr>
<tr>
<td>CCG Internal Audit undertaken by NHS Audit Yorkshire</td>
<td>Audit Committee</td>
<td>Provided “significant assurance” with actions concerning training compliance and strategy which have been completed.</td>
</tr>
<tr>
<td>Section 11 Safeguarding Children Audit Provided annually to the Calderdale</td>
<td>CSCB Performance Monitoring &amp; Quality Assurance Audit Sub Group.</td>
<td>Majority of sections were RAG rated as green. There were no RAG ratings of red. One area was RAG rated as Amber which focused on training and recognised the ongoing work.</td>
</tr>
</tbody>
</table>
**Safeguarding Children Board (CSCB)**

| NHS England Children ‘Looked After’ Self – assessment Audit Requested by NHSE | NHS England and reported via CCG Quality Committee & Governing Body | Majority of sections were RAG rated as green. There were no RAG ratings of red. One area was RAG rated as Amber which focused on reporting lines into the CCG and access to the Head of Quality |
| CSAB Safeguarding Adults self-assessment completed November 2016 | CSAB | 37 out of 41 areas rated as fully compliant. The other 4 areas are rated as partially compliant:  
- Evaluating the impact of training  
- Engaging further with patients and carers to develop safeguarding strategy, planning and delivery  
- Linking CCG safeguarding policies with other policies (now complete)  
- Information for patients being available in languages other than English. |

### 3.3 CCG Safeguarding Training Compliance

The Safeguarding Team provide Safeguarding, Mental Capacity Act and Prevent training for CCG staff. It is the responsibility of all staff and their line managers to ensure they are fully compliant with all statutory and mandatory training.

All CCG staff are required to undertake Level 1 Safeguarding Adults and Children Training every 3 years. In addition to this Governing Body Members are required to attend a face to face training session every 3 years. Continuing Health Care staff who do not have patient contact are required to undertake Level 1 training and clinical staff require Level 3 training in both Children and Adults Safeguarding every 3 years. Training is available via both face to face sessions and e-learning.

The table below shows training compliance for different CCG staff groups at the end of March 2017:-

<table>
<thead>
<tr>
<th>CCG Staff Group</th>
<th>Training Compliance Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body members</td>
<td>82%</td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>71%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Continuing Health Care (CHC)</strong></td>
<td></td>
</tr>
<tr>
<td>Level 1 Adult Safeguarding</td>
<td>100%</td>
</tr>
<tr>
<td>Level 3 Adults Safeguarding</td>
<td>18%</td>
</tr>
</tbody>
</table>
Since this time further face to face level 3 sessions have been delivered for CHC staff. The safeguarding team has also reminded other individual staff members and their line managers of their training requirements and this has resulted in significantly improved compliance levels. Safeguarding training compliance is monitored by the Quality Committee, Senior Management Team and through Heads of Service on a regular basis.

### 3.4 Summary of Progress and achievement 2015/16:

The 2015/16 Calderdale CCG Annual Safeguarding Report (October 2016) identified safeguarding priorities for achievement in 2016/17, below is a summary of progress against those priorities:

<table>
<thead>
<tr>
<th>2015-16 Priority area</th>
<th>Progress in 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued partnership work with the Local Safeguarding Boards</td>
<td>The CCG safeguarding team has continued to make significant contributions to the CSAB and CSCB – (see sections 5.2 &amp; 5.3)</td>
</tr>
<tr>
<td>To ensure that the voice of the adult at risk and their carers influences the development of safeguarding adults within the CCG and CSAB</td>
<td>An engagement and communication strategy has been produced by the CSAB. The CSAB strategic plan identifies areas for further engagement with adults at risk and their carers.</td>
</tr>
<tr>
<td>To ensure that the voice of the child continues to influences the development of safeguarding children within the CCG and CSCB</td>
<td>Young Advisors have supported and advised the safeguarding partnership, who have in turn drawn on: the electronic Health Needs Assessment (eHNA), which is an annual survey carried out across schools by Public Health; children and young people who work with the Council; children who are looked after by the Local Authority (LA); and national work carried out by the Office of the Children’s Commissioner. As a result we have a good idea of some of the things that matter to children, which means that as we go forward we are better able to balance what matters for adults and what matters for children when it comes to deciding where as a partnership we should focus.</td>
</tr>
<tr>
<td>To ensure that appropriate DoLS applications are made to the CoP</td>
<td>Several DoL applications have been made to the Court of Protection in 2016-17. (see section 5.9.1) for further details</td>
</tr>
<tr>
<td>To ensure internal governance for safeguarding activity is effective within the CCG via internal reporting processes</td>
<td>Quarterly reports to the CCG Quality Committee provide oversight of activities and challenge. Internal audit demonstrated significant assurance (see section 3.0)</td>
</tr>
<tr>
<td>Further improve engagement from GP in safeguarding adults and children</td>
<td>Quarterly safeguarding GP leads meetings, training sessions delivered and various resources distributed including the development of a safeguarding newsletter to keep practices updated on local and national developments. (see section 4.2)</td>
</tr>
</tbody>
</table>
Continued and extended support to General Practice and support for commissioned providers

Telephone advice provided by safeguarding team on an as required basis. Primary Care safeguarding training plan in place. Prevent training provided to most GPs and other clinicians in primary care. GP safeguarding standards in place. GP safeguarding leads meeting every quarter. (see section 4.2)

Continued monitoring of commissioned providers to deliver assurance of their continued engagement with the safeguarding work and agenda

Attendance at Trust safeguarding meetings. Performance included in quarterly reports to CCG Quality Committee. Safeguarding standards in place and reviewed. Safeguarding Self-assessment completed for CSAB. Regular supervision with Heads of Safeguarding and Named Nurses. Children’s Health Advisory Group and Adults Health Alliance meets quarterly to update providers, group supervision and share best practice. (see section 4.0)

Review the current arrangements for Children’s Looked After Health Service

Review of service undertaken and new service specification produced. Contract advisory board now leading this process

To review the outcomes of the first year of the commissioned domestic abuse health service

Annual report produced by the service and potential cost savings produced for if further funding is obtained to maintain the service

### 4.0 CALDERDALE’S STRATEGIC APPROACH TO SAFEGUARDING

NHS Calderdale CCG is required to provide assurance that safeguarding activity within all commissioned services meets national safeguarding standards and demonstrates a model of continuous improvement. This is reflected in local policy and procedure and reflected in the CCG governance framework and delivery plan.

Commissioning and planning of most health services are carried out by Calderdale CCG and the local authority Public Health

All provider services are required to comply with the Care Quality Commission Essential Standards for Quality and Safety that include safeguarding standards (Regulation 13).

NHS Calderdale CCG performance manages each provider organisation via formal contract review meetings. In addition the following arrangements have been in place to strengthen the NHS Calderdale CCG’s safeguarding assurance processes:

- CCCG safeguarding standards are in place which reflects the safeguarding standards expected of all commissioned providers. These are regularly reviewed and the main providers (CHFT and SWYFT) are expected to self-assess on an annual basis and provide a response and action plan in areas of limited compliance. Locala will also be asked to undertake these from July 2017 when they are delivering the 0-19 service

- Designated Leads are members of each Provider Trust’s internal Safeguarding Committees. This gives the opportunity for the Designated Nurses an opportunity to review and challenge performance information as well as support developments.

- Reviewing all new service specifications when procuring services to ensure compliance with standards prior to the start of the newly re-procured service.
- Regular meetings with Heads of Safeguarding in provider agencies to support ongoing developments and seek assurance.
- Review of Serious Incidents with a safeguarding element
- Close working with safeguarding boards to gain whole system safeguarding assurance.
- Leading the GP safeguarding leads forum, this offers case supervision, updates on new requirements and initiatives and support to practices.

### 4.1 Provider Safeguarding Committee Key Headlines

<table>
<thead>
<tr>
<th>Name of Provider: Safeguarding Committee</th>
<th>Key Headlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust (CHFT)</td>
<td>The CHFT Safeguarding Committee to meets on a monthly basis with representative from all divisions and with attendance from Designated Nurses for Adult and Children’s Safeguarding within Calderdale CCG (in a shared CCG Safeguarding Team approach – all information from the committees are shared within the team). Of note in the last year:-</td>
</tr>
<tr>
<td></td>
<td>• The organisation has reported the low compliance rate for some areas of safeguarding training from both an adults and children perspective (although compliance rates have risen). The Designated Nurses have raised concerns about this and within the organisation all divisions have been requested to take a focussed approach to addressing the low compliance level.</td>
</tr>
<tr>
<td></td>
<td>• Level 1 training figures have increased from 81% to 87% this year</td>
</tr>
<tr>
<td></td>
<td>• Level 2 has increased from 60% to 74% (adults) and from 63 % to 75% (children).</td>
</tr>
<tr>
<td></td>
<td>• Level 3 Adults – was a new data capture since the allocation of Level 3 to particular staff groups, and continues to increase from 13% to 39%</td>
</tr>
<tr>
<td></td>
<td>• Level 3 Children has increased from 33% to 61%.</td>
</tr>
<tr>
<td></td>
<td>• FGM training compliance is now at 48%. The eLearning package became available in January 2017</td>
</tr>
<tr>
<td></td>
<td>• Prevent compliance figures have increased by 10% from 62% to 72%. This training has been delivered face to face this past year.</td>
</tr>
<tr>
<td></td>
<td>• Requirement to attend safeguarding children supervision continues in line with the Intercollegiate Document 2014 and Working Together 2015.</td>
</tr>
<tr>
<td></td>
<td>• A DoLS audit that was undertaken within the Trust by the internal safeguarding team demonstrates improved awareness of staff as to how to identify a potential DoL and when to make an application of assessment.</td>
</tr>
<tr>
<td></td>
<td>• Overviews of the SAR/DHR/SCR that the organisation have been involved have been presented, and it has been noted that the committee</td>
</tr>
</tbody>
</table>

Safeguarding leads have been identified throughout the organisation and part of this role will require them to be trained to facilitate safeguarding supervision in line with their staff requirements to help improve compliance.

Training for supervisors is in place and mechanisms for monitoring safeguarding supervision compliance have been established.

- A DoLS audit that was undertaken within the Trust by the internal safeguarding team demonstrates improved awareness of staff as to how to identify a potential DoL and when to make an application of assessment.
- Overviews of the SAR/DHR/SCR that the organisation have been involved have been presented, and it has been noted that the committee
is responsible for addressing any issues that arise in such cases so that lessons can be learned within the organisation.

- The CHFT Domestic Abuse policy has been approved.

CCG Safeguarding standards: completed their annual CCG safeguarding adults assurance self-assessment document. The self-assessment indicates compliance with the standards with a small number of areas that require some further development work. Overall the return was consistent with expectations.

A CQC inspection in the Trust identified a concern in relation to staff understanding ‘Gillick principle’ and made a recommendation to remedy this. Action taken has involved a member of the safeguarding team visiting the relevant ward/clinical areas. The outcome of this was that: for those ward/clinical areas visited there appears to be a good understanding of the Gillick principle and when to apply it. For those areas less knowledgeable, it will be covered in the Level 3 training.

**Prevent Assurance** – the Trust continue to make steady improvement in delivery of WRAP3 training to clinical staff across the organisation with weekly WRAP training sessions being delivered for staff. The Trust has made 2 referrals to the Prevent Channel Process in the last year and has in place a Prevent Delivery Plan that is on target.

**South West Yorkshire Partnership Trust. (SWYPFT)**

In January 2017 a decision was made to amalgamate the adults Trust Action Group and children’s operational group for safeguarding with to enable a more defined and joint overall approach to safeguarding within the Trust. The new amalgamated group is chaired by the Assistant Director of Nursing, Governance and Safety and attended by representatives from all main divisions in the Trust.

Achievements of note include:

- Safeguarding Adults Training stats for the organisation identified that level 2 training statistics were below the target percentage (80% of staff) in some departments and actions have been identified to begin to target the areas for improvement.
- The safeguarding adult’s team have revamped the safeguarding training workbook for Level 1 training and are targeting areas that require improvement.
- Compliance with Prevent training is 100% for basic level and 60% for WRAP. There is an upward trajectory for Health WRAP training.

Two regulatory inspections by the Care Quality Commission (CQC), a themed inspection in Calderdale for Children in April 2016 and a Trust Inspection in February 2017 afforded SWYPFT the opportunity to critically review safeguarding procedures and practices, highlighting areas of good practice, as well as those requiring development or improvement. The Trust CQC Inspection found safeguarding to be good and report to be integral to the Trust with robust governance arrangements. Further work is required to ensure staff fully implements the Mental Capacity Act and this has now become part on the mandatory training programme.

**Prevent assurance** - The Trust continues with consistent delivery of WRAP3 training to clinical staff across the organisation- a total of 15 WRAP sessions being provided each quarter. The organisation had made 1 referral to the Channel process in the last quarter, and has supplied relevant
information to Channel for two other cases. They have a Prevent Strategy in place that is on track for achievement including the total percentage of staff receiving WRAP training having risen from 50% to 60%. 100% of staff have received Prevent Basic Awareness training.

**Locala**

Locala CIC are commissioned by Public Health to deliver Community Dental Services and since April 2016 they have also delivered the school nursing services. Following a re-procurement process from July 2017 they will also be delivering health visiting and breast feeding peer support services.

The Designated Nurse Safeguarding Children has supported Public Health during the re-procurement process and has linked in with Local operational management team to provide the support required in the role out of the new service delivery arrangements and with the safeguarding team to update on the Calderdale partnership arrangements.

The Locala Safeguarding Committee meet on bi-monthly basis and The Designated Nurses from GHCCG/NKCCG attend on behalf of the team. In the last year: The Designated Nurse in Calderdale will attend the committee to introduce herself and ensure appropriate links are in place.

The last figures for Safeguarding Children and Adult Learning Compliance in August 2017 were:

- Level 1 training figures have increased to 91.3% this year
- Level 2 has increased from to 86.3%
- Level 3 continues to increase now at 91.6%
- Level 4 for safeguarding leads is at 100%

The CQC inspection of four Locala services in October also highlighted areas for development in relation to safeguarding and resulted in a major review of our safeguarding governance arrangements and assurance processes. Safeguarding children and adults is an integral aspect of care, requiring all services to work effectively together to prevent harm and intervene only when harm, neglect, or abuse is suspected. Work is continuing across the organisation, both at an operational and strategic level, to ensure that safeguarding children and adults at risk becomes ‘everybody’s business’ as opposed to being seen as the remit and responsibility of the specialist practitioners within the safeguarding team.

**Yorkshire Ambulance Service (YAS)**

NHS Wakefield CCG are the lead commissioners for YAS and there are communication mechanisms for safeguarding performance issues established between Wakefield and Calderdale CCG.

A Memorandum of Understanding has been agreed between the Children’s and Adults Safeguarding Boards and YAS to ensure that YAS is represented on each board and is kept informed of any safeguarding issues which require YAS to take to action.

4.2 **General Practitioners Services (GPs)**

The CCG Safeguarding Team have continued to actively engage with General Practice in Calderdale this includes:-

- Continued provision of contact details for safeguarding children specialist roles i.e. Designated Nurse, Designated Doctor and Named staff to all independent contractors.
- Advice and support - The CCG Shared Safeguarding Team are available during office hours to provide advice, information and support. The team contact numbers are readily
available on the CCG intranet and are re-sent to all practices when the contact leaflet is updated.

- Provision of a safeguarding area on the CCG intranet is being developed further to be divided into specific safeguarding adult information and safeguarding children information. The safeguarding pages are a source of information, guidance and key local contacts for member GP Practices.
- Briefing papers to all GP practices addressing a variety of issues such as; training requirements, training options, learning from serious incidents, serious case reviews and practice issues relevant to safeguarding as they arise.
- The safeguarding team have developed a safeguarding newsletter for GP Practices which incorporates all information with regards to changes nationally and locally.
- Safeguarding information is regularly included in the CCG Newsletters circulated to member GP Practices.
- Face to face training safeguarding training sessions. These have been evaluated extremely well, comments from participants included “(I have) increased knowledge of MCA/DOLS”, “the trainers were interesting and engaging”, “(I am now) aware of how make a referral and who to refer to”. Many participants believed the training is too short and the safeguarding team will consider innovative ways to address this issue whilst being mindful of the time pressures GP practice staff face.

In Calderdale the majority of GP practices have now been reviewed by CQC. In 2016 the overall findings are good rating in practices for safeguarding.

4.2.1 GP Safeguarding Leads Meetings

All GP practices now have identified GP safeguarding leads, all safeguarding leads are also practice leads for Prevent. The GP safeguarding lead within each practice is expected to have a higher level of safeguarding knowledge in order to advise and supervise colleagues. The GP safeguarding leads meet with the Designated Nurses on a quarterly basis to discuss new developments, share best practice and for group supervision of cases. Whilst attendance at the meetings means that less than 50% of practices are represented at the meeting, minutes and actions are shared with all GP leads.

4.2.2 GP Safeguarding Children and Adults Standards

In 2016 practices were asked to undertake a self-assessment of their safeguarding structures and practices, in order to identify their strengths and areas for further development. The CCG safeguarding team then offered support to individual practices that wanted to strengthen their safeguarding structures. All practices completed the self-assessment and the actions for the safeguarding team have been completed. These actions will help ensure that all practices have the resources to be fully compliant with the standards. The safeguarding standards for 2017-18 have been revised to place a greater emphasis on complying with the Mental Capacity Act.

In 2017-18 the safeguarding team will:

- Provide practices with a safeguarding training offer
- Develop 7 minute briefings for Practices on all aspects of safeguarding including FGM, CSE, covert medication and learning from Case Reviews
- Provide practices with template policies in children and adult safeguarding, Mental Capacity Act, Domestic Abuse and Prevent
- Ensure that practices have access to a safeguarding adults / domestic abuse template for SystmOne and EMIS.
- Provide masterclasses in the Mental Capacity Act for all GP practice clinical staff
- Continue to provide Safeguarding Newsletters
4.2.3 Flagging in Electronic Records – Vulnerable Children

Following a GP practice audit in January 2017, undertaken by the Named Nurse Safeguarding Children, a workshop ‘GP Flagging of Vulnerable Children’ took place on the 5th July 2017 at Dean Clough by the Safeguarding Children CCG Nurses. The workshop was intended to highlight best practice and the associated benefits of flagging the records of children and their parent/s or carer/s where appropriate.

It is envisaged that the percentage of GP practices flagging the records of vulnerable children in Calderdale will increase as a result. Any practices who are not flagging currently can contact the CCG’s Named Nurse Safeguarding Children for further information, advice and support where necessary. A subsequent piece of work will continue to make contact with GP practices to identify if the workshop has increased the percentage of practices identifying and flagging vulnerable children.

4.2.4 Safeguarding Newsletter

The Safeguarding Project Support Officer has developed a safeguarding newsletter to share both local and national key headlines for the GPs which has been well received with the GP safeguarding leads now making more suggestions to its content to make it a useful resource for them.

4.3 CQC Review of Health Services for Children Looked After and Safeguarding

The Care Quality Commission commenced a programme of inspections in September 2013. This is a review of how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers. This review programme focuses on:
- Evaluating the quality and impact of local health arrangements for safeguarding 10 children.
- Improving healthcare for children who are looked after

Calderdale health economy had the full CQC review conducted in April 2016; its aim to explore the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health organisations.

The nature of the Review (as opposed to an inspection) means that there was no judgement of adequacy or inadequacy made by the inspectors at the end of review process, only a series of recommendations.

The CQC used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible the inspectors met and spoke with children and young people or parents. This approach provided the CQC with evidence that could be checked and confirmed in several ways and maintained the focus on the experiences of children and their families.

Throughout the week, five inspectors visited the following services: -

- Acute services at Calderdale & Huddersfield NHS Foundation Trust (CHFT), with a focus on emergency departments and maternity services. It also included paediatric liaison services and paediatric wards
- General Practices (2 practices visited in total across the Borough)
- School Nursing (Locala)
- Health Visiting services (CHFT)
- Child & Family Mental Health Services (SWYPFT)
- Contraceptive & Sexual Health Services (CHFT)
- Adult Mental Health Service at South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT)
The review report was published on the 25th October 2016 and an action plan was submitted to the CQC in November 2016. The full copy of the report can be found at: http://www.cqc.org.uk/content/child-safeguarding-and-looked-after-children-inspection-programme-clas#PublishedReports

Where the CQC found areas for improvement in services provided by NHS but commissioned by the local authority, the CQC have stated they will inform the public health team in the Local Authority of these issues. Public Health received the notification, and have continued to work in partnership with the CCG Designated Nurse to develop further recommendations to facilitate changes in practice and add these to the action plan.

5.0 ENGAGEMENT AND PARTNERSHIP WORKING

Safeguarding is most effectively delivered through multi-agency arrangements where partners work collaboratively to achieve a shared vision. The Calderdale Safeguarding Adults Board (CSAB) and Calderdale Safeguarding Children Board (CSCB) are the primary Boards that scrutinise multi-agency safeguarding arrangements. Other key strategic partnership meetings include the Health and Wellbeing Board, Calderdale Community Safety Partnership, Domestic and Sexual Violence Strategic Board (see Section **) and the Children’s and Young People’s Partnership Executive (CYPPE) meetings. In addition to these there are a number of operational meetings which focus on specific issues and include the Multi-Agency Screening Team (MAST); Daily Domestic Abuse Hub (DA Hub); Child Sexual Exploitation (CSE) Hub and the Multi-Agency Pregnancy Liaison Group (MAPLAG).

Calderdale CCG is represented by the Head of Quality, Penny Woodhead, on the CSCB/CSAB and their associated sub groups as well as the other board meetings. Attendance at operational meetings is on a needs led basis. NHS Calderdale CCG Leads and the Safeguarding Team have actively supported the work of the Safeguarding Boards and reinforced a shared partnership approach.

5.1 Engagement with the Calderdale Local Authority

Whilst the responsibility for coordinating safeguarding arrangements across Calderdale lies with Calderdale Metropolitan Borough Council (CMBC), effective safeguarding is based on a multi-agency approach. NHS Calderdale CCG is a willing multi-agency safeguarding partner and has robust governance arrangements in place to ensure that its own safeguarding structures and processes are effective; and that the agencies from which the CCG commission services meet the required standards.

It should be recognised that the Designated Nurses undertake a leadership role in the whole health economy role, and also work with the local safeguarding boards and CMBC to support safeguarding work, details of which can be seen throughout this report, providing further assurance that the CCG is fulfilling its responsibilities.

5.2 Calderdale Safeguarding Adults Board (CSAB)

Following the introduction of the Care Act (2014), each local authority must establish a Safeguarding Adults Board (SAB) for its area. The role of a Safeguarding Adults Board is detailed in Schedule 1 of the Care Act 2014, which states the objective of Safeguarding Adults Boards as being to help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does and the Board may do anything which appears to it, to be necessary or desirable for the purpose of achieving its objective.
The Act details the statutory requirement to have a Safeguarding Adults Board (SAB) and that the Board has three primary functions:

1. It must publish a strategic plan for each financial year that sets how it will meet its main objectives, and what the members will do to achieve these objectives. The plan must be developed with local community involvement and the SAB must consult the Local Health Watch organisation.

2. It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan and what each member has done to implement the strategy, as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews.

3. It must conduct any Safeguarding Adults Reviews.

Additionally, the Care Act specifies core membership for the Board (CCG, Local Authority and Police) and suggests wider membership.

The stated aims of the CSAB are:

- Assurance that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- Assurance that safeguarding practice is person-centred and outcome-focused
- Working collaboratively to prevent abuse and neglect where possible
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The CSAB website provides relevant information about the work of the Board including strategic plans, annual reports and Safeguarding Adult Reviews. The website is due for an overhaul in October 2017 with the stated intention of this website to be hub for all safeguarding adults’ matters in Calderdale for both professionals and members of the public. [https://www.calderdale.gov.uk/socialcare/safeguardingadults/board.html](https://www.calderdale.gov.uk/socialcare/safeguardingadults/board.html).

The CSAB is jointly funded by the CCG, Calderdale Council and West Yorkshire Police.

The CCG is represented on the CSAB by the Head of Quality and the Designated Nurse for Adult Safeguarding. The Designated Nurse chairs the Safeguarding Adult Review subgroup and is a member of the Performance and Quality Assurance. The Named Nurse represents the CCG on the Training and Workforce Development and the Communication and Engagement subgroup.

In April 2016, Ged McManus was appointed as the first Independent Chair of the CSAB. Whilst an independent chair is not specifically required by the Care Act (2014) most SABs in country are chaired by an independent person. In Calderdale, this appointment has helped to ensure that the business of the CSAB has been planned and driven and has enabled a greater level of scrutiny and challenge.

After a significant period of interim board managers, in 2016, an agreement was reached between the CSAB and the CSCB to join together the dedicated “back office” function of the boards. The safeguarding board team provide essential support to the functioning of the boards. The team consists of a safeguarding boards manager, quality assurance, training and development posts and administration staff.
5.2.1 Key CSAB achievements 2016-17

- A strategic and annual business plan has been developed which describes the priority work areas for the board over a 1 and 3 year timeframe.
- Development of a performance data scorecard which provides members with a high level overview of safeguarding adults performance at every meeting. This tool is under constant refinement and there are plans to undertake “deep dives” in specific areas on a regular basis.
- The development of a communication and engagement strategy
- A programme of multi-agency safeguarding adults training
- A Safeguarding Adults Review (SAR) Toolkit has been written and implemented, which describes the process for conducting SARs in Calderdale.
- Production of a “how to report adult abuse” leaflet.
- Work with other SABs in the region to revise the West Yorkshire, North Yorkshire and York Adult Safeguarding Policies and Procedures (which describes the approach and process for managing safeguarding concerns). The revised document (due to be published in December 2017) has a greater emphasis on achieving the safeguarding goals of adults at risk of abuse.
- Commissioning of e-learning safeguarding products for use by all agencies in Calderdale
- Commenced a Safeguarding Adult Review that focuses on the safeguarding process in Calderdale.

5.3 Calderdale Safeguarding Children Board (CSCB)

The Calderdale Safeguarding Children’s Board (CSCB) is the key statutory body overseeing multi agency child safeguarding arrangements across Calderdale. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Regulations 2006, the Calderdale Safeguarding Children’s Board is comprised of senior leaders from a range of different organisations. It has two basic objectives defined within the Children Act 2004;

- To co-ordinate the safeguarding work of agencies and
- To ensure that this work is effective.

The Safeguarding Children Boards are required to have sub-groups to carry out the business of the Board. They are made up of all organisations that provide a service to children locally. The Designated and named nurse for safeguarding children are active members of the sub-groups and offer their expertise on all issues relating to the whole health economy. The CSCB have also jointly funded e-learning safeguarding packages for all partner agencies including child sexual exploitation and domestic violence modules.

The CSCB is jointly funded by the CCG, Calderdale Council and West Yorkshire Police.

The CCG is represented on the CSCB by the Head of Quality and the Designated Nurse for Safeguarding Children. The Designated Nurse chairs the Case Review subgroup and is a member of the Business Group; Child Death Overview Panel and Performance and Quality Assurance Group. The Named Nurse represents the CCG on the Quality Assurance Audit Group and the Joint Targeted Area Inspections Operational Group.

5.3.1 Section 11 Audit

The annual completion of a Section 11 self-assessment audit with robust challenge supports the CSCB improvement objective identified by Ofsted (2015 Ofsted 15: para 168: Effectiveness of scrutiny and challenge). Ensure that Section 11 audits are completed annually by all agencies and organisations involved in the safeguarding children and young people, that audits include questions about Child Sexual Exploitation (CSE) and learning from
Serious Case Reviews (SCRs), and that results from audit are subject to rigorous challenge. This objective is included in the CSCB Business plan.

CCGs have a statutory duty to be members of the Local Safeguarding Children’s Board working in partnership with local authorities to fulfil their safeguarding responsibilities. These statutory duties fall under Section 11 of the Children Act 2004 and apply to a range of organisations as well as the health economy. All health organisations in Calderdale, including providers and CCGs, have been required to submit an s.11 self-assessment with final submissions to Calderdale Safeguarding Children’s Board in May 2016. The designated nurse for safeguarding children has submitted assessments on behalf Calderdale CCG and General Practitioners during this year. The next S11 is audit due in May 2017.

In this third year of carrying out the annual Section 11 self-assessment audit, learning and improvement from previous feedback has enhanced the Challenge Event process. The format of the Challenge Event this year allowed more clarity of the shared learning opportunity it has presented to participants and the Board. For the first time it has allowed a significant proportion of organisations represented on the Board to participate together in a valuable opportunity to share knowledge and good practice, to be able to make new links and to experience direct input and feedback from young people via the participation of the Young Advisers.

The focus of the event on a few targeted areas allowed participants to examine both operational and strategic opportunities for synergy both between agencies in the Calderdale area and potentially within the wider West Yorkshire boundary. This strategic horizon scanning beyond the boundaries of Calderdale has great relevance given the post-Wood report environment in which the future of LSCBs is on the cusp of change.

5.3.2 Quality Assurance Group (QAG)

Multi-Agency Audit Group (MAAG) the Named Nurse has recently undertaken and presented an audit report to analyse the quality of multi-agency referrals into children’s social care; specifically relating to risk and need being appropriately identified and communicated by professionals. There is room for improvement with regard to the overall quality of the information sent into MAST from all agencies and the use of the referral form should be encouraged in all cases.

The overall analysis of information, regarding the concerns of professionals using the referral form should be improved. Evidence of any risk assessment tools used by the referring agency should be included within the referral. The use of chronologies would aid this process and enable clearer identification of current concerns. Professionals should clearly demonstrate what response they feel is required when referring a child into MAST, lack of clarity and general ambiguity do not evidence or prioritise the needs of the child with regard to potential risk of significant harm.

All agencies’ systems should be improved with regard to any other types of referrals being sent into the correct place, thus avoiding delay and clogging up MAST systems designed for urgent safeguarding cases. It is imperative that all agencies record accurately the outcomes of all referrals made and information received back from MAST, particularly with regard to cases where ‘no further action’ was the outcome of the referral. The voice of the child is not being well captured within the majority of the referrals that were audited and the child’s wishes and feelings should be recorded routinely in any consultations with children where appropriate.

5.3.3 Child Death Overview Panel (CDOP)

Since 1st April 2008, all deaths of children (up to the age of 18 years, excluding still births and planned terminations) are reviewed by a Panel of people from a range of organisations and
professional areas of expertise. This review is part of a national process called the Child Death Overview Panel (CDOP) which is outlined in national guidance (Working Together to Safeguard Children, 2015). This process is undertaken locally for all children who are normally resident in Calderdale and Kirklees.

The Child Death Review Service works in partnership with the Calderdale’s Health Economy to ensure that the statutory requirements of regulation 6 of the Local Safeguarding Children Board Regulations, 2006, made under section 14(2) of the Children Act 2004 are met. Health commissioners have a duty to employ, or have arrangements in place for Consultant Paediatricians with designated responsibilities (Health and Social Care Act 2012) to provide expertise and advice on commissioning services. These Paediatricians undertake enquiries into unexpected deaths in childhood, medical investigative services and the organisation of the CDOP process.

In 2016/2017 there were a total of 48 child deaths across Calderdale and Kirklees 20 of which were in Calderdale. There has been a year on year decrease in child deaths across Calderdale and Kirklees, with a 20% decline between 2012/13 and end of year 2016/17. The decrease in child deaths is consistent with the national picture, although the decrease in Calderdale and Kirklees is greater than the national average. The full CDOP annual reports can be accessed at [http://www.calderdale-scb.org.uk/professionals/child-deaths/](http://www.calderdale-scb.org.uk/professionals/child-deaths/)

### 5.3.4 Sudden Unexplained Death in Childhood (SUDIC)

An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death. There were 12 Calderdale cases under this category discussed in the 2016-17 period.

All unexpected child deaths are reviewed in depth by the SUDIC Paediatrician who collates a file for each child. The review takes into account the involvement of all agencies with the child and their family. The Designated Doctor for Child Deaths, Dr Eilean Crosby, undertakes the functions via a service level agreement between the CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT). Once the SUDIC Paediatrician considers the review to be complete, they present the case details to the other members of the Panel which are then discussed along with all other child deaths. The members of the bi-monthly CDOP are able to offer a further level of scrutiny to the SUDIC Review. During 2016/17 there were no deaths categorised as SUDIC across Calderdale discussed at CDOP.

When a child death occurs within Calderdale but the child is from another area, the Calderdale and Kirklees SUDIC Paediatrician undertakes all the initial investigations and passes this information on to the Local Safeguarding Children Board of the child’s residence area.

### 5.3.5 Children and Social Work Act 2017

In January 2016, Alan Wood (CBE) was commissioned by HM Government to undertake a fundamental review of LSCBs, including processes for Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOP). The report and the Government’s response were published in June 2016. The report made 34 recommendations in total – 19 around LSCBs, 10 around SCRs and 5 in respect of CDOPs. With regard to LSCBs, the fundamental change that was proposed: “To require the three key agencies, namely health, police and local authorities, in an area they determine, to design multi-agency arrangements for protecting children, underpinned by a requirement to work together on the key strategic issues set out in this report.” The subsequent [Children and Social Work Act](http://www.gov.uk/guidance/children-and-social-work-act) received royal assent on 27th April 2017. The statutory guidance (Working Together to Safeguard Children) accompanying this new legislation is yet to be published. However, Calderdale Safeguarding Children’s Board has facilitated preliminary discussions between partner agencies to consider the implications of this new legislation. The DfE is planning to update the document in three ways to:
Reflect changed legislation
Clarify specific areas where we know the current guidance is not clear enough
Update to the links and annexes to reflect current policy priorities.

The aim is to publish in early 2018, with a formal public consultation running over the summer 2017 and regular circulation of updates.

5.3.6 Child Sexual Exploitation (CSE)
CSE continues to remain a high profile at national and local level. The Government response to the chronic failure to protect children from child sexual exploitation in Rotherham was published in March 2015. In recognition that those failures were not unique to Rotherham and affects all communities, the Government took a “step change approach” in their response to child sexual exploitation making a number of recommendations for all partner agencies working with children and young people. These recommendations include the need to strengthen accountability; to change the culture of denial; to improve joint working and information sharing; to protect vulnerable children by improving the local response to child sexual exploitation; to better protecting children who go missing or who are placed in care; stopping offenders and supporting victims and survivors

The requirement for providers to have a CSE lead and comply with CSE guidance has been monitored through the safeguarding monitoring arrangements within commissioned services. CSE has remained a strategic priority for Calderdale LSCB. In partnership the Designated Leads have directly contributed to the work of the LSCB including strategic direction and a review of operational oversight. Each NHS provider has a CSE Lead in place.

In Calderdale there is in place a CSE Hub which meets three times a week to discuss all new cases identified who could be at risk and review young people who have been reported as missing overnight. There were a total of 7 young people on the CSE MATRIX at the end of March 2017 with a total of 143 cases referred to the CSE Hub during the year.

The CCG Designated Leads have linked directly with the NHSE national sub group on CSE. This has included sharing of tools and resources including risk assessments, training events and learning from national SCRs.

5.3.7 Female Genital Mutilation (FGM)
Safeguarding guidance: Female genital mutilation risk and safeguarding – guidance for professionals was published by the Department of Health in March 2015, this provides support to NHS organisations when developing or reviewing safeguarding policies and procedures around female genital mutilation (FGM). It can be used by health professionals from all sectors, particularly designated and named safeguarding leads, and local safeguarding children board members. The guidance is available at:

The Department of Health are regularly publishing updated guidance for NHS staff regarding identification and response and prevention of FGM. Whilst reports of FGM are relatively low in Calderdale staff still need to be alert to the potential of FGM actual and at risk of cases.

The Health and Social Care Information Centre (HSCIC) has started collecting data on FGM within England on behalf of the Department of Health (DH) and NHSE. The data is aimed at improving the NHS response to FGM and to inform commissioners of services to support women who have experienced FGM, in addition to safeguarding women and girls at risk of FGM.

Acute Trusts put in significant efforts during the last financial year to comply with the mandatory requirement to record FGM in a patient's healthcare record and submit monthly returns, which were then published by the Health and Social Care Information Centre
National data shows that between April 2016 and March 2017 there were 9,179 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure for FGM was undertaken. 87% of these attendances were in midwifery or obstetrics services, where this was reported. Data for the treatment area was recorded for six in every ten attendances. The average age at attendance was 31 years. 95% of the women and girls first recorded in the data in 2016/17 had undergone FGM before they were 18 years old. This information was recorded for three in ten women and girls.

For the year 2016-17 period the data shows that Calderdale recorded 5 attendances at a GP where FGM had been identified and CHFT as recording 35 attendances but these will be across Calderdale and Kirklees.

In Calderdale an FGM Strategic Response has been produced on behalf of the partnership (Safeguarding Children Board, Safeguarding Adults Board & Community Safety Partnerships Board). There is a comprehensive action plan in place for the implementation of the Calderdale FGM Strategic Response with the Designated Nurse contributing and leading on the completion of this on behalf of the CCGs. Recording FGM prevalence and embedding routine enquiry for at risk groups is a particular area that has been monitored via the CSCBs Performance Monitoring Sub Group with ongoing assurance around provider compliance with FGM requirements and good practice.

The CCG Designated Leads have linked directly with the NHSE national sub group on FGM. The work and tools developed have been rolled out across the health economy including the service standards for examining children under 18 with FGM, an eLearning session – ‘The Psychological Impact of FGM and the quick guide version of DH Safeguarding guidance. The CCG have contributed to the regional mapping on FGM

5.3.8 Key CSCB achievements 2016-17

- Conference during Safeguarding Week highlighting key government issues for FGM, Forced marriage and Honour Based Violence
- Launch of the Calderdale FGM Strategic Response
- Updating of the Board priorities and accompanying Business Plan
- Review of the Performance Indicator Set to ensure more outcomes focused
- Undertook a review of the Sub Groups to ensure fulfilling the remit of the Business Plan
- Produced easy read Safeguard Guides to highlight safeguarding issues such as FGM and CSE
- Commissioning of e-learning safeguarding products for use by all agencies in Calderdale
- Commenced a Safeguarding Adult Review that focuses on the safeguarding process in Calderdale.

5.4 Safeguarding Week

Calderdale Safeguarding Week was jointly organized by the Adults and Children’s Boards and ran from 17th October 2016 and included several information and training sessions per day for professionals and the public. Both Designated Nurses contributed significantly to the activities including presenting at the conference on Female Genital Mutilation, Forced Marriage and Honour Based Violence which also included contributions from the National organization Karma Nirvana and was attended by 104 professionals; facilitating a multi-agency workshop on the advanced planning aspects of the Mental Capacity Act which attracted over 70 participants and received very positive feedback. The Designated Nurse also presented a live broadcast on Pheonix Radio to raise public awareness of the Mental Capacity Act. An audio copy of this interview is available on request.
5.5 DOMESTIC ABUSE

Domestic Abuse remains a significant issue nationally and in Calderdale. It is a complex issue experienced by females and males, the young and the elderly. It occurs in heterosexual and same sex relationships and has no economic boundary. It is not just about physical violence but can include financial, sexual, emotional and psychological abuse and includes issues of honour based abuse, forced marriage and female genital mutilation. It is known that domestic abuse has a major negative impact upon health and is a major contributory factor related to negative health consequences for victims and children.

5.5.1 Domestic Violence and Sexual Violence Strategic Board

The Calderdale Domestic Violence and Sexual Violence Strategy Group drafted a strategy for 2016 – 2019 for consultation with partners; the Strategy describes the plans for tackling domestic abuse in Calderdale and provides a context and framework for addressing the issue. Additionally, the Strategy is informed by the government’s national Strategy to End Violence Against Women and Girls: 2016 to 2020:

- **Prevention:** Increase public awareness of domestic abuse and increase knowledge of the support available. This includes educating young people about healthy relationships, abuse and consent in order to build resilience.

- **Provision:** More victims are identified at the earliest possible opportunity, with effective interventions put in place at all risk levels. This includes early identification of perpetrators and referral into effective programmes and the provision of support for children from households where there is domestic abuse.

- **Protection:** Establish a consistent and better developed response to perpetrators.

- **Partnership Working:** Ensure that the response to domestic abuse is “everyone’s business”. Accurate data and intelligence informs action and all those whose work brings them into contact with those affected by domestic abuse have access to learning and development.

5.5.2 The Domestic Abuse Hub

Calderdale introduced a daily Domestic Abuse (DA) Hub in January 2016 to accelerate the response to domestic abuse and reduce repeat victimisation. The case for change was highlighted in the 2014 Calderdale DA Needs Assessment. Recommendations included the need for earlier intervention, improved information sharing, better risk assessments and clear pathways of support. The Police are the lead organisation for the Hub and strategic oversight is the responsibility of the Domestic Abuse Strategic Board. A total of 4359 incidents of domestic abuse were reported to the police with 1,263 referrals discussed at the daily meeting in the year to April 2017.

5.5.3 Calderdale Domestic Abuse Health Service

The Department of Health have published Guidance for Health Professionals working with Domestic Abuse and Female Genital Mutilation and there are now expectations that health professionals are equipped with the knowledge and skills to respond effectively towards victims, their children and perpetrators of domestic abuse as reflected in the Nice Guidance (2014) and NICE Quality Standards (2016). The NICE Quality Standards (2016) recommend that Commissioners commission services that ensure:

- ensure staff are trained to recognise the indicators of domestic abuse and who can perform routine enquiry safely
- ensure staff are trained to provide appropriate responses
- ensure referral pathways are in place and that there is a wide range of support available
- correct pathways are in place for people who perpetrate domestic abuse
NHS Calderdale CCG has continued to commission a dedicated health domestic abuse (DA) service during 2016-17 on behalf of the health partnership in Calderdale. The role of the Dedicated DA Health team takes the principles of the IRIS model. This is done by establishing integrated pathways and specialist training for health professionals including GPs. The broad principle is to engage victims in specialist support as early as possible, thereby reducing the likelihood of further incidents (and ongoing emotional, societal and financial costs).

In the first 12 months of the DA Hub, Calderdale has been able to establish a lot more about the presentation of health needs for the victims and perpetrators who access services. From this, it has identified where within our services opportunities are missed and areas for improvement including training, closer working with partner agencies and improving processes and pathways.

Since the introduction of the hub referrals have risen from Health agencies across Calderdale and this is as a direct result of the training and awareness by the health representatives at the hub. The current data for Calderdale found that individuals were attending local Emergency Departments (ED) with numerous incidents relating to domestic violence and abuse (DVA) or disclosing previous incidents of DVA. Over 30% of victims attended ED in the twelve months previous directly relating to DVA. The perpetrator attendances are often injuries from the assault e.g. wrist injuries, or suicidal following the end of the relationship/incident.

DA Hub data from the first twelve months confirms that local data is in line with the national evidence that pregnancy is a high risk time for women at risk of domestic abuse as 6.4% of cases referred to the Calderdale DA Hub involved a pregnant woman. The DA Health Service has worked with Maternity Services to review maternity guidance, pathways and assessment processes to be in line with local and national guidance. In Calderdale 14% of all victims and perpetrators of the DA Hub case have been open referrals to secondary mental health services e.g. has active involvement from CMHT or Insight. On average 33.5% of both victim and perpetrator have had previous input from MH services; mostly hospital liaison input. The majority of these individuals have disengaged from services following assessment e.g. failed to attend appointments so have been discharged, or have been referred onto other services e.g. Insight.

Just over 50% of cases were not known to mental health services at all.

The DA Health service has established a service that is effective, feeding significant health information into multi-agency risk management causing no extra time or tasks for health professionals. There has been a reduction in duplication of information resulting in less wasted time and a health workforce who are better informed of the risks posed to patients they are treating.

Ultimately if this service continues, there will be further development in Calderdale’s health economy’s understanding and approach to domestic abuse. There will be more health initiatives and targeted approach to prevent domestic abuse escalation which will ultimately impact on health resources. The overall outcome for the partnership in Calderdale is a reduction in repeat victimisation – health is seen as a significant partner in driving this as health would inevitably make the most savings if repeat victimisation is reduced.

As well as the main Domestic Abuse Hub telephone line; there is a specific ‘health’ line that is in place to direct all health providers to access confidential advice regarding their case. As this phone line has been promoted there has been a steady and consistent increase in phone calls. On average there are between 6-8 phone calls a day from different departments/services asking for advice, referral information and information sharing advice. The majority of telephone calls are from Insight Healthcare, Health visiting services and Maternity services. Being part of the DA Hub team means that health representatives are at hand to answer other
queries phoned in but also provide health advice to police officers who attend the hub for advice.

5.6 MODERN SLAVERY AND HUMAN TRAFFICKING

The Modern Slavery Act 2015 introduced changes in UK law focused on increasing transparency in supply chains, to ensure that our supply chains were free from modern slavery. Although not listed NHS employees are expected to be mindful of the cause and health and social care impact of the victims of modern slavery.

Victims of slavery are likely to come into contact with Healthcare providers; Healthcare settings should be safe places where victims of modern slavery have what is often their only opportunity to come into contact with people who have knowledge about modern slavery, can identify the signs of trafficking and can refer them to organisations which can provide support.

NHS England have produced a video to explain Modern Slavery and its relevance and impact on healthcare. Please click on the following link https://youtu.be/cRskjgSsN The Department of Health has also produced a guidance leaflet Identifying and supporting victims of modern slavery.

The Department of Health launched further leaflets and e-learning resources for health professionals, to raise awareness about the issue of human trafficking and enable health professionals to identify and respond to victims more effectively.

From 31st March 2017 the West Yorkshire Pilot of changes to the National Referral Mechanism (NRM) will end. This will therefore, slightly change the processes currently in place for ‘Health’ practitioners to refer victims of HT/MDS.

Human trafficking is the illegal trade of human beings for the purposes of commercial sexual exploitation or reproductive slavery, forced labour, or a modern-day form of slavery. The health consequences of human trafficking can be very significant, which means that the NHS may be the one public agency to which a victim can turn for assistance. The provision of healthcare services to victims may present the opportunity not only to address their health needs, but also to facilitate access to wider support services that can afford them care and protection. The resources are being posted on the Nursing Directorate website, to view these, follow the link below to the resource:


The CCG Safeguarding Team are members of the West Yorkshire Trafficking Modern Slavery Group aimed at delivering the Partnership responsibilities in relation to Trafficking/Modern Slavery. This includes discharging its direct commissioning responsibilities, demonstrating strong system leadership, working as committed partners and investing in effective co-ordination and robust quality assurance of safeguarding arrangements. There is also a Calderdale Group attended by the team. All meetings are held quarterly and will therefore champion good practice initiatives with specific regard to local working partnership arrangements including GP practices.

5.7 FORCED MARRIAGE/ HONOUR BASED VIOLENCE

Forced marriage/ Honour Based Violence Revised practice guidelines are being developed alongside the revised statutory guidance “The Right to Choose” originally issued under s.63 Q(1) of the Family Law Act 1996. The statutory guidance is different to the multi-agency practice guidelines in that it provides advice and support to all frontline professionals who have responsibilities to safeguard children with or without learning disabilities, and protect all adults, with or without learning disabilities from the abuses associated with forced marriage. It also outlines the responsibilities of Chief Executives, Directors and Senior Managers within those agencies involved with handling cases of forced marriage and incorporates Honour Based Violence. It also covers issues such as staff training, developing inter-agency policies and procedures, raising awareness and developing prevention programmes through outreach work.
Within Calderdale two community engagement events took place in October during Safeguarding week. Alyas Karmani delivered both events to encourage dialogue about the issue, and to set out the religious and legal context.

A conference for professionals took place on Forced Marriage, Honour Based Violence and FGM on 18th October, led by the CSCB. This was well attended and delegates heard from Jasvinder Sanghera from Karma Nirvana who spoke powerfully of her own experience of escaping Forced Marriage. Jasvinder also reported that West Yorkshire was region with the second highest number of calls to the helpline in the country. Of the 319 West Yorkshire calls between Jan and June 2016, 6% were from Calderdale.

For the year to date there has been 1 referral to Calderdale Police with regards to concerns about forced marriage.

5.8 PREVENT

The Prevent Duty is applicable to all NHS organisations and become statute on 1 July 2015. PREVENT is designed to illicit a proportionate and reasoned response to the threat of people being radicalized into extremist / terrorist activity from far right, animal rights, Al Quaeda type and other extremist organisations. Health care staff are well placed to recognise individuals, whether patients or staff who may be in vulnerable situations and therefore susceptible to radicalisation by violent extremism or terrorists. It is fundamental to our ‘duty of care’ and falls within our statutory safeguarding responsibilities. Every member of staff has a role to play in protecting vulnerable individuals who pass through our care. The Department of Health will continue to oversee the implementation of Prevent to ensure all healthcare staff are aware of their roles and responsibilities.

Calderdale is one of around 50 PREVENT priority areas across the UK, this means that the risk of radicalisation and extremism in Calderdale is considered high. Calderdale CCG must seek assurances from our providers and evidence that they are committed to ensuring at risk individuals are safeguarded from supporting terrorism or becoming terrorists themselves as part of the Home Office counter terrorism strategy Prevent.

The safeguarding team provide support and advice to health care professionals to help identify staff and patients in their organisations who may be at risk of radicalisation and appropriately signpost for intervention. We maintain close links with the Regional Prevent Coordinator and the local authority Prevent coordinator. The safeguarding team ensures that relevant referrals are made to the Channel panel, which aims to divert those at risk of radicalisation. The CCG as a commissioning body is not a member the multi-agency channel panel but seeks assurance that relevant provider agencies engage with this panel.

Depending on their role, all CCCG staff must receive Prevent training either basic level – delivered through written material or through a 1 hour Health WRAP training session delivered by an accredited Prevent trainer. All staff requiring level 1 have received the required information. All staff requiring WRAP have been offered it and the vast majority of these have attended. WRAP training sessions run twice yearly.

National priorities for Prevent include ensuring health staff receive training in order to identify and intervene with people who are at risk of radicalisation and to effectively manage people returning from Syria who may have been involved in terrorist activities.

5.8.1 Channel

Channel meetings are multi-agency forums which aim to engage those who are at risk of being radicalised. In Calderdale both CHFT and SWYFT are engaged with this forum and CCCG have provided NHSE with assurance in this area. A discussion between the Local Authority Prevent Lead and the Designated Nurse confirmed that the health sector’s input to the forum is consistent and helpful.
5.8.2 Prevent Information Returns

NHSE have required NHS Trusts and CCGs in “priority areas” to submit quarterly returns that describe progress on training compliance, partnerships, policies and referrals (for details of compliance please see provider sections of this report). In 2016 NHSE decided to cease requiring CCGs to provide these returns and expand the detail required from NHS Trusts using a new system (Unify 2). 2016-17 has seen significant progress.

5.9 MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS

The House of Lords post legislative scrutiny report (2014) described the Mental Capacity Act as a visionary piece of legislation but recognised that it has not been fully implemented in either health or social care settings. It described the Deprivation of Liberty Safeguards as not fit for purpose and recommended a review. The Law Commission’s review of DoLS was completed in March 2017 following an extensive consultation exercise. The Designated Nurse Safeguarding Adults (who acts as the CCG MCA DoLs Lead), contributed to the consultation exercise on a local, regional and national basis, to provide direct feedback to the changes being proposed.

The recommendation is that the DoLS should be replaced with a new scheme – to be called the Liberty Protection Safeguards. The report and draft Bill will now be considered by Government (please see link below to directly access the proposal). Once a decision is made by the Government regarding the new proposal the Designated Nurse will undertake a full review to assess the implications for the CCG and local area both on behalf of CCG requirements and also for the health providers in the area.


5.9.1 Continuing Healthcare funded patients requiring a Deprivation of Liberty Authorisation

When a person requires restrictions which amount to a deprivation of liberty and the placement (supported living or own home), it is the responsibility of the CCG to seek authorisation of that deprivation of liberty from the Court of Protection. Only a small minority of these applications will require a court hearing and most will be dealt with on papers (called the Re X process).

The CCG has been involved in one complex case that required a number of court hearings. A resolution was reached. The judge praised the work of the CCG in this case.

The CCG has ensured that people’s right to appeal against their deprivation of liberty have been upheld. In all these appeal cases the deprivation of liberty was judged to be lawful.

Despite several recruitment rounds we have been unable to appoint to a substantive position within the CHC team to undertake DoLS assessments and coordinate MCA / DoLS activity within the CHC team. An experienced Social Worker is currently working with the CHC team, to amend CHC processes to become MCA / DoLS compliant as well as making DoL applications to the Court of Protection.

Four applications have been made to the Court of Protection for CHC funded patients, under the Re X process and we are awaiting authorisation from the Court. A further 55 applications are required. As the new processes are developed it is expected that the numbers of applications made to the Court will rise more quickly.

A database of patients requiring DoL applications in the community and in care homes has been developed. This enables the CCG to have a better understanding of which commissioned services are making appropriate DoLS referrals and those who require more support.

The CHC reviewing team are monitoring conditions of DoLS to ensure they are implemented, as well as highlighting when appropriate DoLS applications have not been made. This information can also contribute to the overall monitoring of care homes and help identify when a care home maybe showing early signs of poor quality of service.
6.0 LOCAL CONTEXT FOR SAFEGUARDING CHILDREN

There are 209,800 people in Calderdale according to the ONS 2016 Mid-year population estimates with 61,660 children & young people from age 0-24 which includes 7,000 children aged 0-15 years. Children and young people under the age of 20 years make up 24.3% of the population of Calderdale, approximately 12% are from an ethnic minority. This is an increase of approximately 5,900 people since the 2011 Census. There are around 28,200 of Calderdale’s residents living in neighbourhoods ranked by Index of Multiple Deprivation (IMD) 2015 as being within the 10% most deprived in England. The Indices of Deprivation (2014) ranked Calderdale as the 105th most deprived district in England out of 326 with an estimated 10,050 children and young people growing up in poverty.

6.1 Safeguarding Children Activity

There has been a significant increase in numbers of children on CP plans during the year. This could be for a variety of reasons and probably not one alone: more effective referral mechanisms, lower thresholds, increase in the impact of poverty, reduction in services etc.

<table>
<thead>
<tr>
<th>Child Protection Plans</th>
<th>March 2016</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total numbers of children and young people subjected to a CP Plan at 31st March</td>
<td>188</td>
<td>252</td>
</tr>
<tr>
<td>Average over the year</td>
<td>222</td>
<td>230</td>
</tr>
<tr>
<td>Children Looked After</td>
<td>298</td>
<td>317</td>
</tr>
<tr>
<td>Children In Need</td>
<td>344</td>
<td></td>
</tr>
<tr>
<td>Child Protection Medicals</td>
<td>80 Calderdale &amp; Kirklees data</td>
<td>39 for Calderdale only</td>
</tr>
</tbody>
</table>

Table ** Number of children with plans by type

6.2 Children Looked After (CLA)

Local Authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area. The CCG responsibility for CLA extends to Children who are Looked After, wherever they are placed, including placements outside the Borough area.

Whilst the overall number of children in care increased by 6% from 297 to 317, the cohort number of children eligible to receive statutory health assessments reduced by 5% from 236 to 224. This is due to there being fewer children aged under 5 in the cohort, therefore, the majority of assessments are a once a year occurrence.

The number of new entries into care increased by 29.5% from 71 to 92.

Of the current 317 children in the care of CMBC children’s care services, 127 are placed out of the Calderdale boundary; this equates to 40%, the majority of these children are within a 50 mile radius, however, placement decisions can result in children being placed anywhere across the country; this in turn increases the challenges for the health team to deliver timely health interventions to all Calderdale children in care.

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 Board is assured that those children placed in Calderdale by external local authorities, who are notified...
to the CHFT health team are registered with a GP and any requests by the originating area to undertake statutory health assessments are met.

6.2.1 Health Needs of Children Looked After

Local Authorities are responsible for ensuring that a health assessment of physical, emotional and mental health needs takes place within 20 working days of a child entering care and at intervals of every six months for a children under five years and every twelve months for children more than five years; this should be an appropriately timed medical assessment conducted by an appropriately skilled health professional irrespective of which area the child resides.

- The initial health assessment (IHA) currently undertaken / coordinated by the Designated LAC Doctor results in a health plan, which should be available in time for the first statutory review of the child’s care plan by the Independent Reviewing Officer (IRO). The review must take place within 20 working days from when the child started to be looked after.
- The review health assessment (RHA) must happen at least once every six months before a child’s fifth birthday and at least once every 12 months after the child’s fifth birthday. The CCG must ensure that these reviews take place and are on time.
- The health professional, child’s social worker, foster carer or residential placement in addition to the IRO have a role to play in monitoring the implementation of the health plan as part of the child’s wider care plan.

There were a total of 224 children eligible for RHA to be undertaken during the reporting period 2016-17.

6.2.2 Unaccompanied Asylum Seeking Children and Young People (UASC)

Following the 'Dubs' amendment to the Immigration Act in 2016 and the disestablishment of the 'Calais jungle', the UK received a number of unaccompanied asylum-seeking children. This was in addition to and separate from the Syrian Refugee Resettlement Plan and was not associated with any additional funding. Research has identified that Asylum seekers face a large variety of physical, psychological and social challenges. These challenges have previously been described in relation to four distinct phases of experience: pre-flight, flight, temporary settlement and resettlement. These phases have a considerable impact on UASCs’ physical and mental health. Trauma experienced by UASC may include conflict, starvation and limited access to health care in their home country, physical violence, trafficking, female genital mutilation, sexual exploitation and discrimination.

In August 2016 Designated Lead were notified of the national dispersal arrangements and transfer protocol (as devised by the DfES, Home Office, ADCS and Local Government Association) relating to the relocation of UASC from Kent. The protocol set out the agreed roles and responsibilities for Local Authorities. The number of UASC in Calderdale went up by 22% in this period which is in keeping with national picture and the introduction in July 2016 of the government dispersal programme. In total, 22 children and young people were placed in Calderdale.

The Designated Leads have been engaged with the Calderdale wide arrangements to ensure that children and young people placed in county or the responsibility of Calderdale have good access to primary and secondary care facilities including mental health services. This has included the need for immunisation catch up and screening for infectious diseases.

6.3 The Independent Inquiry into Child Sexual Abuse (IICSA) (previously known as the Goddard Enquiry)

On the 17th October 2016 the Chair of the Independent Inquiry into Child Sexual Abuse set out her strategy to ensure the Inquiry meets its remit to recommend measures to better protect children in the future.
Professor Alexis Jay was clear that the Inquiry would hold true to its commitment to look at past and present failings by institutions in England and Wales. Professor Jay also set out four thematic strands that will be the focus of the work and recommendations across all the institutions the Inquiry is examining. This will ensure the big changes that will have the most impact on better protection for children.

The four strands are:

- Cultural: examining the attitudes, behaviours and values within institutions that prevent us from stopping child sexual abuse.
- Structural: looking at the legislative, governance and organisational frameworks within and between institutions.
- Financial: considering the financial, funding and resource arrangements for relevant institutions and services.
- Professional and political: focusing on the leadership, professional and practice issues for those working or volunteering in relevant institutions.

Locally, in 2016 the CCG Designated Nurse provided a briefing report to the safeguarding children’s board which included the key elements of the Goddard and related inquiries (Lampard Report, Myles Bradbury case).

In addition in January 2017 NHS England requested assurance from health organisations in relation to actions completed in response to the Lampard Report (Savile Inquiry). NHS Calderdale CCG received assurance from health trusts, which reflected that health organisations have action plans in place and were progressing with final actions or had met all the recommendations of the report.

The Designated Leads have also supported awareness of the Truth Project where victims or survivors of child sexual abuse are supported to share their experiences in a safe and confidential way.

6.4 Inspection Framework

The CQC since September 2013 have been carrying out a review of how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers. The reviews focus on:

- Evaluating the quality and impact of local health arrangements for safeguarding children.
- Improving healthcare for children who are looked after.

Inspections have looked at the quality and effectiveness of the arrangements that health care services have made to ensure children are safeguarded and how health services promote the health and wellbeing of looked after children and care leavers.

They inspect health services within local authority areas in England and case track individual children in each area. They use powers under Section 48 of the Health and Social Care Act 2008 to conduct these reviews. This means that they can review:

- All aspects of the provision of healthcare
- Exercise of function of NHS England

For safeguarding the review is undertaken under section 48 of the Health and Social Care Act in line with working together 2015 guidelines. The in depth review of child safeguarding by CQC assess how services work together to provide early help to children in need and support to children at risk of significant harm.

In 2016 Ofsted, the Care Quality Commission (CQC), Her Majesty’s Inspectorate of Constabulary (HMIC) and Her Majesty’s Inspectorate of Probation (HMI Probation) began a programme of ‘Joint Targeted Area Inspections’ (JTAI) into arrangements and services for
children in need of help and protection in local authority areas in England. JTAIs are carried out under section 20 of the Children Act 2004. They are an inspection of multi-agency arrangements for:

- The response to all forms of child abuse, neglect and exploitation at the point of identification
- The quality and impact of assessment, planning and decision making in response to notifications and referrals
- Protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers (evaluated through a deep dive investigation into the experiences of these children)
- The leadership and management of this work
- The effectiveness of the LSCB in relation to this work.

Each JTAI includes a ‘deep dive’ theme with the first theme being Child Sexual Exploitation (CSE); the second Domestic Abuse and the third which commences March 2017 will be Neglect in the 7 to 15 age group. A total of six inspections take place with the area being inspected receiving a letter with findings and recommendations. In Calderdale multi-agency planning meetings have taken place to review each of the ‘deep dive’ topics to ensure we are working together effectively to safeguard children and young people.


Ofsted and CQC launched a programme of joint inspections in 2016 to see how well health and local authorities fulfil their responsibilities for children and young people with special educational needs and/or disabilities (SEND). In 2016 Calderdale was one of the first areas in the country to receive an inspection. The Designated professionals supported health providers, the Partnership Commissioning Unit and the CCGs during the inspection process, providing evidence regarding health care provision for children and young people in care who have SEND.

### 7.0 CASE REVIEWS IN CALDERDALE (SCR/DHR/SCR/LLR/SI) – See appendix B

#### 7.1 Serious Case Reviews

When a child dies or is seriously injured and abuse or neglect are suspected, the LSCB is required to commission a Serious Case Review to consider how any learning can be identified from the case. When completed the LSCB is required to publish the report.

#### 7.1.2 Pathways to Harm

The Department of Education have produced the Final Report, ‘Pathways to Harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014’ (May 2016). This final report highlights learning points for key statutory agencies and other organisations involved in safeguarding children. Calderdale LSCB continue to action key learning points.

In the annual reporting period there have been a number of high profile inquiries and review reports, as part of the Jimmy Saville/ Bradbury investigation, reports into historic cases of child abuse. The Independent Inquiry into Child Sexual Abuse (IICSA) has been commissioned with national initiatives to investigate whether public bodies have taken seriously their duty to protect children from sexual abuse and to identify if there have been any organisational failures to protect children. Also, produced is further guidance to stop Female Genital Mutilation, Honour Based Violence/ Arranged Marriages and Counter Terrorism Prevention strategies in the United Kingdom.

Learning from all reviews is shared and built into training and quality measures of activity during the 2016-17 to ensure sustainability. The health related actions would be monitored
through Designated Nurses supervision meetings with the Named Professionals for Safeguarding in the main providers. Additionally the completion of the actions and exceptions are reported to Safeguarding Committee meetings with providers during 2016-17 and CCG Quality Committees within the safeguarding quarterly reports.

7.2 Safeguarding Adult Reviews (SARs)

When adult in its area dies or is injured as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is to establish from the case, how professionals and organisations have worked either individually or together, to safeguard, promote the welfare of adults at risk and establish what lessons can be learnt. This enables both single and partner agencies to make changes in working practices to better safeguard people. In order for effective learning to be identified from SARs there must be active interagency working from all organisations involved in the case.

CCGs have a statutory duty to work in partnership with SABs in conducting Safeguarding Adult Reviews in accordance with Working Together to Safeguard Children 2015 and Care Act 2014.

One SAR commenced in 2016 (the first SAR Calderdale has conducted since 2014) – (see Appendix B)

7.3 Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. The purpose is for the strategic multi-agency network to identify and implement learning from the review.

The CCG Designated Professionals coordinate and evaluate the health services inputs into the reviews and provide professional scrutiny and challenge. The CCGs must ensure all actions following the reviews are carried out according to the timescale set out by the individual panels.

7.4 Serious Incidents

The Safeguarding Team work closely with the serious incident review team to provide expert safeguarding reviews of serious incidents. This provides an additional level of scrutiny as well as identifying areas requiring further development and improvement.

8.0 CONCLUSION AND SUMMARY OF ACHIEVEMENTS 2016-2017

There has been significant progress made over the last 12 months in raising the profile even higher within the Clinical Commissioning Group. The increased scrutiny of safeguarding arrangements has highlighted our gaps and we have a clear action plan in place to address these in 2017/18. Safeguarding in Primary Care is a key priority and the CCG Safeguarding Team are developing strong relationships across primary care providers which we anticipate will produce improved outcomes for vulnerable adults, children & young people over the coming year.

9.0 Areas for development:

<table>
<thead>
<tr>
<th>Overarching development areas are:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Development area</strong></td>
</tr>
<tr>
<td>Safeguarding Children and Adults at Risk as per the principles and guidance set out in</td>
</tr>
</tbody>
</table>
| Improving Services to Safeguard Adults as required by The Care Act (2014) | The Safeguarding of adults is a high priority for NHS Calderdale CCG and there is a strong commitment to ensuring that structures and governance arrangements for safeguarding are robust. Safeguards against poor practice, abuse, neglect and exploitation are an integral part in the delivery of care and support, as well as within regulation, commissioning and contract monitoring arrangements.  
- Delivery of training is a priority for NHS Calderdale CCG employees/Primary Care Practitioners on their roles and responsibilities for safeguarding adult’s at risk, the Care Act (2014) and the Mental Capacity Act (2005).  
- The Safeguarding Team will work with providers, including primary care, to develop mechanisms to evaluate the implementation of the Mental Capacity Act. |
| Improving Services to Safeguarding Children as required by Working Together (2015) | Ensuring attendance and active participation at Calderdale Safeguarding Children Board (CSCB) and Calderdale Health & Social Care Partnership Safeguarding Collaborative to drive forward improved outcomes. To ensure safeguarding children and young people is embedded into all commissioned services and procurements.  
A bespoke piece of work has commenced across primary care now to strengthen the |
<table>
<thead>
<tr>
<th>Recommendation Area</th>
<th>Detailed Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening training arrangements across primary care</td>
<td>Developing the training strategy to provide a comprehensive programme of training to support primary care with all aspects of safeguarding practice.</td>
</tr>
<tr>
<td>Improving Services for Looked After Children as required</td>
<td>To increase the performance and quality of CLA health input by regularly monitoring the timeliness and quality of all health CLA reviews. Establishing the health offer for care leavers across the health economy. The service specification contract meetings are commencing to deal with this issue.</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>Domestic Abuse is an adult and children’s safeguarding priority. To ensure that the commissioning of services reflects local, national, strategic and operational guidance produced in response to the growing recognition of the detrimental effects of domestic abuse. To complete a bespoke piece of work to review the outcomes for children from the daily DA Hub meetings.</td>
</tr>
<tr>
<td>Radicalisation/ PREVENT</td>
<td>To fulfil CCG statutory responsibilities to protect 21 vulnerable people who may be susceptible to radicalisation by violent extremists or terrorists. This will be embedded into training programmes, contractual monitoring and policy and procedure.</td>
</tr>
<tr>
<td>Safeguarding Boards</td>
<td>Work with the CSAB and CSCB to increase engagement from service users and carers. Produce additional multi-agency guidance and policies. Further develop data and intelligence to inform priorities in the delivery of safeguarding services.</td>
</tr>
</tbody>
</table>

### 10.0 RECOMMENDATIONS

It is requested that the CCG Governing Body:-

- Receives and notes the contents of report.
- Makes any further comments or recommendations as appropriate
- Is assured that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity
11.0 REFERENCES
Calderdale Safeguarding Children Board: http://www.calderdale-scb.org.uk/
Calderdale Safeguarding Adults Board Strategic
Plan: https://www.calderdale.gov.uk/socialcare/safeguardingadults/board.html
Children and Social Care Act 2017 April 2017
Care Quality Commission: NOT SEEN, NOT HEARD. (2016)
Children and Social Care Act
Cm_9310_Web_Accessible_v0.11.pdf
Department of Health 2009: Deprivation of Liberties Safeguards
m_dh/groups/dh_digitalassets/documents/digitalasset/dh_094389.pdf
HM Government 2005: The Mental Capacity Act
HMSO. The Children Act (1989),
HMSO. The Children Act 2004,
Safeguarding Children and Young people: Roles and Competencies for Health Care Staff.
Intercollegiate Document supported by the Department of Health.
http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%
20%20%20(3)_0.pdf
Joint Targeted Area Inspections (2016)
argeted_area_inspections_inspection_framework_and_guidance.pdf
P v Cheshire West and Chester Council and another and P and Q v Surrey County Council,
Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance
Framework (2015)
Page 35 of 41

Luke Turnbull & Gill Poyser-Young Designated Nurses Safeguarding Calderdale CCG
Combined Adults at Risk and Children’s Safeguarding Annual Report 2016/17


The Goddard Enquiry: Investigating the extent to which institutions have failed to protect children from sexual abuse (2016)
https://www.iicsa.org.uk/


39 Essex Street (2015)
Glossary of Terms and Abbreviations

1. **PREVENT**
   One strand of the Government’s national strategy (CONTEST), PREVENT aims to stop people from being drawn into terrorism, and ensure that they are given appropriate advice and support.

   1.1 **WRAP**: Workshop to Raise Awareness of Prevent. The Prevent training required by all clinical healthcare staff.

   1.2 **Channel Panel**: is an early intervention multi-agency process designed to try safeguard people who may be susceptible to being drawn into violent extremist or terrorist behaviour.

2. **Safeguarding Adults Review (SAR): Previously Serious Case Review (SCRs)**
   Section 44 of the Care Act 2014 and associated statutory guidance require Safeguarding Adults Boards (SAB) to conduct (SARs) in certain circumstances, and permits the SAB to arrange them in other circumstances. The Act requires SAB member agencies and partners cooperate with and contribute to SAR’s where they have any involvement.

   A SAR must always be conducted when there is reasonable cause for concern about how the SAB, member agencies or persons with relevant functions worked together to safeguard an adult with care and support needs (regardless of whether the local authority was meeting any of those needs) who:

   - Has died (including suicide), and the SAB knows or suspects that the death resulted from abuse or neglect (regardless of whether or not the abuse or neglect had been reported); OR
   - Is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect

   The purpose of a SAR is for all partner agencies to identify the lessons that can be learned.

3. **Safeguarding Children Serious Case Review (SCR)**
   Serious Case Reviews (SCRs) are a statutory requirement led by the Local Safeguarding Children Boards and are undertaken following the death or serious injury to a child where abuse or neglect are thought to be a factor: and there are concerns about the way agencies have worked together (Working Together, 2015).

4. **Domestic Homicide Review (DHRs)**
   Established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004), and led by the Safer and Stronger Community Partnership, on behalf of the Home Office. A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:-

   - A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship
   - A member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

   The purpose of a DHR is to;
• Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

• Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result

• Apply these lessons to service responses including changes to policies and procedures as appropriate and

• Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

5. Whole Service Enquiries/Investigations (WSE) – also termed section 42 enquiries

Whole Service Enquiries/Investigations are undertaken where there has been an allegation of institutional abuse or a number of adults at risk have been allegedly abused, or patterns or trends are emerging from data that suggest significant serious concerns about poor quality of care that is or has the potential to cause significant harm to adults at risk.

The purpose is to have in place multi-agency arrangements to respond to a complex/whole service incident and most investigations involve multiple-partners from the Health and social care continuum, and frequently include the CQC as regulators of the service and on occasion the Police
### Appendix B

**Safeguarding Adults Reviews (SAR), Domestic Homicide Reviews (DHR), Serious Case Review, Serious Incidents, WSE**

<table>
<thead>
<tr>
<th>Type of Review/ Date commenced</th>
<th>Overview of case</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual safeguarding issue</strong></td>
<td>A case of a young adult with a learning disability. Concerns about neglect from family members.</td>
<td>Being investigated by West Yorkshire Police for possible neglect. The person is currently safely residing in respite care. Planning for future long term placement.</td>
</tr>
<tr>
<td><strong>SAR</strong></td>
<td>A woman in a care home suffered an unwitnessed incident which resulted in significant bruising. Family discovered the bruising. There are concerns about the multi-agency response.</td>
<td>2 panel meetings have taken place. Learning event planned for May 2017. The review is on track to be completed by June 2017.</td>
</tr>
<tr>
<td><strong>WSE</strong></td>
<td>A whole service enquiry is ongoing concerning a care home in Calderdale. The home has decided to close and suitable alternative care placements have been found for residents.</td>
<td>All patients are due to have moved to alternative accommodation w/c 17/4/17.</td>
</tr>
<tr>
<td><strong>DHR</strong></td>
<td>Led by Lincoln Community Safety partnership as the victim was a Lincoln resident and the incident took place in Lincoln. There have been some concerns from Calderdale organisations about the draft report and comments have been made.</td>
<td>The final draft is much improved and further comments are being collated. Resulting actions for Calderdale GP practices have been completed</td>
</tr>
<tr>
<td><strong>DHR</strong></td>
<td>The second DHR concerns a resident of Calderdale and has been completed, approved by the Community Safety Partnership. The report will be sent for Home Office approval.</td>
<td>Awaiting home office approval</td>
</tr>
<tr>
<td><strong>SCR</strong></td>
<td>This case is involves a young person who was made subject to being Looked After following multiple agency concerns over possible sexual exploitation.</td>
<td>The final overview report was presented to an extraordinary board meeting on the 29th July 2016. A media strategy was prepared with consultation with all partners. The final report was submitted to national panel and published on the 16th November 2016 and can be accessed on the following link: <a href="http://www.calderdale-">http://www.calderdale-</a></td>
</tr>
</tbody>
</table>
**Executive Summary**

**Key messages at month 05:**
- The CCG is planning to deliver an in-year deficit of £3.13m however the overall level of risk has increased from £2.5m to £3.3m.
- The CCG has a QIPP (Quality, Innovation, Productivity and Prevention) target of £11.5m but has a gap in plans of £1.6m which has reduced from £2.4m. The projected QIPP delivery is £7.2m, giving a risk of £4.3m on QIPP delivery.

**Previous consideration**

<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Finance and Performance Committee</th>
<th>Meeting Date</th>
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</thead>
<tbody>
<tr>
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<td>28/09/2017</td>
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</table>

**Recommendation(s)**

It is recommended that the Governing Body NOTES the content of this report and the financial position.

**Decision**

☑ Assurance  ☐ Discussion  ☐ Other

**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**

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

**Risks (Corporate risk register)**

- Risk 829 – delivery of planned surplus
- Risk 826 – appropriate QIPP schemes in place
- Risk 849 – acute contract

**Legal / Constitutional Implications**

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

1.1 This report updates the financial position as at month 5, key messages are:

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

- In month 5 the CCG is showing an increased unmitigated risk to £3.3m, which reflects the risk assessment review in relation to QIPP\(^1\) delivery and also potential contract overtrades.

- 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 has allocated QIPP to individual budget lines, with the exception of a gap of £1.6m, for which no QIPP plans are in place at the moment. The gap figure has reduced by £0.8m reflecting additional QIPP stretch plans. 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.

2.0 Financial Performance 2017/18 – Delivery of Planned Surplus

2.1 Below shows a summary of the financial performance of the CCG’s programme budgets. Key messages are shown below:

- **Acute** - Calderdale & Huddersfield NHS Foundation Trust (CHFT) at the end of month 4 is showing an over-trade of £0.3m, this continues to include an estimate for EPR (Electronic Patient Record). The main variances are Daycase activity under-trade £0.2m, Elective under-trade £0.2m, Non Elective over-trade £0.6m, Outpatients under-trade £0.7m, A&E activity has reduced against plan £0.3m, other NHS Non-Tariff activity over-trading by £0.6m.

  Leeds Teaching Hospital NHS Trust at month 4 continues to show an under-trade of £0.1m. We have forecast this to be a full year effect of £0.4m.

  Spire has seen a drop in referrals and is currently under trading at £0.1m; we have forecast this to have a full year effect of £0.2m. Detailed information can be found in the contracting report.

- **Prescribing** - The CCG has received the first prescribing forecast information relating to 2017/18. This information has not been used to inform the forecast until we have ample data to make a sound judgement. Information for the first 4 months of the year has been received continues to be lower than plan giving a year to date variance of £0.4m.

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

- **QIPP** - QIPP is showing a pressure of £1.6m which is covered in more detail below.

---

\(^1\) Quality Innovation, Productivity and Prevention (QIPP)
3.0 Public Sector Payment Policy

3.1 The CCG has a target of 95%, Non NHS invoices have improved in the month to 97.31%. Performance for NHS invoices is above target with 99.97%. Actions taken to increase performance have worked but needs to be maintained.

4.0 Contracting Key Messages

4.1 Calderdale & Huddersfield NHS Foundation Trust

The contract position as at the end of Month 4 has shifted from an under-trade of £261k to an over-trade of £298k and continues to include an estimate due to the implementation of Electronic Patient Record (EPR).

4.2 Other Acute and Independent Sector providers

The contract position at the main acute providers shows under-trades at Mid Yorkshire Hospitals of £52k, East Lancashire Hospitals £63k, Bradford Teaching Hospitals £191k, Leeds Teaching Hospital £140k, and Pennine Acute Hospitals £1k. In respect of the independent sector providers there are currently under-trades at Spire Elland £132k and The Yorkshire Clinic £8k; with BMI Huddersfield over-trading by £35k.

4.3 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

There were 787 occupied acute-inpatient bed days in Month 4 which was 35.5% higher than expected Year to Date (YTD). At the end of the month there were 23 patients receiving inpatient care, 2 of whom had a length of stay greater than 6 months. 7 patients were receiving inpatient care out of area. No patients were receiving Psychiatric Intensive Care Unit (PICU) services out of area.

4.4 Yorkshire Ambulance Service (YAS) 999 Ambulance

The Ambulance Response Programme (ARP2.2) Month 4 performance is measured against a target of 75%. 81.8% of Category 1 calls were reached within 8 minutes. YAS overall performance was 71.8%.

4.5 NHS 111 and West Yorkshire Urgent Care (WYUC)

The Contract position at Month 34, based on 2017/18 values, shows that the validated NHS 111 activity allocated to Calderdale was 4,203 calls compared with 4,195 in Month 4 of 2016/17. Validated WYUC activity shows 1,638 cases compared with 1,706 cases in July 2016.

4.6 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. Accident & Emergency (A&E) attendances for Month 4 were 4.1% higher than Month 4 in 2016. Emergency hospital admissions were 30.2% higher in Month 4 this year than in Month 4, 2016.
4.7 Posture and Mobility (Wheelchairs) Service (OpCare)

The service continues to experience pressure in respect of increased demand and complexity. A number of Key Performance Indicators (KPIs) are currently breaching the target in Calderdale. There has been an improvement in performance in a number of indicators in Month 4. There has been a further reduction in performance in the 2-week urgent referral pathway.

4.8 Walk-in Centre

Walk-in services are currently commissioned from Locala and based at Todmorden and Home Street at weekends and bank holidays. Month 4 activity shows that 797 patients were seen at walk-in centres, which is an increase on Month 3 when 617 patients were seen. Activity continues to be above contracted levels. The percentage of patients seen within 1 hour of arrival in Month 3 was 94.98% against the 95% target. All patients were seen within 4 hours.

5.0 Procurement Update and Issues

The Contract Management System (Accord) has been demonstrated to the Local Authority (adult and children team leaders); this will be discussed at the next Integrated Commissioning Executive meeting. Questions were raised about a small number of amendments to make the system work; these will be forwarded to Accord.

6.0 Current and Completed Tenders

6.1 Medicines Optimisation Service

The current tendered service is in place until November 2017 at an approximate cost of £225k per year. Following a review of the performance of the current service and following discussion at the Senior Management Team (SMT) on 13 March 2017, it was proposed that the service should be re-commissioned. It was agreed that in order to generate the appropriate level of interest from the market, that the procurement of the service would be based on a contract term of 3 years, with the option to extend by up to 2 further years (1 +1).

The draft procurement timeline began on 29 May 2017 with evaluation of submissions on 3 August 2017. A recommendation to award was approved by the Governing Body at its meeting on 10 August, following this approval the contract was awarded to the North of England Commissioning Support (NECS) with a contract value of £674,790. The contract and service leads will meet to initiate mobilisation ready for a 1 November 2017 service start.

6.2 Children & Young Persons ASD (Autistic Spectrum Disorder) Service

The demand for the current service outweighs the level of investment. It is proposed that an independent organisation will review existing services, data flows and predict future demand to produce a report and suggest recommendations for change.

The allocated budget is £15,000 and a quotation process for a provider to undertake the review is being carried out by the Senior Service Improvement Manager. Further updates will be shared when available.
6.3 Specialist Mental Health Service for Refugees and Asylum Seekers affected by Trauma/Torture/Sexual Violence

The objective of this service would be to provide the required support for patients who have specific mental health needs as a result of complex trauma and to reduce the reliance on secondary care for these patients who would access A&E or have emergency admissions as a result of their condition that could be managed in Primary Care.

The procurement process is through a quotation request from three specialist providers, with the following timelines.

- Request for quotation issued: 14 August 2017
- Deadline for quotation responses: 10 September 2017
- Evaluation of quotations: 11 – 15 September 2017
- Notification of results to all bidders: w/c 18 September 2017
- Anticipated start date: 1 November 2017

Further updates will be shared when available.

6.4 Voluntary Sector Infrastructure

The CCG and Calderdale Council are interested in securing infrastructure support for the local voluntary and community sector in Calderdale. The requirement is for interested parties to come together as an alliance and to use an allied contract approach to the procurement. Calderdale Council is the lead organisation.

A bidder’s day was held on 18 July 2017, which was open to all interested organisations. Potential bidders were made aware of the aim for new ways of working, and commitment from interested parties in working to develop the approach and services provided.

A Prior Information Notice has been published requesting expressions of interest to be returned to the Local Authority by the 31 August 2017. The contract will be for 3 years with an overall budget of £240,000 per annum. Calderdale Council is the lead organisation.

Further updates will be shared when available.

7.0 Proposed Tenders

The currently advised procurement intentions identified for 2017/18 are:

GP Safe Haven Practice

The provision of the GP Safe Haven Practice is under discussion. Further updates will be shared when available.

Community Ophthalmology Schemes

Waivers have been approved to directly award contracts to the current providers until March 2018; this will allow time for the services to be reviewed and a procurement process to be carried out. A further update will be shared when available.
GP Enhanced Services

Waivers have been approved to directly award contracts to the current providers until March 2018; this will allow time for the services to be reviewed and a procurement process to be carried out. A further update will be shared when available.

8.0 Recovery Key Messages

There were 4 contract reviews discussed at the Finance and Performance Committee on the 28 September, which were approved. The 4 reviews were:

a) Stopping prescribing certain products of lower clinical priority - It was agreed that the CCG would consult the Calderdale population on a proposal to limit the routine availability of a list of lower priority medicines on prescription.

b) Approach to repeat prescribing ordering services - The CCG agreed to ask member practices to stop third party repeat prescription ordering for the majority of their patients. The CCG agreed that member practices can allow continued third party prescription ordering for a restricted number of patients that have been identified as requiring support with ordering repeat medicines.

c) Virtual Ward - It was agreed to continue funding the service for a time limited period, but that additional KPIs be developed to monitor the impact of the service. The CCG did not agree to continue funding the virtual ward as a hospital based service, however recommended that the service be incorporated as part of community out of hospital services as part of care closer to home strategy.

d) A&E Physician - It agreed that this continue to be funded. The committee agreed a further option needed to be developed for the A&E Physician to be included in the review/remodelling of the urgent care offer and that the current contract should continue until that new model was in place and operational.

8.1 Recovery Updates

Health Optimisation

This was discussed at the Clinical Development Forum (CDF) on the 7th September and a first draft of the output from this discussion has been produced and was shared initially with the SMT to develop a further draft.

(Sustainability and Transformation Partnership) STP Financial Strategy

The York Health Economic Consortium work is continuing, the financial model is nearly complete and will set out the financial challenge in a common version. Risks have been raised that this may only present the challenge differently and not support a common strategy for the STP Places. Discussions are due to take place at the West Yorkshire Chief Finance Officer/Directors of Finance meeting on Friday 22 September and a workshop is due to be held at Healthy Futures in October. Themes emerging from the work are:

- Governance - need to further develop governance/leadership.
- This work should focus on STP-wide solutions not repeating the size of the gap.
• Workforce pressures and high agency spend - could we adopt a common approach to agency and bank rates and consider skill mix at scale.

• Payment by Results (PBR) does not incentivise appropriately.

• Establish common thresholds across STP

• Benchmarks suggest current levels of treatment are high compared to areas with similar funding.

• Innovation - unclear if good examples of delivery elsewhere can/will improve local services.

NHS England QIPP Support Phase 2

Work is progressing and initial meeting between NECS and our health system leaders has taken place, no messages have yet been received and a workshop to discuss findings is yet to be arranged.

The joint outpatients work is currently being developed and the CCGs have a joint lead, working with the CHFT and NECS to drive this area forward. An update will be provided on an ongoing basis through the recovery report.

Health System Recovery Plan

The CCG is working jointly with Greater Huddersfield CCG and CHFT to develop our “system” financial recovery, which recognises that we have significant pressures across all health organisations and a level of unmitigated risk which all three organisations are currently reporting. As previously discussed this has come about as part of discussions with both regulators but also through our ongoing relationships to ensure we have a financially sustainable health system. As part of the process, we recently met with colleagues from Bolton health economy, which has addressed the similar challenges our system faces and created an environment that supports a financially sustainable health economy. Their process of an Aligned Incentives Contract has fundamentally reversed the perverse incentives of a PBR contract between the hospital and CCG. Their contract model aligns to clinical priorities for the system benefit. Learning from this will assist our CCG in developing a new contract method, which we aspired to in our original financial recovery plan.

Executive Sponsors

Arrangements are now in place regarding Senior Management Team Executive Sponsors for Recovery Programmes. Executive Sponsors, Clinical Leads, Project Leads and Project Managers have been agreed for each of the recovery programmes. A description of the roles has been agreed / shared with the SMT and CDF.

In addition Dr Steven Cleasby retains the lead for Children and Young People (whilst this is not a discrete recovery programme, it aligns with a number of other recovery programmes)

9.0 Recommendation

It is recommended that the Governing Body NOTES the content of this report and the financial position.
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<td>Quality and Safety Report / Quality Dashboard</td>
<td>Agenda Item No.</td>
<td>9 b)</td>
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<tr>
<td>Report Author</td>
<td>Louise Burrows, Quality Manager</td>
<td>Public / Private Item</td>
<td>Public</td>
</tr>
<tr>
<td>GB / Clinical Lead</td>
<td>Dr Majid Azeb</td>
<td>Responsible Officer</td>
<td>Penny Woodhead, Head of Quality and Safety</td>
</tr>
</tbody>
</table>

### Executive Summary

Please include a brief summary of the purpose of the report

This report provides the Governing Body with an update on progress against recent quality and patient safety activities including:

- Electronic patient record implementation update
- Clinical effectiveness and compliance
- Commissioning for Quality and Innovation (CQUINS) Quarter 1 2017-18 achievement
- Patient Transport Services – Yorkshire Ambulance Service (YAS)
- Revised guidance on Quality Surveillance Groups and Risk Summits.

The report also includes a copy of the Quality Dashboard for September 2017, providing quality and safety information for our main providers.

### Previous consideration

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<tr>
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### Recommendation (s)

It is recommended the Governing Body RECEIVES this report and NOTES the actions being taken within the dashboard.

### Decision

☐ Assured
☒ Discussion
☐ Other 38T

### Implications

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

- 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.

Public / Patient / Other Engagement

None identified

Resources / Finance implications (including Staffing/Workforce considerations)

CQUINs have a financial value attached to outturn contract value.

Strategic Objectives

- Achieving the agreed strategic direction for Calderdale
- Improving quality

Risks (Corporate risk register)

984 Risk relating to HCAI
863 Risk relating to quality of services at CHFT

Legal / Constitutional Implications

None identified

Conflicts of Interest

(include detail of any identified/potential conflicts)

None identified

1.0 Introduction
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 Electronic Patient Record Implementation Update

2.1 The Quality Committee discussed the implementation of the electronic patient record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT) in detail at their meeting on 31 August 2017. The Committee raised concerns about the impact of the EPR on patients and clinicians in other parts of the system, particularly in relation to the number of incidents related to the EPR, and to issues such as duplicate discharge summaries.

2.2 The Committee learned that discussions were ongoing between the Head of Quality, Head of Service Improvement and CHFT, and that the Trust had acknowledged the scale of the issues. Since the Quality Committee meeting, two ‘go see’ visits have taken place, including GPs, quality managers, patient experience officers and a pharmacist (to the Huddersfield Royal Infirmary visit only).

2.3 The CHFT Clinical Quality Board meeting on 26 September 2017 focused on the EPR implementation. The CCG received assurance from the Trust that a robust risk and hazard approach was in place, including number of measures introduced to assess and mitigate the impact of the implementation of EPR. These include:

- Establishment of a weekly Clinical Risk panel chaired by the Medical Director and review of governance for Business As Usual (BAU)
- Work with primary care to safely manage communications between secondary care and GPs
- Fortnightly partnership meeting had been re-established with primary care and social care colleagues
- Directorate meetings with every specialty, as an MDT, to listen directly to concerns and ideas
- A refreshed communication and engagement plan
- Retention of some data quality expertise and focussed external deep dives into key services
- Increased booking team capacity
• Ongoing dialogue with regulators
• Business case for additional hardware
• Clinical and operational support to Bradford for Go-live and increased ‘front end’ capacity at CHFT for the Bradford cutover and first week of deployment
• Testing of Business continuity plans
• Formal system testing between the 2 Trusts
• Increased BAU capacity
• Review of the deployment Tactical programme
• Review of SOPs (Standard Operating Procedures) and associated training
• Further actions in relation to correspondence.

2.4 The quality team, Quality Committee and CHFT Clinical Quality Board will continue to monitor the impact of these measures in resolving the issues raised, and will escalate any further concerns as necessary.

3.0 Clinical effectiveness and compliance

3.1 At its meeting on 31 August 2017, the Quality Committee received a report about national audits and clinical effectiveness and compliance. The report included information about three national audits undertaken in quarter 1, and a description of provider compliance with NICE\(^1\) guidance. CHFT had provided the CCG quality team with updates on their responses to the audits and compliance with NICE guidance was being monitored. The Committee noted that CHFT was non-compliant with 18 out of 58 new or updated NICE guidelines published in quarter 1. Reasons for non-compliance had been provided for three guidelines. The governing Body can be assured that non-compliance with NICE guidance is reviewed in detail at the CHFT Clinical Quality Board.

3.2 The Quality Team will continue to gain assurance that the main Providers are participating in 100% of audits relevant to their Trust and that they have internal governance processes around participation, review of findings and actions taken in place.

3.3 The Quality Committee noted and were assured by the process in place within the CCG quality team to manage national audit data and NICE guidance compliance.

4.0 Commissioning for Quality and Innovation (CQUINS) Quarter 1 2017-18 achievement

4.1 The Commissioning for Quality and Innovation (CQUIN) payment framework was introduced in financial year 2009/10. It is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider.

4.2 The overview of the development of local CQUIN schemes, including the implementation, trajectories setting, improvement plans and recommending these to the relevant Contract Management Boards continues to be managed through the Clinical Quality Board arrangements.

4.3 An update on the Quarter 1 position for CQUINs for Calderdale CCG’s main providers was received at the Quality Committee on 31 August 2017, details of which can be seen below:

\(^1\) National Institute for Health and Care Excellence
<table>
<thead>
<tr>
<th>Provider</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tr>
<td>CHFT</td>
<td>85.7%</td>
<td></td>
<td></td>
<td></td>
<td>Indicators not achieved include 2a) sepsis screening for emergency admissions and inpatients; and 2b) antibiotic administration and review for patients identified as having sepsis, in the emergency department and for inpatients. This was discussed at the CHFT Clinical Quality Board on 26 September 2017 and CHFT colleagues explained that a change of computer system meant that sepsis screening was no longer a mandatory field in the IT system, so the screening taking place was not always recorded. Communications were planned to make staff aware of the requirement to still record the sepsis screening. An improvement in results was expected by Q3. In addition, a new programme of work on identifying patients vulnerable to sepsis was being introduced.</td>
</tr>
<tr>
<td>SWYPFT</td>
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<td></td>
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</tr>
<tr>
<td>Spire Elland</td>
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<td>BMI Huddersfield</td>
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<td>All available indicators achieved.</td>
</tr>
<tr>
<td>YAS</td>
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<td></td>
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<td>All available indicators achieved.</td>
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5.0 Patient Transport Services – Yorkshire Ambulance Service (YAS)

5.1 Yorkshire Ambulance Service (YAS) received an overall rating of “good” from the Care Quality Commission (CQC) inspection published in February 2017; however the Patient Transport Service (PTS) which is part of YAS received a “requires improvement” rating. Since then a programme of work has commenced to address the issues identified.

5.2 A review of staff has been undertaken and a restructure of the management and leadership team has been completed. Some new roles have been created including the appointment of a Quality Manager who is leading on the delivery of the quality improvement plan. The Quality Manager met with commissioners on 9th August 2017 to discuss the quality improvement plan and progress made to date.

5.3 PTS are working with the Improvement Academy and have a number of staff members who have attended the Silver Quality Improvement Training. They have successfully implemented weekly safety huddles at some of the stations and are looking to roll out across the whole
organisation. These huddles give the teams chance to meet and discuss any safety concerns, equipment problems, access difficulties or important information about patients.

5.4 Infection Prevention Control issues were identified by CQC so they have placed yellow stickers in all the vehicles reminding staff to wipe down after each patient. They have also developed a cleaning checklist for team leaders to use for spot checking vehicle cleanliness.

5.5 The PTS Quality Manager is revising the Trust mandatory training to make it more relevant to PTS staff because at the moment it is aimed at the type of activities Paramedics undertake. They are developing a library of case studies based on reported incidents from PTS to support the mandatory training.

5.6 They are about to commence a piece of work with renal patients to introduce a patient passport and will be conducting a patient survey to see how the service to renal patients can be improved.

5.7 The PTS Quality Manager is working with commissioners to review and update the quality indicator report that is presented at the monthly contracting meeting, and in future will supplement the data with a quality highlight report to describe the quality improvement work in more detail.

5.8 The monthly PTS contracting meeting receives the CQC improvement plan on a monthly basis to monitor progress and gain assurance. Two Quality team representatives from Greater Huddersfield and Leeds attend this meeting and will ensure any risks are escalated via the Quality Performance and Finance Committee.

6.0 Revised guidance on Quality Surveillance Groups and Risk Summits

6.1 In July 2017 the National Quality Board (NQB) has published “revised guidance on quality surveillance groups (QSGs) and risk summits”. The guidance has been revised following a recent NQB review of the QSG and Risk Summit model, as well as in response to changes signalled in the “Next Steps on the Five Year Forward View” and the NQB’s “Shared Commitment to Quality”. For further information, both documents can be accessed via the following link:

https://www.england.nhs.uk/ourwork/part-rel/nqb/

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 CQUINs have a financial value attached to outturn contract value.

9.0 Recommendations

9.1 It is recommended 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>
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<td>58</td>
</tr>
<tr>
<td>Complaints</td>
<td>No target</td>
<td>30</td>
<td>Quarter 1 2017-18</td>
<td>30</td>
</tr>
</tbody>
</table>

**C-Diff** - 3 cases reported in July giving a YTD figure of 19 against an annual target of 39. This remains over trajectory.

**MRSA** – No cases reported in July YTD figure 2.

**E-coli** – this indicator continues to be over trajectory. A CKW wide improvement plan has been written. Primary care data extraction template has been created and testing will commence this month.

**Healthcare Associated Infections (HCAI)** - Infection numbers for all HCAI discussed at Quality Committee. Further information sought from the Infection prevention and control team at the local authority on activities being undertaken to support the HCAI agenda.

**Complaints** - Quarter 1: 5 level 3 and 0 level 4 complaints were received regarding services commissioned/provided by the CCG.

11 level 1 enquiries, e.g. concerns about a GP surgery requiring signposting/advice
14 level 2 concerns, e.g. providing advice on how to access hospital medical records.
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 July 2017.

**Time to Theatre for patients with a fractured neck of femur:** July performance has deteriorated slightly on reporting for June to 65.91%, and remains below target. Of the 38 patients admitted with fractured neck of femur in July, 29 were operated on within 36 hours. There were 4 patients with clinical reasons for delay to theatre and 5 that were operated on within 48 hours due to lack of capacity. The number of breaches due to non-clinical reasons has significantly reduced since the implementation of new pathways. CHFT has changed the process so there is better visibility of all Trauma patients which should improve the planning generally and improve the hip fracture patients having surgery in a timely way. There is a new guideline for managing hip fracture patients on anticoagulants - previously they had to wait for 48 hours but can now be operated on after 24 hours, which will reduce some of the clinical delays. The quality team is closely monitoring the trust’s performance on this indicator and expects to see improvements over the coming months, further information has also been requested on the numbers of clinical and organisational delays but as yet this information has not been received.

**Complaints:** Of the 47 complaints closed in July, 46% were closed within target timeframe. The number of overdue complaints was 25 at the end of July; which is a 16% decrease from June. The focus remains closing overdue complaints. Work with the divisions continues and performance is expected to be back on track from Q2, 2017. Complaint scales are monitored weekly, which highlights all breaches and potential breaches to the Complaint leads for each Division. Each breached complaint is investigated weekly as to the reason of delay.

**Friends and family test:** Response rates in A&E and inpatients have improved in July, with 12.5% of A&E patients responding. While this still does not achieve the target of 14%, it is the highest response rate the trust has received since November 2016. The inpatient response rate is 30.5%, thereby exceeding the target of 28%. The re-established task and finished group continues to meet and will monitor response rates.

**The Electronic Patient Record (EPR) issues** continue to cause concerns within primary care, although the Trust appears to now have a greater understanding of the problems. A board has been re-established to deal with the issues and the Clinical Quality Board on 26 September 2017 will review the progress made. The Trust invited commissioners to visit to view the system in action and on 6th September a GP, Quality Manager and Patient Experience Officer from GHCCG visited A&E and the Medical Assessment Unit at HRI. The visit was positive and the staff were honest about the problems that had been identified since the system went live. Staff talked about the work that had been done to resolve the problems and issues that still concerned them that needed to be resolved. Some of the problems relate to user error and additional training has been given supported by standard operating procedures. Some issues relate to problems with the software and the Trust are working very closely with the software company to resolve these. A second commissioner visit will take place at Calderdale on 22nd September 2017.

The risk to patient safety as a result of EPR implementation has been recorded on the CCGs Risk Register; the current score is 16.
Staffing: At the end of July 2017 the Trust was reporting 176 wte staff nurse vacancies, from September there will be 2 generic adverts managed centrally by the Head Nurse for Professional and Workforce Development, to support all future band 5 inpatient nurse jobs (ward/departments). The area with the highest rate of vacancies is healthcare scientists. Discussions are in progress with the pathology general manager to understand the high turnover rate and produce a retention plan. Total reported agency spend in June was £1.46m; this is as planned against the NHS Improvement Agency Ceiling. Figures for July are not available at the time of completing this report.

VTE Risk Assessments
Since EPR was implemented the performance on completing VTE risk assessment forms had dropped and has below the 95% target for the past 3 months. The Trust is unclear as to why this is the case, however there is no evidence that VTE risk assessments are not being completed and the EPR triggers appear to be effective. Further analysis will be undertaken by the Informatics teams, informed by the clinical leads to better understand the current position. Next steps include review of clinical pathways and admission processes. Findings will be fed back to the Medical Director in September, and the aim is to get performance back on track by Q3.
## Calderdale and Huddersfield NHS Foundation Trust

### Quality Dashboard - September 2017

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period Target</th>
<th>YTD 2017-18</th>
<th>Month / Period / Year data from</th>
<th>Corresponding month 2016/17</th>
<th>CHFT</th>
<th>Direction of Travel</th>
<th>Trend information 2016-17</th>
<th>Trend information 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emsa</td>
<td>Monthly</td>
<td>0</td>
<td>5</td>
<td>Jul-17</td>
<td>↔</td>
<td>0</td>
<td>M</td>
<td>J J</td>
<td>A S O N D J F M A M J J A</td>
</tr>
<tr>
<td>% complaints closed within target timeframe</td>
<td>Monthly</td>
<td>100%</td>
<td>46.00%</td>
<td>51.8%</td>
<td>↑</td>
<td>0</td>
<td>M</td>
<td>J J</td>
<td>52.00% 52.00% 46.00% 46.00% not avail</td>
</tr>
<tr>
<td>C diff</td>
<td>Monthly</td>
<td>Max 21 for the year</td>
<td>2</td>
<td>0</td>
<td>Jul-17</td>
<td>↑</td>
<td>↑</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E coli</td>
<td>Monthly</td>
<td>n/a</td>
<td>5</td>
<td>13</td>
<td>↑</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>10 3 4 3 5 4 6 2 6 2 not avail</td>
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<tr>
<td>Mrsa</td>
<td>Monthly</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>↓</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0 1 0 0 0 0 0 0 0 0 0 0 0 1 0 not avail</td>
</tr>
<tr>
<td>Never events</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↑</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 not avail</td>
</tr>
<tr>
<td>Safety thermometer - % of harm free care</td>
<td>Monthly</td>
<td>n/a</td>
<td>94.27%</td>
<td>-</td>
<td>↓</td>
<td>94.42%</td>
<td>94.21%</td>
<td>92.23%</td>
<td>95.42% 95.14% 94.17% 95.78% 94.21% 95.17% 94.01% 94.15% 93.64% 94.51% 93.96% 93.14% 94.27% not avail</td>
</tr>
<tr>
<td>Staffing levels - average fill rate - registered nurses/midwives % (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>83.82%</td>
<td>-</td>
<td>↓</td>
<td>90.51%</td>
<td>90.00%</td>
<td>87.44%</td>
<td>78.60% 80.42% 81.13% 83.35% 85.63% 85.10% 85.69% 84.68% 82.22% 85.31% 88.82% 84.56% 83.82% not avail</td>
</tr>
<tr>
<td>Staffing levels - average fill rate - care staff % (day)</td>
<td>Monthly</td>
<td>n/a</td>
<td>102.48%</td>
<td>-</td>
<td>↑</td>
<td>103.59%</td>
<td>105.97%</td>
<td>97.49%</td>
<td>102.16% 101.30% 102.80% 101.30% 104.49% 104.80% 102.67% 101.50% 106.84% 103.10% 105.91% 102.67% 102.48% not avail</td>
</tr>
<tr>
<td>Staffing levels - average fill rate - registered nurses/midwives % (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>92.54%</td>
<td>-</td>
<td>↑</td>
<td>94.84%</td>
<td>94.58%</td>
<td>92.81%</td>
<td>89.76% 87.55% 88.38% 89.67% 92.00% 91.18% 92.02% 90.45% 88.25% 91.30% 95.96% 92.27% 92.54% not avail</td>
</tr>
<tr>
<td>Staffing levels - average fill rate - care staff % (night)</td>
<td>Monthly</td>
<td>n/a</td>
<td>115.87%</td>
<td>-</td>
<td>↑</td>
<td>120.13%</td>
<td>119.17%</td>
<td>118.23%</td>
<td>116.88% 116.33% 120.21% 123.61% 124.37% 122.98% 125.08% 133.04% 132.45% 116.09% 115.04% 113.60% 115.87% not avail</td>
</tr>
<tr>
<td>NPSA safety alerts - CAS alerts completed within deadline</td>
<td>Monthly</td>
<td>n/a</td>
<td>97.6%</td>
<td>-</td>
<td>↑</td>
<td>97.7%</td>
<td>97.14%</td>
<td>98.00%</td>
<td>98.14% 97.00% 93.13% 94.6% 94.19% 92.8% 92.3% 97.6% 100% 100% 96.9% 97.5% 95.3% not avail</td>
</tr>
<tr>
<td>Percentage non-elective IHaF Patients with admission to Procedure of &lt; 36 hours</td>
<td>Monthly</td>
<td>85%</td>
<td>65.91%</td>
<td>67.33%</td>
<td>↔</td>
<td>87.50%</td>
<td>67.4%</td>
<td>75.53%</td>
<td>52.38% 71.74% 86.05% 58.10% 78.72% 82.05% 53.30% 82.90% 83.30% 78.57% 55.88% 67.44% 95.91% not avail</td>
</tr>
<tr>
<td>Vte risk assessment</td>
<td>Quarterly</td>
<td>95%</td>
<td>91.44%</td>
<td>91.44%</td>
<td>↓</td>
<td>95.01%</td>
<td>95.14%</td>
<td>95.35%</td>
<td>95.14% 95.10% 95.14% 95.07% 95.20% 95.02% 95.03% 95.86% 94.34% 88.31% 91.39% not avail</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
<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
<th>Description</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSA NRLS</td>
<td>41.19</td>
<td>Incidents reported per 1000 bed days (April - Sept 16) 6 monthly – next update Sept 17</td>
<td></td>
</tr>
<tr>
<td>SHMI</td>
<td>104.7</td>
<td>1 year rolling data Jan – Dec 16 Monthly – updated Sept 17</td>
<td></td>
</tr>
<tr>
<td>HSMR</td>
<td>98.71</td>
<td>1 year rolling data May 16 – April 17 Monthly – updated Sept 17</td>
<td></td>
</tr>
<tr>
<td>CQC Rating</td>
<td></td>
<td>Inspection rating August 2016 – requires improvement</td>
<td></td>
</tr>
<tr>
<td>CQUINS</td>
<td>87.5%</td>
<td>Quarter 1 2017-18</td>
<td></td>
</tr>
<tr>
<td>CQC Inpatient Survey – respect &amp; dignity</td>
<td>4.01/5 – better than average Annually – updated March 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Inpatient Survey - involved in care decisions</td>
<td>3.72/5 – worse than average Annually – updated March 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Rating</td>
<td></td>
<td>9.1 – about the same as other trusts. Annually – updated Sept 17</td>
<td></td>
</tr>
<tr>
<td>CQC Inpatient Survey – quality of work &amp; patient care able to deliver</td>
<td>7.3 – about the same as other trusts. Annually – updated Sept 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Staff Survey – quality of work &amp; patient care able to deliver</td>
<td>4.01/5 – better than average Annually – updated March 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Staff Survey – respect &amp; dignity</td>
<td>3.72/5 – worse than average Annually – updated March 17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2017
Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2017

Friends and Family Test

- **CHFT - Place to work**
  - Monthly
  - Percent would recommend: 94.0% (July 17)
  - Percent would not recommend: 4.2%

- **CHFT - Place to receive care**
  - Monthly
  - Percent would recommend: 90.0% (July 17)
  - Percent would not recommend: 5.0%

- **CHFT - % of patients that would recommend**
  - Monthly
  - A&E: 92.0% (July 17)
  - Inpatient: 91.0% (July 17)
  - Maternity Q1: 85.0% (July 17)
  - Maternity Q2: 86.0% (July 17)
  - Maternity Q3: 87.0% (July 17)
  - Maternity Q4: 88.0% (July 17)

- **CHFT - % of patients that would not recommend**
  - Monthly
  - A&E: 7.0% (July 17)
  - Inpatient: 8.0% (July 17)
  - Maternity Q1: 13.0% (July 17)
  - Maternity Q2: 14.0% (July 17)
  - Maternity Q3: 15.0% (July 17)
  - Maternity Q4: 16.0% (July 17)

**Patient-led Assessment of the Care Environment (PLACE) 2016**

- **Cleanliness**: 99.17%
- **Food & Hydration**: 94.44%
- **Privacy, Dignity & Wellbeing**: 88.97%
- **Condition, Appearance & Maintenance**: 95.46%
- **Dementia**: 82.92%
- **Disability**: 89.14%

**CHFT Safety Thermometer**

- New Harm (total)
- All New Pressure Ulcers
- Catheter and New UTIs
- New VTEs
- Falls with Harm

**Trend information**

- Corresponding month 2016/17
- Direction of Travel
- Month/Period data from CHFT Quality Domain

**Indicator**

- Response Rate - A&E
  - Monthly 84.0% (July 17)
  - Previous Month/Period: 76.0%
  - Target: 80.0%

- Response Rate - Inpatient
  - Monthly: 94.0% (July 17)
  - Previous Month/Period: 92.0%
  - Target: 90.0%

- Response Rate - Maternity question 2 - care during birth
  - Monthly: n/a (July 17)
  - Previous Month/Period: n/a
  - Target: n/a

- Response rate - staff
  - Quarterly: 25.0% (Q1 17-18)
  - Previous Quarter: n/a
  - Target: n/a

**Quality Domain**

- Patient Experience
## 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>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>A meeting took place 20th July between CCG clinical and quality representatives and the general manager for orthopaedics. Assurance was given as to actions taken and this showed a correlation with improved performance.</td>
<td>Performance dropped in May, June and July due to increases in numbers of patients admitted with fractured neck of femur. Work is ongoing and it is anticipated that an improved position will be reported in the coming months.</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, following 2 full page adverts in the BMJ.</td>
<td>A detailed staffing report was due to be discussed at the July Clinical Quality Board, but this meeting was cancelled. The staffing report will be discussed at the next meeting in September 2017.</td>
</tr>
<tr>
<td>Complaints</td>
<td>The % of complaints closed within target timeframe is significantly below target, and shows no signs of sustained improvement.</td>
<td>Improvement work is underway in each division; complaint scales are monitored weekly to highlight all breaches and potential breaches to the Complaint leads. Each breached complaint is investigated weekly to understand the reason of delay.</td>
<td>Performance is expected to be back on track from Q2 2017. The Quality Team will continue to monitor.</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>The response rate for the Friends and Family Test in A&amp;E is consistently below target, but has improved in July.</td>
<td>The response rate from text messages has now improved, so work will focus on encouraging patients to return the FFT cards. A new matron has now commenced in post and is looking at further approaches to improve responses rates. A Standard Operating Procedure for distribution of the FFT cards has been written, and was well received, this will be rolled out Trust-wide.</td>
<td>The trust expect to see an improvement by October 2017, with the ED delivering a comparable level of response and satisfaction compared to other ED departments locally.</td>
</tr>
<tr>
<td>Electronic Patient Record (EPR)</td>
<td>Multiple problems have arisen since the Trust went live with the EPR some of which threaten to compromise patient care</td>
<td>The Trust have established a clinical risk panel and developed a recovery plan. Commissioners have undertaken a visit to HRI to better understand the issues and a visit is planned for CRH at the end of September.</td>
<td>Unclear at present. Some issues have already been resolved. Recovery plan is being monitored through the Quality Board and Contracting Board.</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>

---
This page provides a summary in relation to the maternity services provided at Calderdale and Huddersfield NHS Foundation Trust for the period up to June 2017. The Quality Team will continue to monitor the regional dashboard against CHFTs local data, the local data is more timely.

The August data is displayed in the dashboard, Maternity Safety Thermometer information is also included on the dashboard slide. Overall the dashboard shows a slight deterioration in performance for August.

Areas where indicators are red in month are: emergency C sections; total still births; total still births and perinatal/neonatal deaths; and percentage of women smoking at delivery (13.3% against a target of 11%). The percentage of emergency C sections in August increased to 16.6% against a target on 15.2%. The trust has previously been performing well against this indicator, with most results reaching target for the previous 12 months. The percentage of women smoking at delivery was 13.3% in August, against a target of 11%. The performance of this indicator has been steadily worsening over the past six months.

It should also be noted that 1:1 care in labour continues to remain above target at 99.5% in August against a target of 98%. There were also 0% assisted births with 3rd or 4th degree tears.

This performance is being considered by the CCG service improvement lead, clinical lead, quality team and Public Health Consultant. Any areas where it is felt further assurance is required will be agreed and escalated to the head of midwifery for response, in addition to further details being provided in the next quarterly report.
## Key Indicators

<table>
<thead>
<tr>
<th>Thresholds</th>
<th>By Month</th>
<th>By Month</th>
<th>By Month</th>
<th>By Month</th>
<th>By Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Amber</td>
<td>Red</td>
<td>Green</td>
<td>Amber</td>
<td>Red</td>
</tr>
<tr>
<td>Total Bookings</td>
<td>&gt;90%</td>
<td>Monitoring Only</td>
<td>&gt;90%</td>
<td>Monitoring Only</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Total Births within Service</td>
<td>&gt;64.7%</td>
<td>Monitoring Only</td>
<td>&gt;60.9%</td>
<td>Monitoring Only</td>
<td>&gt;60.5%</td>
</tr>
<tr>
<td>Normal births</td>
<td>&gt;11.0%</td>
<td>Monitoring Only</td>
<td>&lt;12.5%</td>
<td>Monitoring Only</td>
<td>&gt;12.9%</td>
</tr>
<tr>
<td>Assisted vaginal births</td>
<td>&lt;9.4%</td>
<td>Monitoring Only</td>
<td>&gt;9.4%</td>
<td>Monitoring Only</td>
<td>&gt;9.9%</td>
</tr>
<tr>
<td>Elective C/S deliveries</td>
<td>&gt;9.3%</td>
<td>Monitoring Only</td>
<td>&gt;9.5%</td>
<td>Monitoring Only</td>
<td>&gt;9.9%</td>
</tr>
<tr>
<td>Emergency C/S deliveries</td>
<td>&gt;13.3%</td>
<td>Monitoring Only</td>
<td>&gt;13.9%</td>
<td>Monitoring Only</td>
<td>&gt;15.4%</td>
</tr>
<tr>
<td>3rd/4th degree tear - normal birth</td>
<td>&lt;0.3%</td>
<td>Monitoring Only</td>
<td>&gt;0.3%</td>
<td>Monitoring Only</td>
<td>&gt;3.3%</td>
</tr>
<tr>
<td>3rd/4th degree tear - assisted birth</td>
<td>&lt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;18.0%</td>
</tr>
<tr>
<td>PPH ≥ 1500ml</td>
<td>&gt;3.8%</td>
<td>Monitoring Only</td>
<td>&gt;3.3%</td>
<td>Monitoring Only</td>
<td>&gt;3.8%</td>
</tr>
<tr>
<td>Total stillbirths</td>
<td>&gt;3.8%</td>
<td>Monitoring Only</td>
<td>&gt;4.1%</td>
<td>Monitoring Only</td>
<td>&gt;4.5%</td>
</tr>
<tr>
<td>Total stillbirths and Perinatal /Neonatal Deaths</td>
<td>&gt;3.8%</td>
<td>Monitoring Only</td>
<td>&gt;4.1%</td>
<td>Monitoring Only</td>
<td>&gt;4.5%</td>
</tr>
<tr>
<td>Low birth weight at term - live births - % of live babies at term &lt; 2200g</td>
<td>&gt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;0.6%</td>
</tr>
<tr>
<td>Incidence of shoulder dystocia (With Harm)</td>
<td>&gt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;0.0%</td>
<td>Monitoring Only</td>
<td>&gt;2.5%</td>
</tr>
<tr>
<td>Total number of maternity incidents</td>
<td>&gt;207</td>
<td>Monitoring Only</td>
<td>&gt;161</td>
<td>Monitoring Only</td>
<td>&gt;143</td>
</tr>
<tr>
<td>Total number of maternity incidents - Harm Caused</td>
<td>&gt;161</td>
<td>Monitoring Only</td>
<td>&gt;143</td>
<td>Monitoring Only</td>
<td>&gt;129</td>
</tr>
<tr>
<td>Delay in delivery of Category 1 C. Section (&gt;30 minutes from decision to delivery)</td>
<td>&gt;2</td>
<td>Monitoring Only</td>
<td>&gt;1</td>
<td>Monitoring Only</td>
<td>&gt;1</td>
</tr>
<tr>
<td>Delay in delivery of Category 2 C. Section (&gt;75 minutes from decision to delivery)</td>
<td>&gt;2</td>
<td>Monitoring Only</td>
<td>&gt;1</td>
<td>Monitoring Only</td>
<td>&gt;1</td>
</tr>
<tr>
<td>Planned Home Birth</td>
<td>&gt;104</td>
<td>Monitoring Only</td>
<td>&gt;105</td>
<td>Monitoring Only</td>
<td>&gt;110</td>
</tr>
<tr>
<td>% of Mothers Smoking at Delivery</td>
<td>&gt;10.4%</td>
<td>Monitoring Only</td>
<td>&gt;8.6%</td>
<td>Monitoring Only</td>
<td>&gt;8.0%</td>
</tr>
<tr>
<td>% of Mothers Breastfeeding at Initiation</td>
<td>&gt;76.8%</td>
<td>Monitoring Only</td>
<td>&gt;79.6%</td>
<td>Monitoring Only</td>
<td>&gt;76.7%</td>
</tr>
</tbody>
</table>

### Maternity Dashboard – September 2017

- **Positive**
- **Negative**

- **Total Bookings**: >90% (Monitoring Only)
- **Total Births within Service**: >64.7% (Monitoring Only)
- **Normal births**: >11.0% (Monitoring Only)
- **Assisted vaginal births**: <9.4% (Monitoring Only)
- **Elective C/S deliveries**: <9.3% (Monitoring Only)
- **Emergency C/S deliveries**: >13.3% (Monitoring Only)
- **3rd/4th degree tear - normal birth**: <0.3% (Monitoring Only)
- **3rd/4th degree tear - assisted birth**: <0.0% (Monitoring Only)
- **PPH ≥ 1500ml**: >3.8% (Monitoring Only)
- **Total stillbirths**: >3.8% (Monitoring Only)
- **Total stillbirths and Perinatal /Neonatal Deaths**: >3.8% (Monitoring Only)

- **Low birth weight at term - live births - % of live babies at term < 2200g**: >0.0% (Monitoring Only)
- **Incidence of shoulder dystocia (With Harm)**: >0.0% (Monitoring Only)
- **Total number of maternity incidents - Harm Caused**: >207 (Monitoring Only)
- **Delay in delivery of Category 1 C. Section (>30 minutes from decision to delivery)**: >2 (Monitoring Only)
- **Delay in delivery of Category 2 C. Section (>75 minutes from decision to delivery)**: >2 (Monitoring Only)
- **Planned Home Birth**: >104 (Monitoring Only)
- **% of Mothers Smoking at Delivery**: >10.4% (Monitoring Only)
- **% of Mothers Breastfeeding at Initiation**: >76.8% (Monitoring Only)
South West Yorkshire Partnership NHS Foundation Trust
Overview

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 July 2017.

Friends and Family Test
There has been an improvement seen throughout Q1 in the percentage of patients who would recommend the Trust as a place to receive care. This has improved even further in July with 89% of patients recommending SWYPFT mental health services as a place to receive care. This is likely to be the result of the work the Trust is undertaking to try and improve the response rates both in terms of the numbers responding and the numbers likely or extremely likely to recommend. The types of initiatives include:

- Development of a dashboard comparing response rates between teams and support offered to those teams struggling from the Quality improvement and Assurance team.
- Development of ‘You said we did’ posters in key areas so patients can see outputs from their opinions.
- Using electronic survey available via tablets.
- Utilising volunteers to help collect capture data in out patient areas.
- Development of an easy read version produced to improve understanding.
- Development of child friendly versions using emoticons.
- Updated guidance to support staff to collect from patients with dementia and their families

Complaints
The number of complaints that include staff attitude as an issue has maintained in July at 24%. The number of complaints closed within 40 days is still poor with only 10% closed within the timescale in July. This metric has now been added to the dashboard to enable monitoring. The Q1 customer services report was presented at the September Quality Board. SWYPFT advised there had been an increase in the number of formal complaints, mainly around access, as well as an increase in the complexity of the complaints. They explained the current complaints investigation process and advised that a number of people are involved in the sign off process, which can cause delays. The Trust has reviewed this and is now looking to streamline this process, with more accountability at clinical lead level and less sign off at director level. They confirmed that the Trust is in weekly dialogue with the complainants to keep people up-to-date with the progress and timescales but acknowledged that whilst the quality of responses to complaints is good, the timescales need to be worked on. An improvement plan would be tabled at the next Quality Board.

Information Governance
The total number of incidents reported relating to confidentiality issues has decreased this month compared to the previous three months. Incidents involving incorrect patient addresses continue to occur but the number is significantly lower than it has been. Other types of incidents reported this month relate to the Trust providing people with sensitive data about the wrong patient, and one relating to a patient video-recording activity on the ward and uploading onto Facebook.
<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period/Period</th>
<th>Month/Period YTD 2017-18</th>
<th>Month/Period Yearly data from Previous Month/Period</th>
<th>Corresponding month SE/17</th>
<th>A</th>
<th>M</th>
<th>J</th>
<th>J</th>
<th>A</th>
<th>S</th>
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<th>A</th>
<th>M</th>
<th>J</th>
<th>J</th>
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</tr>
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<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>EWSA</td>
<td>Monthly</td>
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<td>0</td>
<td>Jul-17</td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td></td>
<td>CQUIN - monitor the quality of care plans</td>
<td>Quarterly</td>
<td>Q1 - 95%</td>
<td>Q1 - 100%</td>
<td>Q4 2016-17</td>
<td></td>
<td>8%</td>
<td>8%</td>
<td>15%</td>
<td>11%</td>
<td>0%</td>
<td>9%</td>
<td>6%</td>
<td>22%</td>
<td>13%</td>
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<td>0%</td>
<td>6%</td>
<td>13%</td>
<td>20%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>% Complaints incl staff attitude as an issue</td>
<td>Monthly</td>
<td>&lt;20%</td>
<td>54%</td>
<td>Jul-17</td>
<td></td>
<td>8%</td>
<td>1%</td>
<td>11%</td>
<td>9%</td>
<td>6%</td>
<td>6%</td>
<td>13%</td>
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<td>20%</td>
<td>14%</td>
<td>10%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Complaints closed within 48 days</td>
<td>Monthly</td>
<td>80%</td>
<td>10%</td>
<td>Jul-17</td>
<td></td>
<td>10%</td>
<td>14%</td>
<td>7%</td>
<td>10%</td>
<td>8%</td>
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</tr>
<tr>
<td></td>
<td>% of Service Users on CPA given or offered a copy of their care plan</td>
<td>Monthly</td>
<td>80%</td>
<td>85%</td>
<td>Jul-17</td>
<td></td>
<td>80%</td>
<td>74%</td>
<td>85%</td>
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<tr>
<td><strong>Never Events</strong></td>
<td></td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>Aug-17</td>
<td></td>
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<tr>
<td><strong>Serious Incidents</strong></td>
<td></td>
<td>Monthly</td>
<td>n/a</td>
<td>100%</td>
<td>Aug-17</td>
<td></td>
<td>2</td>
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</tr>
<tr>
<td><strong>CAMHS - under 18’s admitted to adult wards</strong></td>
<td></td>
<td>Quarterly</td>
<td>n/a</td>
<td>93.2%</td>
<td>Jul-17</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td><strong>Staffing levels - average full time - registered nurses/midwives (day)</strong></td>
<td></td>
<td>Monthly</td>
<td>n/a</td>
<td>99.9%</td>
<td>Jul-17</td>
<td></td>
<td>99%</td>
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<tr>
<td><strong>Staffing levels - average full time - registered nurses/midwives (night)</strong></td>
<td></td>
<td>Monthly</td>
<td>n/a</td>
<td>120.3%</td>
<td>Jul-17</td>
<td></td>
<td>120%</td>
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<tr>
<td><strong>NPSA Safety Alerts - CAS alerts completed within deadline</strong></td>
<td></td>
<td>Monthly</td>
<td>n/a</td>
<td>100%</td>
<td>Jul-17</td>
<td></td>
<td>100%</td>
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</tr>
<tr>
<td><strong>Information Governance Confidentiality Breaches</strong></td>
<td></td>
<td>Monthly</td>
<td>&lt;= 8 Ovens</td>
<td>6</td>
<td>Jul-17</td>
<td></td>
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<tr>
<td><strong>Aging Cap</strong></td>
<td></td>
<td>Monthly</td>
<td>KS 7m 2017-18</td>
<td>n/a</td>
<td>Jul-17</td>
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<td>97%</td>
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<tr>
<td><strong>Chiral Medicines</strong></td>
<td></td>
<td>Monthly</td>
<td>95%</td>
<td>97%</td>
<td>Jul-17</td>
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<tr>
<td><strong>% Service users on CPA follow up within 7 days from diagnosis/ care</strong></td>
<td></td>
<td>Monthly</td>
<td>95%</td>
<td>97%</td>
<td>May-17</td>
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</tr>
<tr>
<td><strong>% Service users on CPA having formal review within 12 months</strong></td>
<td></td>
<td>Monthly</td>
<td>95%</td>
<td>97%</td>
<td>May-17</td>
<td></td>
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</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 – September 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

CQUINS
100%

Quarter 1 2017-18

Staff Survey – recommend as a place work or receive treatment

3.99 – better than average
Annually – updated March 17

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
Friends and Family Test

Positive      Negative

South West Yorkshire Partnership Foundation trust
Quality Dashboard – September 2017

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
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%) May 17 – action plan does not seem to be having a significant impact on results. June 17 – Data shows increase again following good performance in April &amp; May.</td>
<td>Q3 16-17 – Ward level action plan developed. May 17 - 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. Trust agreed. Next meeting 3rd October.</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>
Spire Elland/BMI Huddersfield

Overview

Spire Elland

Nothing to report.

BMI Huddersfield

Friends and Family response rate and participation in the inpatient survey continues to be monitored. Following a decline in June to 3.55%, July saw an increase with 18.7%, still under the 20% target.

There was a serious incident recorded in June following a patient fall with the investigation report due on the 25th September 2017.
# Spire Elland
## Quality Dashboard – September 2017

### Trend Information

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period/Target</th>
<th>YTD 2016-17</th>
<th>YTD 2017-18</th>
<th>Month/Period/Year data from</th>
<th>Direction of Travel</th>
<th>Trend Information</th>
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<tbody>
<tr>
<td></td>
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<td></td>
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<td>2016-17</td>
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<td>A</td>
</tr>
<tr>
<td>F&amp;FT Response Rate</td>
<td>Monthly</td>
<td>20%</td>
<td>39.20%</td>
<td>-</td>
<td>-</td>
<td>↑</td>
<td>41%</td>
</tr>
<tr>
<td>EMSA</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>↔</td>
<td>0</td>
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<td>C Diff</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
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<tr>
<td>MRSA</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
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<td>Monthly</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>↔</td>
<td>100%</td>
</tr>
<tr>
<td>Never Events</td>
<td>Monthly</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>0</td>
</tr>
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<td>Serious Incidents</td>
<td>Monthly</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
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</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

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**CQUINS 100%**

Quarter 1 2017-18
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Frequency</th>
<th>Period</th>
<th>YTD 2016-17</th>
<th>YTD 2017-18</th>
<th>Monthly/Period/Year data from</th>
<th>Previous Month/Period</th>
<th>Corresponding month 2018/17</th>
<th>2016-17</th>
<th>2017-18</th>
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<tbody>
<tr>
<td>F&amp;FT Return Rate (inpatient)</td>
<td>Monthly</td>
<td>20%</td>
<td>18.70%</td>
<td>-</td>
<td>-</td>
<td>Jul-17</td>
<td>17.60%</td>
<td>44.20%</td>
<td>A M J J A S O N D J F M A M J J A</td>
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<tr>
<td>EMSA</td>
<td>Monthly</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Jul-17</td>
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<td>C Diff</td>
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<td>Jul-17</td>
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<td>MRSA</td>
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<td>0</td>
<td>Jul-17</td>
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<tr>
<td>MSSA</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>Jul-17</td>
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<td>Jul-17</td>
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**Arrow key:**
- ↑ movement towards target
- ↓ movement away from target
- ↔ no change at/above target
- ↔ no change below target
- ↔ no change no target set
Spire Elland/BMI
Exception Report - September 2017

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.

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<thead>
<tr>
<th>Area under performance</th>
<th>Why off plan</th>
<th>Proposed actions</th>
<th>When expected back on track</th>
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Routine Monitoring
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<th>Governing Body</th>
<th>Meeting Date</th>
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<tr>
<td>Title of Report</td>
<td>Performance Report</td>
<td>Agenda Item No.</td>
<td>9 c)</td>
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<tr>
<td>Report Author</td>
<td>Tim Shields, Performance Manager</td>
<td>Public / Private Item</td>
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<tr>
<td>GB / Clinical Lead</td>
<td>Dr Nigel Taylor</td>
<td>Responsible Officer</td>
<td>Neil Smurthwaite, Chief Finance Officer/Deputy Chief Officer</td>
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**Executive Summary**

This report provides an update on the progress being made towards achieving the standards set out in the NHS Constitution and an update on the transfer of care from hospital.

**Previous consideration**

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</table>

**Recommendation(s)**

It is recommended that the Governing Body notes:

1) Progress being made towards achieving the standards set out in the NHS Constitution;

2) Progress being made with transfers of care.

**Implications**

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>Not applicable</th>
</tr>
</thead>
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<tr>
<td>Public / Patient / Other Engagement</td>
<td>Not applicable</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>
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<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>
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<tr>
<td>Risk (on corporate risk register)</td>
<td>62 - Sustaining the 4 hour target in A&amp;E</td>
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<tr>
<td>Legal / Constitutional Implications</td>
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<tr>
<td>Conflicts of Interest</td>
<td>Conflicts of Interest</td>
</tr>
<tr>
<td>Any conflicts of interest will be managed in line with the CCG’s Conflicts of Interest Policy</td>
<td></td>
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</tbody>
</table>
1. **Introduction**

1.1 This report provides:

- an update on the progress being made towards achieving the standards set out in the NHS Constitution;

- an update on transfer of care from hospital.

2. **Summary**

2.1 In month 4 (July) and year to date progress against the constitutional standards is summarised in Appendix 1.

3.0 **Key Areas of Variance**

3.1 **Sustaining the 4 hour target in A&E**

3.2 Accident and Emergency (A&E) performance during July achieved 93.4%.

3.3 The underperformance against the four hour standard is connected with the introduction of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT) which has seen:

- increases in patient waiting times in A&E
- increases in the volume of breaches of the 4 hour standard during this period of transition
- an increase in the volume and rate of admissions to hospital via A&E
- a negative impact on the responses to the Friend and Family Test (% of patients who would recommend the service)

3.4 The A&E department has introduced a recovery plan for emergency care with a focus on recruitment into vacancies within medical specialties and patient flow through the hospital.

3.5 CHFT has also developed a Stabilisation Plan to resolve the outstanding issues with EPR implementation. The plan includes responses to:

- Appointments & booking
- Correspondence issues for elective admission pathways
- Diagnostic and pre-assessment
- Capacity Management
- Outpatient clinics access
- Validation & data quality

Progress continues to be reviewed at the A&E Delivery Board where assurances are sought on the impact the EPR transition is having on patient safety and experience.
3.5 **Diagnostic Waiting Times**

3.6 Patients who require a diagnostic test should wait less than 6 weeks following their referral. The standard to achieve is <1% of patients should wait greater than 6 weeks for their test. Overall CCG performance in July was 95.4%.

3.7 The underperformance for diagnostics previously reported to the Governing Body had been associated with a peak in referrals for MRI and non-obstetric ultrasound scans at CHFT. The improvement plan developed by CHFT and shared with NHS Improvement has seen performance levels improve during May, June and July with the hospital currently reporting 98.5%.

3.8 During this period, the CCG’s overall level of performance has been impeded by issues facing Bradford Teaching Hospitals Trust where there have been challenges associated with an increase in referrals for CT scans as well a reduction in capacity. Performance levels are expected to improve by August/ September 2017.

3.9 **Cancer Waiting Times**

3.10 **Two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP**

3.11 Patients with an urgent referral from their GP should receive their first outpatient appointment within 2 weeks. The constitutional standard to achieve is 93%.

Of the 571 patients referred for an appointment in June 2017, 47 patients breached the constitutional standard, achieving 91.8% for July.

3.12 **Two-week wait for first outpatient appointment for patients referred urgently with breast symptoms**

3.13 Patients with an urgent referral from their GP should receive their first outpatient appointment within 2 weeks. The constitutional standard to achieve is 93%.

Of the 93 patients referred for an appointment in June 2017, 9 patients breached the constitutional standard, achieving 90.3% for the period.

3.14 Key issues affecting the achievement of the 2 weeks standard at CHFT and include:

- booking centre pressures post-EPR deployment
- appointments made very close to 14 days. Subsequent patient cancellations have pushed waiting times over the 14 day standard
- reduction in workforce capacity due to the impact of IR35

Actions being taken by CHFT to resolve the position include:

- extra locums have been brought in to meet demand. Pressures with gastro-intestinal capacity resolved
- daily review of fast track registrations implemented
- weekly performance meetings with the Chief Operating Officer
- audit on a sample of patients to understand why they did not attend

3.15 **Two month (62-day) wait from urgent GP referral to first definitive treatment for cancer**

3.16 Patients with an urgent referral from their GP should receive their first definitive treatment for cancer within 62 days. The constitutional standard to achieve is 85%.

3.17 Of the 41 patients referred for treatment in June 2017, 11 patients breached the constitutional standard, thus achieving 84.0% for the period. All patients have now received their first definitive treatment.

3.18 The majority of the breaches involved patients on complex pathways. However delays with patients accessing outpatient appointments within the 2 week waiting time standard has also had an adverse impact on provider’s ability to deliver treatment within the 62 day waiting time standard. The majority of inter provider transfers in July took place after day 38 of the pathway.

Progress with all the cancer waiting times standards is reviewed at the Cancer Locality Network.

4. **Transfer of Care**

4.1 The trend in the chart below shows a major increase in the number of non reportable Calderdale patients being discharged from CHFT who require a transfer of care (TOC).

4.2 This improvement has made a significant impact on the number of patients awaiting discharge at CHFT - see chart below:
4.3 The trend shows a major reduction in the number of Calderdale patients awaiting discharge. From February to date there has been a month on month reduction. This is the result of a significant focus on the implementation of the 8 high impact changes to improve patient flow and reduce unnecessary delays across the health and care system. These improvements have been supported by the co-location of the joint health and social care discharge team on both hospital sites.

4.4 It’s important to note the significant improvement that has been made by the system. In September 2016 there were 173 patients awaiting discharge on the TOC list across both Councils. This is compared to 99 as at August 2017 – see chart below:

4.5 This demonstrates an overall reduction in patients awaiting discharge but also illustrates an increase in the proportion of reportable delays in the system. In January reportable delays accounted for 21% of the total patients. This has risen to 55% in August. Soft intelligence indicates that the joint discharge team is becoming more effective in identifying reportable delays. However, the team will be looking forensically at how this is being captured to ensure that only delays that meet the full criteria are captured as a reportable delay. Activities undertaken by the system to reduce delays remain focused on all patients, not just those who are formally reported as a delay.
4.6 In relation to the discharge of individuals with a rapidly deteriorating condition entering a terminal phase that requires ‘fast tracking’ for immediate provision of NHS continuing healthcare”, we are undertaking work with partners. Where a recommendation is made for an urgent package of care via the fast-track process, this should be accepted and actioned immediately by the CCG” (National Framework for NHS Continuing Healthcare and NHS –funded nursing care 2012). This process is managed by the Continuing Health Care (CHC) team. There has been an increase in the volume of requests for fast track funding and in the size and cost of packages required. This has led to delays in discharge because of pressures sourcing packages as well as a significant increase in cost incurred to the CCG.

4.7 The Head of CHC is working with the local authority and CHFT to implement a process of discharge to assess for all people eligible for fast track funding. Individuals and families will be supported by a level of care that is required to support their return home and will have an appointment for a CHC nurse to visit within 2 weeks at their home to assess their needs for care. This process will support the timely discharge of individuals with the assurance that their needs will be properly assessed at home and that a package of care will be commissioned that meets needs and is cost effective. This process will start in October 2017 with ongoing review led by the Head of CHC in partnership with the Local Authority and CHFT. Performance will be reviewed on a monthly basis and the financial and quality impact reported through the CCG recovery process. Additional work is being undertaken to review the application process for fast track and end of life services to ensure that the correct services are commissioned.

5. Recommendations

It is recommended that the Governing Body notes:

1) Progress being made towards achieving the standards set out in the NHS Constitution;

2) Progress being made with transfers of care.
### Appendix 1

#### NHS Constitution Rights and Pledges 2017/18

<table>
<thead>
<tr>
<th>Outcome/Measure</th>
<th>Referral To Treatment waiting times for non-urgent consultant-led treatment</th>
<th>Diagnostic test waiting times</th>
<th>A&amp;E waits</th>
<th>Cancer waits – 2 week wait</th>
<th>Cancer waits – 31 Days</th>
<th>Cancer waits – 62 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>N/A</td>
<td>77.9%</td>
<td>74.9%</td>
<td>92%</td>
<td>90%</td>
<td>93%</td>
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<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>N/A</td>
<td>89.5%</td>
<td>95.4%</td>
<td>92%</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral</td>
<td>92%</td>
<td>92.6%</td>
<td>93.1%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
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<tr>
<td>Number of patients waiting more than 52 weeks</td>
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<td>0</td>
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<tr>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>99%</td>
<td>95.4%</td>
<td>94.5%</td>
<td>95%</td>
<td>93.4%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>95%</td>
<td>93.4%</td>
<td>91.8%</td>
<td>95%</td>
<td>93.4%</td>
<td>92.6%</td>
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<td>No waits from decision to admit to admission (trolley waits) of more than 12 hours</td>
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<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred</td>
<td>93%</td>
<td>91.8%</td>
<td>90.7%</td>
<td>95%</td>
<td>94.7%</td>
<td>95.5%</td>
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<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms</td>
<td>93%</td>
<td>90.3%</td>
<td>92.6%</td>
<td>95%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Maximum-one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>97.7%</td>
<td>98.8%</td>
<td>95%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Maximum-31 day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>94.7%</td>
<td>95.5%</td>
<td>94%</td>
<td>100.0%</td>
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<tr>
<td>Maximum-31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
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<td>Maximum-31 day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
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<td>94%</td>
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<tr>
<td>Maximum-two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>73.2%</td>
<td>82.6%</td>
<td>80%</td>
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<td>Maximum-62 day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
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<td>75.0%</td>
<td>92.9%</td>
<td>75.0%</td>
<td>75.0%</td>
<td>92.9%</td>
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<td>Maximum-62 day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers)</td>
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<td>100.0%</td>
<td>tba</td>
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#### Reporting Period: Jul 2017/18
### Executive Summary

Please include a brief summary of the purpose of the report

- To provide the Governing Body with a summary of the emergency planning arrangements in place at the CCG.
- To seek approval for the draft Emergency Planning Framework
- To confirm the Emergency Planning roles and responsibilities at the CCG
- To confirm that the CCG reported Substantial compliance with the NHS England Emergency Planning core standards and ‘deep dive’ on emergency planning governance.

### Previous consideration

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### Recommendation(s)

It is recommended that the Governing Body:

1) **APPROVES** the Emergency Planning Framework (appendix 1), subject to any amendment.

2) **APPROVES** the proposals in respect of the EP roles and responsibilities, as set out in paragraph 3.6 of the accompanying paper.

### Implications

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>The Quality and Safety implications of Health Protection issues are reviewed by the Quality Committee in the Infection Control and Prevention Paper</th>
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<tr>
<td>Public / Patient / Other Engagement</td>
<td>None identified</td>
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<td>Resources / Finance implications (including Staffing/Workforce considerations)</td>
<td>All staff need to receive regular awareness raising training or skill development/refresher training commensurate with their roles in emergency planning and business continuity. The role of the Risk, Health and Safety Manager has been reframed to incorporate EP and business continuity.</td>
</tr>
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<td>Strategic Objectives</td>
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**Page 1 of 5**
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| Legal / Constitutional Implications | Civil Contingencies Act 2004  
NHS Act 2006 (as amended 2012)  
NHSE EPRR Core standards | risks) |
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Conflicts of Interest

Any conflicts of interest will be managed in line with the CCG’s Conflict of Interest Policy.
1. Introduction

1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act 2004 and the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires NHSE England, NHS commissioners and providers to demonstrate that they can deal with such incidents whilst maintaining services to patients. In the NHS, this programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

1.2 The CCA 2004 specifies that responders will either be Category 1 (primary responders) or Category 2. Category 1 responders are those organisations at the core of emergency response and for health are:

- Department of Health on behalf of Secretary of State for Health
- NHS England
- Acute service providers
- Ambulance service providers
- Public Health England (PHE)
- Local authorities (Inc. Directors of Public Health)

1.3 NHS England is responsible for providing national oversight, direction and coordination of the NHS response to health incidents and emergencies where appropriate. NHS England’s expectations of the NHS are set out in the EPRR core standards and in the EPRR Framework 2015.

1.4 As a Category 2 responder, the CCG has a role in working with NHS partners and Calderdale Council both in planning and prevention and in responding to emergencies. The CCG fulfills this role in a number of ways including:

- Active participation in the local, system-wide and regional emergency planning fora;
- A senior Manager on-call rota with Greater Huddersfield CCG;
- Participation in local, regional and system wide desk top and ‘live’ exercises;
- Coordination of the local health response, working with local emergency planning partners across the health and care system and supporting NHS England as required dependent upon the nature of incident;
- Review of existing plans to ensure that any learning is taken on board following exercises or incidents to improve our preparedness to respond to different categories of incident should we need to.

1.4 The Audit Committee has a delegated role in scrutinising the Emergency Planning and Business Continuity functions of the CCG. As part of this role, the committee receives regular updates on emergency planning activity as well as the annual self-assessment of compliance against the EPRR core standards, prior to submission to NHS England. A full report of the year’s activities was received by the Audit Committee at its meeting on the 21 September.

2. CCG Emergency Planning (EP) Framework

2.1 A CCG Emergency Planning Framework has been developed in line with the NHS England core standards. The EP Framework sets out the roles and responsibilities of the CCG, the mechanisms by which it fulfils those responsibilities and the arrangements in place for working with partners across the health and care system. It also provides a link to the suite of documents which set out the detail of local operational resilience and emergency preparedness arrangements that are in place with partners. These are:
- Surge and Escalation Plan
- The Winter Plan
- West Yorkshire Emergency Incident Plan and the Calderdale Health Protection Incident Response Framework
- CCG Business Continuity Plan
- Local emergency on-call pack

2.2 The Governing Body is asked to approve the CCG Emergency Planning Framework, subject to any amendments.

3.0 CCG emergency planning partnership working

3.1 The CCG plays an active part in the local, system-wide and regional emergency planning arrangements. The main fora for coordination, joint working, planning and prevention are through the:

- **Local Health Resilience Partnership (LHRP)** – West Yorkshire (see 3.3 below);
- **A&E Delivery Board (A&E DB)** – provides proactive leadership in the system to ensure high quality care and system resilience. The A&E Delivery Board has oversight of the Surge and Escalation and the Winter Plans as well as the supporting communications plan (see the Chief Officer’s Report)
- **Calderdale Health Protection Advisory Group** - Health Protection Issues are reported into the CCG’s Quality Committee as part of the Infection Control and Prevention Report.
- **Calderdale Council** emergency planning and community resilience structures. The CCG is a member of the Calderdale Council ‘Gold (Strategic) Partnership Group.

3.2 Further detail on the roles and responsibilities of these fora is contained within the Emergency Planning Framework (appendix 1).

3.0 Emergency Planning Roles and Responsibilities

3.1 The NHS England EPRR Framework sets out the requirement that all NHS funded organisations, including commissioners, have an Accountable Emergency Officer (AEO).

3.2 The AEO is expected to be a Board level director with responsibility for EPRR and be supported by a non-executive director or other appropriate Board member. They are responsible for:

- Ensuring that the organisation complies with legal and policy requirements;
- Providing assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident;
- Providing assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.

3.3 It is the responsibility of the CCG to be represented at the Local Health Resilience Partnership by a director level individual, either on their own behalf or through a nominated lead CCG representative.
3.4 As the governance arrangements for CCGs differ from the Board Structure of NHS providers, CCG Chief Officers, in general, retain the AEO role and delegate operational responsibility to a member of the Senior Management Team. This is the case in Calderdale, with Chief Officer fulfilling the AEO role and the Head of Corporate Affairs and Governance deputising for the Chief Officer at the LHRP meetings and either the Head of Corporate Affairs and Governance or the Head of Quality deputising at Calderdale Council Gold meetings.

3.5 The CCG does not currently have a second Governing Body member with formal responsibility for EPRR. This responsibility has been fulfilled by a combination of the Audit Committee having a scrutiny role in respect of the EPRR function and the Chair of Audit signing the annual 'statement of compliance' with the Chief Officer, following review of the EPRR self-assessment of compliance by the Audit Committee.

3.6 Following consideration by the Audit Committee on the 21st September, it is recommended that these current arrangements be formalised, i.e:

- The Chief Officer retains the role of the AEO;
- The Head of Corporate Affairs and Governance attends the LHRP in their role as senior manager with responsibility for EPRR;
- The Audit Committee continues to have a scrutiny role in respect of the EPRR function as set out in their terms of reference;
- The Chair of Audit Committee continues to sign the annual 'Statement of Compliance' with the Chief Officer, following approval by the Audit Committee.

4.0 Annual reporting on compliance against the national Core Standards

4.1 A self-assessment of the CCG’s status against the national EPRR core standards and emergency planning governance 'deep dive' has been undertaken. The evidence provided in support of the assessment has been reviewed by Audit Yorkshire with the recommendations taken up.

4.2 A compliance level of 'Substantial' was submitted to NHS England on the 2nd October. Subject to the approval of the Emergency Planning Framework and the acceptance by NHS England of our proposed roles and responsibilities for emergency planning, we will be able to report FULL compliance. This assessment is supported by Audit Yorkshire.

4.3 Copies of the report on the CCG’s emergency planning activity, full self-assessment and improvement plan are available to Governing Body members on request.

5. Recommendations

5.1 It is recommended that the Governing Body:

3) APPROVES the Emergency Planning Framework (appendix 1), subject to any amendment.

4) APPROVES the proposals in respect of the EP roles and responsibilities, as set out in paragraph 3.6 above.

9. Appendices

Appendix 1: Draft CCG Emergency Planning Framework
NHS Calderdale
Clinical Commissioning Group

Emergency Planning Framework
Version 0.3 DRAFT
**Version Control Sheet**

<table>
<thead>
<tr>
<th>Document Title:</th>
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1. Introduction

1.1 The NHS needs to plan for, and respond to, a wide range of significant incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease, major transport accident or chemical incident.

1.2 A significant incident or emergency is any event that cannot be managed within routine organisational arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or Local Authority.

1.3 Whilst NHS Calderdale CCG hopes that such incidents will not happen, the CCG is required to be prepared to respond and work with partners should they occur.

1.4 This Framework outlines how the CCG will meet the duties set out in legislation and associated statutory guidelines, as well as any other issues identified through regular risk assessments and testing of existing arrangements.

2. Statutory and Regulatory Framework

2.1 The Civil Contingencies Act 2004 aims to establish a consistent level of civil protection across the United Kingdom. The Act provides a national framework for organisations and agencies planning for local and/or national emergencies and explains how these organisations and agencies should work together, providing a framework to formalise joint working.

2.2 The Civil Contingencies Act 2004 (CCA) and the NHS Act 2006 (as amended by the Health and Social Care Act 2012)) requires NHS England, NHS organisations and providers of NHS funded care to demonstrate that they can deal with such incidents whilst maintaining services to patients. This programme of work is referred to in the NHS as Emergency Preparedness, Resilience and Response (EPRR).

2.3 The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies). Under the CCA, Category 1 responders are those at the core of any emergency response and who must comply with a full set of legal duties under the CCA 2004. This category includes NHS England, all acute trusts and ambulance trusts, Public Health England (PHE) and Local Authorities.

2.4 NHS England is responsible for providing national oversight, direction and co-ordination of the NHS response to health incidents and emergencies where appropriate.

2.5 Clinical Commissioning Groups

CCGs are classed as category 2 responders and therefore are placed under slightly lesser obligations than category 1 responders. They have a role in both planning and prevention and in responding to emergencies. CCGs work closely with partners and
are required to cooperate, support and share relevant information with other Category 1 and Category 2 responders.

3. **Aims**

3.1 The aims of this document are to ensure NHS Calderdale CCG acts in accordance with the legislative and regulatory framework, national policy and guidance by undertaking the duties listed below:

- To clearly define the governance arrangements for emergency planning, including responsibilities and lines of accountability throughout the organisation;
- To ensure that emergency plans and internal business service continuity plans have been established and are well communicated;
- To ensure that the plans address the consequences of all situations that might feasibly occur;
- To ensure that plans involve robust arrangements for the operational recovery from all such incidents;
- To ensure that all key stakeholders are consulted and collaborated with concerning their role in the plan and that they understand those responsibilities;
- To ensure that the plans are tested and are regularly reviewed;
- To ensure that funding and resources are available to respond effectively to major incidents;
- To ensure that NHS Calderdale CCG has access to up to date guidance relating to emergency planning;
- To ensure that staff receive emergency preparedness training that is commensurate with their role and responsibilities;
- To ensure that indicators demonstrating emergency preparedness and/or early warning of risk are used within contracts and service specifications;
- Work with partners to ensure that the whole system is monitored and tested regularly.

4. **NHS England Responsibilities in Relation to Emergency Preparedness Resilience and Response (EPRR)**

4.1 The generic EPRR role and responsibilities of NHS England are:

- To set a risk based EPRR strategy for the NHS
- To ensure there is a comprehensive NHS EPRR system and assure itself and DH that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004.

4.2 **NHS England national**

At a national level the role of NHS England is to:

- Support the Accountable Emergency Officer to discharge EPRR duties

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• Participate in national multi-agency planning processes including risk assessment, exercising and assurance
• Provide leadership and coordination to the NHS and national information on behalf of the NHS during periods of national incidents
• Provide assurance to the Department of Health (DH) of the ability of the NHS to respond to incidents including assurance of capacity and capability to meet National Risk Assessment (NRA) requirements as they affect the health service
• Provide support to DH in their role to UK central government response to emergencies
• Action any requests from NHS organisations for military assistance

4.2 **At a regional level**, the responsibility of NHS England (NHSE) is to:

• Ensure that each Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) has director level representation
• Ensure integration of plans across the region to deliver a unified NHS response to incidents, including ensuring the provision of surge capacity
• Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7
• Work with relevant partners through the LHRP & LRF structures
• Seek assurance through the local LHRP and commissioners that the Core Standards are met and that each local health economy can effectively respond to and recover from incidents
• Discharge the local NHS England EPRR duties as a Category 1 responder under the CCA 2004

5. **CCG legal duties and responsibilities**

5.1 As a category 2 responders, CCGs are defined as ‘co-operating bodies’ and are placed under slightly lesser obligations than category 1 responders. CCGs have a role to play in planning and prevention and in responding to emergencies.

5.2 CCGs work closely with partners and are required to cooperate, support and share relevant information with other Category 1 and 2 responders. The role of CCGs as set out in the NHS England Emergency Preparedness, Response and Resilience (EPRR) Framework 2015 is to:

• Fulfil the duties of a Category 2 responder under the Civil Contingencies Act (CCA) 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended):
  - Respond to reasonable requests to assist and cooperate
  - Ensure service delivery is maintained across the local health economy
  - Have a robust process in place for escalating significant incidents and emergencies to NHS England.
- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4);  
- Ensure contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity;  
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards;  
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident, the provider can inform the CCG 24/7. Locally this includes a shared emergency on-call rota across Calderdale and Greater Huddersfield CCGs;  
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers;  
- Be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative;  
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness.

6. Underpinning principles for NHS EPRR

The underpinning principles apply to all commissioners and providers of NHS funded services:

a) Preparedness and Anticipation

The NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) Continuity

The response to incidents should be grounded within organisations’ existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

c) Subsidiarity

Decisions should be taken at the lowest appropriate level, with coordination at the highest

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2 Whilst the EPRR alert levels share common actions with the Operational Pressures Escalation Levels Framework (OPEL) they are not interchangeable and should be considered separately.
necessary level. Local responders should be the building block of response for an incident of any scale.

d) Communication

Good two way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) Cooperation and Integration

Positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response.

f) Direction

Clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response.

The CCG’s emergency planning and business continuity arrangements operate in line with the above principles.

7. CCG framework for fulfilling duties related to EPRR

7.1 Planning and Prevention

7.1.1 The CCG will work with partners through local, system-wide and regional emergency preparedness arrangements. The main fora for coordination, joint working, planning and prevention are:

- Local Health Resilience Partnership (LHRP) - West Yorkshire;
- A&E Delivery Board (A&E DB) - Calderdale and Greater Huddersfield footprint;
- Calderdale Health Protection Advisory Group
- Calderdale Council emergency planning and community resilience structures.

Local Health Resilience Partnerships

7.1.2 The role of the LHRP is to coordinate EPRR across the health system, to ensure continuity of patient services and effective engagement across local health organisations. They also support the health sector’s contribution to multi-agency planning through Silver (Tactical) and Gold (Strategic) community and Local Resilience Forum (LRF) meetings attended by NHS England on behalf of the health sector. Key links are with LRF chairs; Public Health colleagues, Public Health England, Local Authority Chief Executives and EPRR teams and other senior EP officers.
7.1.3 LHRPs are not statutory organisations and as such accountability for emergency preparedness and response remains with individual organisations.

7.1.4 It is the responsibility of the CCG to be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative. Individuals attending should be executive representatives who are able to authorise plans and commit resources on behalf of their organisations. They must be able to provide strategic direction for health EPRR in their area. Individual members of the LHRP must also be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

7.1.5 The Head of Corporate Affairs and Governance will attend the LHRP as the CCG representative and will collaborate closely with Greater Huddersfield CCG to ensure a local coordinated approach.

The A&E Delivery Board (A&E DB)

7.1.6 The CCG works with partners to ensure service delivery is maintained across the local health economy through the A&E Delivery Board (formerly known as the System Resilience Group) comprises the key provider and commissioner organisations across Calderdale and Greater Huddersfield and has the role of ensuring a collaborative approach to maintaining the resilience of the system. The A&E DB focuses on current and future resilience across a 12-18 timeframe. The Board meets on a monthly basis and is chaired by the CCG’s Chief Officer.

7.1.7 The A&E Delivery Board has oversight of the Surge and Escalation and the Winter Plans as well as the supporting communications plans.

7.1.8 These documents are reviewed and refreshed on an annual basis.

Calderdale Health Protection Advisory Group (CHPAG)

7.1.9 The role of CHPAG is to provide assurance to the Director of Public Health (Calderdale Council) about the adequacy of prevention, surveillance, planning, quality, safety and response to health protection issues. The meetings are held quarterly and the group has a lead role in the review and development of the Health Protection Incident Response Framework.

7.1.10 The membership is drawn from the CCG Quality and Primary Care teams, Public Health Team (Calderdale Council), screening and immunisations team (NHS England) and the Consultant in Communicable Disease Control, Public Health England.

Calderdale Council emergency planning and community resilience arrangements

7.1.11 The CCG is a member of the Calderdale Council ‘Gold (Strategic) partnership group that meets on a quarterly basis and is co-chaired by the Chief Executive of the Council and the Chief Superintendent, West Yorkshire Police.
7.1.12 The Head of Corporate Affairs and Governance deputises for the CCG Chief Officer and the Head of Quality at these meetings as required.

7.1.13 The CCG also attends Local Authority Community Resilience meetings as required, takes part in Calderdale-wide exercises and is a key partner when an emergency response is required.

7.2 Emergency and Business Continuity Plans

7.2.1 A suite of documents contain further detail of the local emergency preparedness arrangements across the local health and social care economy. These are listed below:

- Surge and Escalation Plan (Calderdale and Greater Huddersfield)
  The Surge and Escalation Plan describes agreed operational processes through which the system will escalate and de-escalate activities to deal with increases in system pressure throughout the year.

- Calderdale and Greater Huddersfield Winter Plan
  The Winter Plan confirms additional specific arrangements related to the winter period; for example dealing with periods of extreme cold weather and ensuring business continuity plans are fit for purpose. The work also includes the development of winter communications plan.

- West Yorkshire Emergency Incident Plan and The Calderdale Health Protection Incident Response Framework

- On-call pack and Rota which sets out the 24/7 on-call arrangements (see 7.2.2)

- CCG Business Continuity Plan (see 7.2.4)

7.2.2 On-call arrangements

Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so each organisation must have an appropriate out-of-hours on-call system. Calderdale and Greater Huddersfield CCGs operate a Senior Manager 24/7 on-call arrangement to ensure that there is someone available to make strategic decisions on behalf of the organisation.

7.2.3 The arrangements, logging, escalation, communications and contact details are contained within the on-call pack which is reviewed and updated on at least an annual basis.
7.2.4 Business continuity plan

Business continuity arrangements have been developed for critical functions with due regard for risks posed to the CCG. CCG has adopted a corporate approach which outlines the response to the impacts of service disruptions for a variety of events. The Business Continuity (BC) Plan primarily focusses on the loss of one or more of the following components, identifying the minimum requirements to maintain and/or recover a critical function:

1.  Staff
2.  Premises
3.  IT and Telephony
4.  Resources

7.2.5 The BC plan sets out the arrangements to facilitate the maintenance and/or recovery of a critical function in a manner which identifies the maximum period of time that the function can be unavailable for based on the loss of one or more of the four components. Arrangements seek to provide an alternative to maintain service continuity. It also sets out:

- Roles and responsibilities
- Command, control and coordination arrangements
- Incidents experienced by other organisations and mutual aid arrangements
- The establishment and operation of an incident room
- Communications arrangements, including cascade arrangements and responding to media enquiries
- Recovery of the service
- Incident logging, reporting and procedures for lessons learned
- Consideration of staff welfare issues
- Mutual aid arrangements with Greater Huddersfield CCG and SWYPFT

7.2.6 Staff Welfare

NHS funded organisations must ensure staff welfare in general which includes anything done for the comfort and improvement of staff. The Senior Management Team must be aware of the potential for stress and/or fatigue to impact upon individual performance and decision making. They must ensure that they are mindful of their own and their team's levels of stress and fatigue and that effective arrangements are in place to minimise the potential impact.

7.2.7 The CCG's incident room procedures include consideration of provision of refreshments rest breaks and rotas, including for incident loggists, if the incident becomes protracted.

7.3 Provider Contracts

7.3.1 The NHS Standard Contract includes the appropriate EPRR provision and this contractual framework will be used wherever appropriate by the CCG when commissioning services. Contract monitoring and review will encompass the review of EPRR and there may be occasions where the LHRP uses the CCG as a route of escalation where providers are not meeting expected standards.
7.3.2 The CCG contracting and procurement team will seek assurance from commissioned provider organisations (including independent and third sector) that they have appropriate and effective internal business continuity plans in place.

7.4 **Response**

7.4.1 As Category two Responders under the CCA, CCGs must respond to reasonable requests to assist and co-operate with NHS England should any emergency require wider NHS resources to be mobilised. CCGs must have a mechanism in place to support NHS England Emergency Planners to effectively mobilise and coordinate all applicable providers should the need arise.

7.4.2 The CCG will work collaboratively with partners across the health and care system to maintain system resilience. The process by which this is carried out is contained within the Calderdale and Greater Huddersfield Surge and Escalation Plan and the Winter Plan. The A&E Delivery Board has oversight of the maintenance and effectiveness of the above plans.

7.5 **Escalation arrangements**

7.5.1 The command and control and Operational Pressures Escalation Levels (OPEL) are set out in the Surge and Escalation Plan.

7.5.2 The EPRR alert levels share common actions with the OPEL but should be considered separately. The EPRR alert levels, as set out in the NHS England EPRR Framework 2015, are set out below (see also appendix 1) and provide clear guidance on when an incident should be escalated to NHS England.

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<th>Incident Level</th>
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<tr>
<td>Level 1</td>
<td>An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.</td>
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<td>Level 2</td>
<td>An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.</td>
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<tr>
<td>Level 3</td>
<td>An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.</td>
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<tr>
<td>Level 4</td>
<td>An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.</td>
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8. **Risk Assessment**

8.1 Risk management is covered within the CCA 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.
8.2 The risk register informs emergency and business continuity planning arrangements, ensuring that the CCG, its commissioned services and partner responders are prepared for the most significant risks.

8.3 The CCG utilises the West Yorkshire Community Risk Register in preparing its business continuity arrangements. The Business Continuity Plan provides an overview of the Very High and High risks which could lead to a service disruption. This is reviewed on an annual basis.

8.4 Any external risk may be required to be entered onto the Local Resilience Forum Community Risk Register if it is felt to pose a significant risk to the population. This action will be coordinated through the Local Health Resilience Partnership.

9.0 CCG Roles and Responsibilities

9.1 Governance and operational management arrangements

9.1.1 The diagram below sets out the governance and reporting arrangements for EPRR and business continuity at the CCG.

9.1.2 The **CCG Governing Body** has responsibility for approving the arrangements for emergency planning and business continuity\(^3\). The Chief Officer in his role as Accountable Emergency Officer (AEO) provides updates to the Governing Body on emergency planning, significant incidents and learning from incidents or exercises, as required.

9.1.3 The Governing Body has delegated scrutiny of the CCG’s Emergency Planning and Business Continuity functions to the **Audit Committee**. This role of the Audit Committee will be supported by regular management updates on Emergency Planning and Business Continuity Matters through the quarterly Governance Assurance Report and on an annual basis as part of the NHS England EPRR assurance process. They will also be supported by Internal Audit reviews of emergency planning and business continuity arrangements as required.

9.1.4 The **Finance and Performance Committee** receives the minutes of the A&E Delivery Board and performance reports on actions to maintain system resilience.

9.1.5 Reports on health protection are incorporated into the Infection Control Report which is submitted to the **Quality Committee**.

9.1.6 The Senior Management Team approves the internal Business Continuity Plan, receives updates on emergency planning and business continuity matters, discusses on-call issues and arrangements, agrees actions to be taken following learning from exercises, incidents or requests from other organisations.

\(^3\) NHS Calderdale CCG Constitution, Scheme of Reservation and Delegation (no.42), May 2017
Diagram 1: Governance and management arrangements

**Governing Body**

**Finance and Performance Committee**
- **Updates/reports/issues**
  - System resilience matters
  - Minutes from A&E DB

**Audit Committee**
- **Updates/reports/issues/assurance**
  - EPRR matters
  - Significant incidents and lessons learned
  - Exercises and lessons learned; training
  - Business continuity matters

**Quality Committee**
- **Updates/reports/issues**
  - Health protection matters in the Infection Control and Prevention Report
  - Significant clinical incidents and lessons learned

**Clinical Development Forum**
(Clinical Governing Body members and SMT)
- System resilience matters
- Minutes from A&E DB

**SMT**
- EPRR matters
- Significant incidents, post incident reports and lessons learned
- Exercises and lessons learned; training
- On-call arrangements
- Business continuity
9.2 Individual roles and responsibilities within the CCG

9.2.1 The Accountable Emergency Officer

The Chief Officer is the Accountable Emergency Officer (AEO) for the CCG. They are responsible for:

- Ensuring that the organisation, and any sub-contractors, complies with the relevant EPRR statutory duties under the CCA 2004 and the NHS Act 2006 (as amended), The NHS England EPRR Framework, policy requirements and the NHS England Core Standards for EPRR;
- Providing assurance to the Audit Committee and Governing Body that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident;
- Providing assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.
- Ensuring that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this;
- Ensuring that the organisation has a robust surge and capacity plan that provides an integrated organisational response and that it has been tested with providers and partner organisations in the local area;
- Ensuring that the organisation complies with reasonable requirements of NHS England, or agents of NHS England, in respect of monitoring compliance;
- Providing NHS England with such information as it may require for the purpose of discharging its functions;
- Ensuring that the CCG is appropriately represented by director level engagement with, and effectively contributes to governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

9.2.2 Senior Management Lead

The Head of Corporate Affairs and Governance is the SMT lead with responsibility for Emergency Planning and Business Continuity management. They are responsible for:

- Supporting the AEO in ensuring that that strategies, systems, training, policies and procedures are in place for emergency planning and business continuity including risk assessments as appropriate.
- Ensuring that the on-call pack is up to date and fit for purpose;
- Taking full part in the LHRP meetings as the CCG’s representative;
- Deputising for the AEO at the Calderdale Council Gold meetings;
- Ensuring the production and implementation of the EPRR annual plan;
- Ensuring that the CCG complies with the NHSE assurance process;
- Ensuring that business continuity arrangements are in place, are fit for purpose;
- Liaising with CCG and other colleagues to develop a coordinated approach to the management of incidents, testing of plans and disseminating the learning. This includes attendance at internal/shared emergency planning meetings to monitor the delivery of the annual plan;
- Ensuring that plans and learning is disseminated to staff and that training is rolled out to staff as appropriate to their needs;
• Liaising with colleagues to ensure a joined up approach to system resilience and emergency planning.

9.2.3 Senior Management Team

• The members of the Senior Management Team are all part of the on-call manager rota.
• The roles of the Heads of Service in maintaining business continuity in their teams and responding to service disruption are set out in the Business Continuity Plan.

9.2.4 Emergency Planning Officer

The Head of Corporate Affairs and Governance will be supported in their role by the Risk, Health and Safety Manager who is currently completing their diploma in emergency planning. This will increase the resilience, expertise and capacity in support of emergency planning and business continuity management.

9.2.5 Incident room loggists

The CCG has a trained incident room loggist who is also qualified to train further loggists for both Calderdale and neighbouring CCGs.

10. Training

10.1 If staff are to respond to an incident in a safe and effective manner they require the tools and skills to do so in line with their assigned role.

10.2 Training is an on-going process to ensure skills and confidence in responding to incidents are to be maintained.

10.3 The training provided by Calderdale CCG, often in collaboration with neighbouring CCGs or other system partners, will focus on the specific roles and requirements assigned to the individual. Dependent on their responsibilities, the training will include wider organisational and multi-agency response structures and take the form of participating in multi-agency desk top or ‘live’ exercises.

10.4 The Standards for NHS incident training as contained within the Skills for Justice National Occupational Standards (NOS) framework will be referred to when identifying staff training needs.

10.5 Training needs as appropriate to individual roles will be identified through the risk assessment process and organised by the Head of Corporate Affairs and Governance as emergency planning / business continuity lead.

10.6 These include:

• Awareness raising of the CCG’s business continuity plan for all staff on induction and on an annual basis either through a desk top business continuity exercise or ‘live’ business continuity exercise (every three years);
• Specialised training as necessary as identified through national/regional guidance or as a result of learning from exercises or incidents. (for example Strategic Leadership in Crisis and Loggist skills or for specific functions within the CCG such as the corporate services team)
• Specialist training for on-call managers relevant to their role

10.7 Training log

A training and exercise participation log will be kept for all on-call managers and will be provided as evidence of continuous professional development as well as informing any training needs analysis.

11 Testing of Plans

11.1 The CCG’s internal Business Continuity Plan will be tested and reviewed on an annual basis as a desk top exercise, with a ‘live exercise being organised every three years. The aims of these exercises are to:

- To validate the emergency planning or business continuity plans
- To test the systems and processes set out in the Business Continuity Plan
- To train staff and build confidence in their ability to respond to a real incident.

11.2 The communication and cascade plans will be tested every six months unless they have been effectively tested during an incident or as part of the annual desk top exercise. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They should include testing the communications methods in use and be both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

11.3 The CCG will continue to play an active role in the multi-agency desk top or live exercises held by partners in health and at the local authority, as appropriate.

11.4 On occasion, a live incident occurs which requires the CCG to activate its business continuity plan and leads to a review and improvements in the existing plan. In such instances, this will replace the desk top exercise unless there is the view that a further exercise would be beneficial.

12 Lessons Learned

12.1 Ensuring that the lessons learned during such exercises and live incidents are captured and acted upon is key to the maintaining the resilience of the organisation and ability to respond to an incident in a managed way.

12.2 The process of hot debrief, cold debrief and production of exercise reports with recommended actions is set out in the surge and escalation plan and CCG business continuity plan.
12.3 Post incident reports will be produced following an incident affecting the CCG or local system.

12.4 The recommendations contained within post-exercise and post incident reports will be reviewed by the Risk, Health and Safety Manager for any local learning.

12.5 Updates on progress against the associated action plans will be reviewed by the SMT.

12.6 Any learning will be disseminated to CCG staff and partners across the health economy and local authority in support of continuous improvement in Emergency Planning.


13.1 The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended).

13.2 The NHS Standard Contract Service Conditions require providers to comply with EPRR Guidance. Therefore commissioners must ensure providers are compliant with the requirements of the Core Standards as part of the annual national assurance process.

13.3 The CCG must undertake a self-assessment of its compliance with the requirements of the Core Standards as part of the annual CCG assurance framework.

14. **Review of Framework**

14.1 This Framework will be reviewed every three years or more frequently due to changes in:

- National statutory, regulatory, policy requirements or guidance;
- Local policy, organisational functions, structure or staffing;
- CCG strategic objectives or processes;
- Key suppliers and contractual arrangements;
- Requirements due to learning from incidents, the testing of existing plans or risk assessments;

15. **Dissemination of the Framework**

The Framework will be stored on the CCG intranet and disseminated to staff via the CCG's communication channels.
16. References and Underpinning Materials

- The CCA 2004 and associated Cabinet Office Guidance
- The NHS Act 2006 (as amended)
- The NHS Constitution
- The requirements for EPRR as set out in the NHS Standard Contract(s)
- NHS England EPRR guidance and supporting materials including:
  - NHS England Core Standards for Emergency Preparedness, Resilience and Response
  - NHS England Business Continuity Management Framework (service resilience)
- Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
- National Occupational Standards for Civil Contingencies
- BS ISO 22301 Societal security – Business continuity management systems
Figure One: EPRR planning structure for the NHS in England


Health resilience sub-groups may exist at LHRP level and also at a local health economy level to undertake strategic and tactical EPRR work.
## Definitions

<table>
<thead>
<tr>
<th>Emergency Preparedness</th>
<th>The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.</td>
</tr>
<tr>
<td>Response</td>
<td>Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.</td>
</tr>
<tr>
<td>Emergency</td>
<td>Under Section 1 of the CCA 2004 an “emergency” means “(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom; (b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; (c) war, or terrorism, which threatens serious damage to the security of the United Kingdom”.</td>
</tr>
<tr>
<td>Incident</td>
<td>For the NHS, incidents are classed as either:</td>
</tr>
<tr>
<td></td>
<td>- Business Continuity Incident</td>
</tr>
<tr>
<td></td>
<td>- Critical Incident</td>
</tr>
<tr>
<td></td>
<td>- Major Incident</td>
</tr>
<tr>
<td></td>
<td>Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.</td>
</tr>
<tr>
<td>Business Continuity</td>
<td>A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)</td>
</tr>
<tr>
<td>Incident</td>
<td>A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.</td>
</tr>
<tr>
<td>Major Incident</td>
<td>A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency as above.</td>
</tr>
</tbody>
</table>

---

4 NHSE, EPRR Framework, 2015
NHS Calderdale CCG

Major Incident:

[NAME]

[DATE OF INCIDENT]

Post Incident Report

| Incident Date:       |  
| Incident Location:  |  
| Date of Report:     |  
| Report Author       |  
| SMT                 |  

Appendix 3
Contents

1. Summary of Incident
2. Sequence of events (summary- full log available)
3. Key observations
4. Lessons to be learned
5. Self-assessment against core standards
[Does this affect our self-assessment against the EPRR core standards?]
6. Actions identified
7. Next Steps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Deadline</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Governing Body needs to be assured that the principal risks to delivering its strategic objectives are captured and that there are sufficient controls in place to mitigate against these risks materialising or manage those risks.

The risks are set out in the Governing Body Assurance Framework (GBAF). This is a working document and is updated on a regular basis. It is reviewed on a six monthly basis.

The Senior Management Team (SMT) reviewed the GBAF at their meeting on 14 August 2017. This followed a review of the principal risks by their respective owners. The GBAF was also considered at meetings of the Finance and Performance and Quality Committees. All the changes made can be seen on the summary of principal risks (pages 3 & 4). A summary of these changes made during this review are:

- Principal risk 2.3 to be merged with 1.5 as they address the same risk. This risk is concerned with not delivering the CCG’s strategic objectives as the CCG has not delivered the proposed clinical model of hospital and community services as set out in the public consultation.
- Principal risk 1.6 now includes more detail on sources of assurance in terms of workforce planning, estates planning and the development of a single communications strategy for Calderdale.
- The action plan has been updated to reflect actions completed or new ones added since the last review.

During this current review the Governing Body is requested to consider the following questions with regards to the principal risks:

- Is the assurance proportionate to the level of risk and of sufficient quality?
- Where the risks are red or amber are the associated actions appropriate?

It is recommended that the Governing Body confirms that the GBAF provides sufficient **ASSURANCE** that:

- The strategic objectives of the CCG are accurate,
- The principal risks to the achievement of those objectives are identified and
- The controls in place to mitigate or manage those risks are identified.

| Decision | ☐ | Assurance | ☒ | Discussion | ☐ | Other | 35T |

### Implications

<table>
<thead>
<tr>
<th>Quality &amp; Safety implications (including Equality &amp; Diversity considerations e.g. EqIA)</th>
<th>There are no quality &amp; safety implications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public / Patient / Other Engagement</td>
<td>Not applicable to this paper</td>
</tr>
<tr>
<td>Resources / Finance implications (including Staffing/Workforce considerations)</td>
<td>There are no resources / finance implications.</td>
</tr>
</tbody>
</table>

#### Strategic Objectives

- Achieving the strategic direction for Calderdale
- Improving Governance
- Improving quality

#### Risk

**Risk (captured on the corporate risk register)**

Risk is managed in line with the CCG’s Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body’s Assurance Framework (GBAF) as appropriate.

#### Legal / CCG Constitutional Implications

- There are no legal / CCG Constitutional implications

#### Conflicts of Interest

**Conflicts of Interest**

(include detail of any identified/potential conflicts)

- There are no conflicts of interest.
1. Introduction

The Governing Body Assurance Framework (GBAF) provides the Governing Body with a method for effective and focused management of the principal risks and assurances associated with their strategic objectives. Unlike the Integrated Risk Management Framework - which records all risks that materialise, is highly dynamic and requires regular reporting - the GBAF contains the strategic objectives which are largely derived from the 5 Year Strategic Plan; are small in number and are unlikely to change significantly over time. As a consequence the principal risks in the GBAF need to be sufficiently significant to prevent the objective being achieved and will rarely change.

If operating effectively the GBAF can bring a number of benefits. It enables the Governing Body to be:

- fully appraised of the principal risks to the achievement of their strategic objectives;
- in full control of the agenda by highlighting areas of priority for their attention;
- confident that the systems, policies and people are operating in a way that is effective in delivering the objectives and minimising the risks;
- able to determine where to focus resources to address issues identified and to streamline reporting and prioritisation of annual work plans.

Since 2001, all NHS Chief Executives have been required to sign the Annual Governance Statement as part of the Annual Report and Accounts. In order to do this, the Governing Body needs to be able to show that it has systematically identified its objectives, has managed the principal risks to achieving them and can demonstrate that it has been properly informed about all the relevant risks and that its conclusions have been drawn from evidence. The GBAF provides a structure to support this process.

This document sets out a summary of the strategic objectives set by Calderdale CCG together with the enabling strategies, delivery plans and management arrangements for the delivery of the objectives.

The GBAF also sets out the principal risks to achieving the objectives, the controls being taken to mitigate/manage those risks, the assurances provided to the Governing Body that the actions being taken to mitigate/manage the risks are having the desired impact and any actions required to close any gaps in controls or mitigating actions.
2. **Glossary of Terms**

<table>
<thead>
<tr>
<th>Principal risk:</th>
<th>A key risk which would prevent the CCG from achieving this strategic objective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Controls:</td>
<td>A key control is a process or ‘something done’ to prevent a risk materialising or to manage a risk</td>
</tr>
<tr>
<td>Sources of Assurance:</td>
<td>What evidence have we received that the principal risks are being managed effectively and that the actions/processes being taken are having an impact?</td>
</tr>
<tr>
<td>Gaps in controls and/or gaps in assurance:</td>
<td>Are there any gaps in the key controls or assurance?</td>
</tr>
<tr>
<td>Corrective action to address/ manage any gaps in controls or assurance</td>
<td>How are we going to address the gap/strengthen the controls, manage/mitigate the risk</td>
</tr>
<tr>
<td>Link to the Risk Register</td>
<td>Is it, or should it be on the risk register, if so, what is the risk number?</td>
</tr>
<tr>
<td>Target date for any action identified or review controls</td>
<td>When will we take the necessary action and who will lead to achieve the action identified above</td>
</tr>
</tbody>
</table>

3. **Key to the risk status (RAG)**

- Green: There is sufficient assurance that controls are operating effectively to mitigate the risk
- Yellow: There are some gaps in controls/assurance
- Red: There are significant gaps in controls or assurance putting the achievement of the strategic objective at risk

4. **Key to initials of SMT/ GB Leads**

<table>
<thead>
<tr>
<th>DG</th>
<th>Debbie Graham</th>
<th>MW</th>
<th>Matt Walsh</th>
<th>AB</th>
<th>Alan Brook</th>
<th>JM</th>
<th>Jen Mulcahy</th>
<th>MA</th>
<th>Majid Azeb</th>
<th>NT</th>
<th>Nigel Taylor</th>
</tr>
</thead>
<tbody>
<tr>
<td>NS</td>
<td>Neil Smurthwaite</td>
<td>DR</td>
<td>Debbie Robinson</td>
<td>KS</td>
<td>Kate Smyth</td>
<td>CT</td>
<td>Caroline Taylor</td>
<td>SC</td>
<td>Steven Cleasby</td>
<td>PW</td>
<td>Penny Woodhead</td>
</tr>
</tbody>
</table>
## Governing Body Assurance Framework - Summary of Principal Risks

<table>
<thead>
<tr>
<th>Triple Aims/strategic objectives</th>
<th>Summary of principal risks to delivering the strategic objectives</th>
<th>RAG</th>
<th>Update since last review</th>
<th>SMT</th>
<th>GB Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Achieving the agreed strategic direction for Calderdale</strong></td>
<td>There is the risk that we do not deliver our strategic outcomes because we have not:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 integrated our commissioning activities with CMBC</td>
<td></td>
<td></td>
<td>Reviewed by DG July 2017. Some changes made - see action plan</td>
<td>DG</td>
<td>AB</td>
</tr>
<tr>
<td>1.2 tackled the wider determinants of health</td>
<td></td>
<td></td>
<td>Reviewed by DG July 2017. Some changes made - see action plan</td>
<td>DG</td>
<td>AB</td>
</tr>
<tr>
<td>1.3 implemented new models of primary care and community services</td>
<td></td>
<td></td>
<td>Reviewed by DG July 2017. No changes.</td>
<td>DG</td>
<td>AB</td>
</tr>
<tr>
<td>1.4 worked effectively on a West Yorkshire footprint</td>
<td></td>
<td></td>
<td>Reviewed by JS July 2017. Action identified from this has been completed - see action plan</td>
<td>DG</td>
<td>AB</td>
</tr>
<tr>
<td>1.5 delivered the proposed clinical model of hospital and community services as set out in the public consultation.</td>
<td></td>
<td></td>
<td>Reviewed by JM July 2017. To be merged with 2.3 and amended to reflect the FBC is being progressed to the next steps.</td>
<td>JM (PW)</td>
<td>MW</td>
</tr>
</tbody>
</table>
| 1.6 fully developed and optimise system working on enabling functions | |     | ▪ PW has identified some actions in terms of workforce plans July 2017  
▪ NHS Property Services have agreed to instigate a plan for all parties to share estate plans  
▪ The Communications Manager has started to develop a communications strategy with the local authority | PW, NS, JS | tbc     |
<p>| <strong>2. Improving Quality</strong> | 2.1 We do not improve patient experience in line with our plans due to a failure to use appropriate patient and public engagement intelligence to support service improvement and plans to change service models | | Reviewed by PW July 2017 no changes | PW | KS      |
| 2.2 We are unable to commission high quality, safe services across the system due to a failure to ensure we have the support of | | | Reviewed by PW July 2017 no changes | PW | MA      |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>We are unable to commission high quality and safe services from CHFT due to the Trust not being able to address the service configuration issues, resulting in the need to effect service change on a clinical needs basis in advance of the proposed changes to hospital and community services being implemented.</td>
<td>Full Business Case has been developed and has now been referred to the Secretary of State for Health by Scrutiny Committee. Q&amp;S case for change and QIAs have been refreshed (July 2017). RAG rating changed from amber to green. To be merged with 1.5.</td>
</tr>
<tr>
<td>2.4</td>
<td>We do not maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients.</td>
<td>Reviewed by PW July 2017 no changes</td>
</tr>
<tr>
<td>2.5</td>
<td>We are unable to provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding arrangements, resulting in harm to children and adults.</td>
<td>Reviewed by PW July 2017 no significant changes</td>
</tr>
<tr>
<td>2.6</td>
<td>We are unable to deliver our strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale</td>
<td>Reviewed by DR July 2017. Some changes made – see action plan</td>
</tr>
<tr>
<td>3. Improving value</td>
<td>3.1</td>
<td>We do not deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable.</td>
</tr>
<tr>
<td>4. Improving governance</td>
<td>4.1</td>
<td>We don’t comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>We don’t have effective governance and risk management processes in place due to not having the right structures, capacity and capability.</td>
</tr>
</tbody>
</table>
**Strategic Objective 1 - Achieving the agreed strategic direction for Calderdale (pages 5 - 13)**

**Our intentions**
- Integration of commissioning
- Tackle the wider determinants of health
- Deliver new models of primary care and community services
- Work on a West Yorkshire footprint where agreed and deliver clinical model of hospital services as set out in the public consultation
- Deliver enabling functions – digitisation, workforce, estates, data quality and analysis, communication

### Strategic Objective 1: Principal Risk 1.1

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Source of Assurance</th>
<th>Action to correct gaps/strengthen control and/or assurance</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>We do not deliver our strategic outcomes because we have not integrated our commissioning activities with CMBC</td>
<td>DG, AB, F&amp;P</td>
<td>Green - Complete</td>
</tr>
</tbody>
</table>

**Key Controls**

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chief Officer, Chair and Assistant Clinical Chair members of the Health and Well Being (HWB) Board to facilitate effective partnership working.</td>
<td>HWB minutes to Governing Body</td>
<td>HWB Board minutes to Governing Body</td>
<td>n/a</td>
<td>Sept '17</td>
</tr>
<tr>
<td>2. Single Plan for Calderdale provides a single strategic direction for Calderdale Council and the CCG.</td>
<td>HWB minutes to Governing Body approving SPFC</td>
<td>n/a</td>
<td>Sept '17</td>
<td></td>
</tr>
<tr>
<td>3. Developing the necessary governance, including the Integrated Commissioning Executive (ICE) established between the CCG, ASC, C&amp;Y and Public Health to provide the governance on integrating commissioning activities; Better Care Fund (BCF) Programme Board oversees delivery of the BCF Plan/resources to integrate health and social care delivery. Procurement and payment mechanisms in order to</td>
<td>ICE minutes to the Health and Wellbeing Board Finance and Performance Committee regular agenda items on: - Better Care Fund - Business Planning process - updates - Care Closer to Home progress - Right Care/Hospital Services Programme Board progress reports to Governing Body</td>
<td>n/a</td>
<td>Sept '17</td>
<td></td>
</tr>
<tr>
<td>Strategic Objective 1: Principal Risk 1.2</td>
<td>SMT Lead</td>
<td>GB Lead</td>
<td>Ctte.</td>
<td>Risk Status</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>1.2 There is a risk of the CCG does not:</td>
<td>DG</td>
<td>AB</td>
<td>F&amp;P</td>
<td></td>
</tr>
<tr>
<td>deliver its strategic outcomes because we have not tackled the wider determinants of health</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Key Controls**

### 1. Partnership working via:
- **a)** Calderdale Council senior staff (Director of Public Health, Adult Health and Social Care, Children and Young People leads invited to the CCG Governing Body meetings highlighting wider determinants of health and facilitating effective partnership working.
- **b)** Single Plan for Calderdale provides single strategic direction for CMBC and CCG
- **c)** Better Care Fund Plan for 16/17 put in place which drew on the JSNA and JHWS in developing the Calderdale Vision and the Plan for 2017/18. The 16/17 Better Care Fund plan and includes in a revised section 75 agreement for 2016/17.

### Sources of Assurance

- HWB Strategy, Terms of Reference in place, Reports Scrutiny Committees (as required)
- Single Plan for Calderdale and two-Year Operational Plan published - [to insert] Vanguard Board, and CC2H developing view of future with partners

### Action to correct gaps/strengthen control and/or assurance

- Health and Wellbeing Board Minutes to Governing Body
- BCF Plan to be updated once national guidance issued

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sept 17</td>
</tr>
</tbody>
</table>

### 2. Intelligence Sharing:
- **a)** CCG strategic priorities informed by Joint Strategic Needs Assessment (JSNA),
- **b)** Patient and Public involvement informs CCG of public’s view of the wider determinants of health
- **c)** New BI model in place and creating links with health intelligence work within the PH team.
- **d)** Use of Commissioning for Value intelligence Packs produced by NHSE and review of benchmarking data comparing Calderdale position against regional and national performance data.
- **e)** Other business intelligence information including information from member practices

### Sources of Assurance

- Monthly updates to F&P on transformation and QIPP
- Quarterly summary report to Finance and Performance
- JSNA - on CMBC website
- Patient and Public Engagement Strategy - on CCG website

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/a</td>
</tr>
</tbody>
</table>

### 3. Governance Arrangements:
- **a)** BCF Board reports into HWB and the Finance and Performance Committee
- **b)** Single Plan for Calderdale reports progress updates to HWB and the Governing Body

### Sources of Assurance

- Finance and Performance Committee regular agenda items on:
  - Better Care Fund
  - Business Planning process -updates
  - Care Closer to Home progress

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>5. Single Plan for Calderdale Plan 2014/15 - 2020/21:</strong></td>
<td></td>
</tr>
<tr>
<td>a) HWB SPFC confirms actions to tackle wider determinants of health</td>
<td>Progress reports to Governing Body</td>
</tr>
<tr>
<td>b) CCG Two Year Operational Plan - 2017/18 - 2018/19 confirms commitments to strategic outcomes in line with SPFC</td>
<td>NHSE assurance on strategic plans</td>
</tr>
<tr>
<td><strong>6. Internal capacity and capability to deliver strategic plan:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Processes to ensure alignment of CCG roles and capacity with strategic plan delivery</td>
<td>Finance and Performance Committee transformation updates includes a view of capacity and capability.</td>
</tr>
<tr>
<td>Strategic Objective 1: Principal Risk 1.3</td>
<td>SMT Lead</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>1.3 We do not delivery our strategic outcomes because we have not implemented new models of primary care and community services</td>
<td>DG</td>
</tr>
<tr>
<td><strong>Key Controls</strong></td>
<td><strong>Sources of Assurance</strong></td>
</tr>
<tr>
<td>1. Single Plan for Calderdale (SPFC) sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. The two year operational plan sets the strategic direction for Calderdale CCG which is aligned to the SPFC.</td>
<td>Monthly update to Finance and Performance (F&amp;P) Committee. Full assurance on the Single Plan and NHS England assurance on the two year operational plan Two year plan submitted to the F&amp;P Committee and Governing Body.</td>
</tr>
<tr>
<td>2. Partnership working through the HWB to develop an integrated model of primary and community services, physical and mental health.</td>
<td>1. Care Closer to Home (CC2H) care model focuses on supported self-care and a community model which supports recovery and independence and an improved model of community provision - updates to the Governing Body. 2. CC2H Phase 2 being developed as part of Accountable Care Organisation (ACO) development/recommissioning of community services in line with HWB strategy - Health and Well Being Board Development Session Minutes 3. Key element of Better Care Fund (BCF) Plans - Better Care Fund Board/Better Care Fund Operational Group minutes and Monthly Better Care Fund standing agenda item on Finance and Performance Committee</td>
</tr>
</tbody>
</table>
3. The Better Care Fund Plan sets out how CCG will deliver supported self-managed care and primary prevention jointly with Calderdale MBC.

| CC2H focus on delivery of prevention, supported self-care | n/a | n/a |
| Better Care Fund Programme Board | | |
| Better Care Fund regular updates to the Finance and Performance Committee | | |

4. Care Closer to Home model specifies which services the CCG will commission to deliver supported self-managed care and primary prevention

| Closer to Home specification - Phase 1 approved by Quality Committee | Develop a view of how the development of an ACO will contribute towards delivery of this objective | Sept 17 |
| Phase 2 specification/ACO model in development | | |

5. Contract with Voluntary Action Calderdale (VAC) to stimulate the third sector to support delivery of supported self-managed care and primary prevention

<p>| Contract documentation with VAC | n/a | n/a |
| Monthly contract compliance meetings with VAC | | |
| Finance and Performance Committee paper on contracting includes reports on monthly contract compliance meetings with VAC | | |</p>
<table>
<thead>
<tr>
<th>Strategic Objective 1: Principal Risk 1.4</th>
<th>SMT Lead</th>
<th>GB Lead</th>
<th>Ctte. Lead</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint.</td>
<td>MW</td>
<td>AB</td>
<td>F&amp;P</td>
<td></td>
</tr>
</tbody>
</table>

### Key Controls

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/ strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Draft Annual workplan agreed by the Healthy Futures group and approved by CCG member practices</td>
<td>1. Evidence of CCG member voting (16 Feb 2017)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2. Governance arrangements for WYSTP including Healthy Futures developed. WY STP provides strategic direction across WY linking to the single plan for Calderdale.</td>
<td>1. WYSTP structure diagram, minutes of meetings  2. Healthy Futures MOU and Joint Committee terms of Reference supported by the Governing Body (9th Feb ’17)and approved by CCG membership (16th Feb ’17)  3. Constitution variation approved by CCG membership (16th Feb ’17) submitted to NHSE for approval.</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3. Chair and Chief Officer are active members of the West Yorkshire STP.</td>
<td>1. Governing Body minutes (9 Feb ’17)  2. HF minutes</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4. WYSTP programme office being developed to take forward workstreams</td>
<td>WYSTP programme office structure</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>
### Strategic Objective 1: Principal Risk 1.5 (to be merged with 2.3)

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/ strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work Plan sets out the actions required to support the production of the Full business case and association documentation.</td>
<td>1. Mins from Hospital Services Programme Board (monthly)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>2. Clinical case for change, hospital standards and refresh of quality impact assessment and associated outcomes and benefits to Quality Committee.</td>
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<tr>
<td></td>
<td>4. Regular reporting through the Chief Officer's Report to Governing Body (Feb '17)</td>
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</tr>
<tr>
<td>2. Working with the regulators to mitigate against any risks of not achieving published deadline for the submission of the funding application.</td>
<td>1. Monthly reconfiguration grid to NHS England.</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

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1. Work Plan sets out the actions required to support the production of the Full business case and association documentation.

1. Mins from Hospital Services Programme Board (monthly)
2. Clinical case for change, hospital standards and refresh of quality impact assessment and associated outcomes and benefits to Quality Committee.
4. Regular reporting through the Chief Officer's Report to Governing Body (Feb '17)
<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps in control and/or assurance</th>
<th>Risk No.</th>
<th>SMT Lead</th>
<th>GB Lead</th>
<th>Ctte.</th>
<th>Risk Status</th>
<th>Target date/lead</th>
</tr>
</thead>
</table>
| 1. System forum to be initiated to understand and develop workforce plans to deliver new models of care | (a) Members of; Health Education England Group and West Yorkshire Local Workforce Board  
(b) Health & Wellbeing Board has agreed that workforce is a key enabler to deliver Single Strategic Plan for Calderdale (SPFC) | Need to develop strategy and implementation plan:  
(a) Convene group with interested parties from Calderdale system  
(b) Scope out strategy  
(c) Engage a strategy  
(d) Draft action plan  
(e) Present strategy and plan to HWB | - | PW | tbc | tbc | | April 18  
Oct ‘17  
Oct – Dec ‘17  
Jan-Feb ‘18  
March ‘18  
April ‘18 |
| 2. System forum to be initiated to understand and develop plans to digitise in order to deliver new models of care building on BCF work | (a) Build on the BCF Digital Forum established to deliver BCF expectations on the use of unique numbers  
(b) Calderdale HWB have agreed the need to develop thinking through dialogue in development mode | HWB initiating development as part of delivery of the SPFC | - | IW (NS) | | | Dec 17 |
| 3. System forum to be initiated to understand and develop Estate plans to deliver new models of care | (a) Building on work undertaken by CMBC as part of One Public Estate Agenda  
(b) Calderdale HWB have agreed the need to develop thinking through dialogue in development mode | HWB initiating development as part of delivery of the SPFC | - | NS | | | Dec ‘17 |
4. There are clear integrated plans to ensure high quality communications to share our narrative with stakeholders and the public.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>4.</td>
<td>There are clear integrated plans to ensure high quality communications to share our narrative with stakeholders and the public.</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>1.</td>
<td>Communications strategy and plans to be approved by Governing Body and Health and Wellbeing Board</td>
</tr>
<tr>
<td></td>
<td>Development of a single communications strategy for Calderdale</td>
</tr>
<tr>
<td>JS</td>
<td>Dec ’17</td>
</tr>
</tbody>
</table>
Improving quality

Our intentions – Care and Quality

Support delivery of the West Yorkshire STP gap by delivering:

- An increase in the proportion of people satisfied with access to care and continuity of care in the GP Patient Survey and Friends and Family tests
- A reduction in the number of people admitted to hospital with a treatable or preventable condition within the community by 70% to 1,695 admissions by 2021
- In 4 years, a 75% reduction in suicides, with an ambition to reach zero
- A halving of the number of patients who have extended LOS in hospital of between 11-100+ days (reduction from the current 157 to 79 per quarter from Q1 16/17 baseline)
**Strategic Objective 2 : Principal Risk 2.1**

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/ strengthen control and/ or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
</table>
2. Annual action plan to Quality Committee June 2016  | n/a | n/a |
| 2. Patient Experience and Engagement Steering Group (including partners) and Patient Experience Group | 1. Regular patient experience report to Quality Committee  
(escalation in key points to GB) (including Friends Family test feedback)  
2. Steering Group minutes scrutinised by Quality Committee  
3. Healthwatch reports into PPE Steering Group  
4. Calderdale Health Forum action notes into PPEE Steering Group  | n/a | n/a |
| 3. Patient Reference Group Network  | Engagement report for specification reflects patient experience  | n/a | n/a |
| 4. Procurement Process (incorporates patient feedback)  | Evidence seen through procurement documentation of patients/public involvement  | n/a | n/a |
| 5. Contracting mechanisms for patient feedback: sections within the standard contract regarding providers’ requirements to engage with patients/public  | Clinical Quality Board minutes reflecting quarterly customer services report  | n/a | n/a |
| 6. Engagement assurance process for development of service specifications includes patient experience and public engagement | 1. Project Management Office paperwork and flowchart  
2. Quality Committee minutes  | n/a | n/a |
| 7. Lay Member for PPI on GB  | Lay member job description  | n/a | n/a |
**Strategic Objective 2: Principal Risk 2.2**

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Patient &amp; Public Engagement &amp; Experience Group (PPEE) and terms of reference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient and Public Engagement Annual Statement of Involvement 2014-15</td>
<td></td>
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</tr>
<tr>
<td>4. Equality and Diversity Strategy and Action Plan</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Lay member PPI</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. Engagement and Equality and Diversity Assurance Process</td>
<td></td>
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</tr>
</tbody>
</table>

There is a risk that the CCG is unable to: commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans - thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire STP.

**Key Controls**

- 1. Patient and Public Engagement and Experience Strategy (-2015 - 18) and annual implementation plan
- 2. Patient & Public Engagement & Experience Group (PPEE) and terms of reference
- 4. Equality and Diversity Strategy and Action Plan
- 5. Lay member PPI
- 6. Engagement and Equality and Diversity Assurance Process
## Strategic Objective 2: Principal Risk 2.3

<table>
<thead>
<tr>
<th></th>
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<th>SMT Lead</th>
<th>GB Lead</th>
<th>Ctte.</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>There is a risk that the CCG is unable to: Commission high quality and safe services from CHFT due to the Trust not being able to address the service reconfiguration issues, resulting in the need to effect service change on a clinical needs basis in advance of the proposed changes to hospital and community services being implemented.</td>
<td>PW</td>
<td>MA</td>
<td>Quality</td>
<td></td>
</tr>
</tbody>
</table>

### Key Controls

1. The CCG use the Quality and Safety dashboard - to identify and track any issues relating to Quality and safety
2. The CCG are working with the Provider to plan short/long term solutions to address any issues
3. The Hospital Service Programme Board meets on a monthly basis and now includes providers
4. Process developed between CCG and CHFT in regards to managing interim service changes
5. We completed consultation on 21st June on proposed future arrangements for hospital and community health services.

### Sources of Assurance

1. Clinical Quality Board standing item, escalation to Partnership Board
2. Regular reports to Quality Committee
3. Action plans in place for specific Q&S concerns
4. ‘Go see’ visits and enhanced surveillance in place
5. NHS England has provided assurance that our Pre-Consultation Business Case meets the four key tests for service change.
6. Consultation report and CCG decision

### Action to correct gaps/strengthen control and/or assurance

- n/a

### Risk No. Target date

- 863
<table>
<thead>
<tr>
<th>Strategic Objective 2: Principal Risk 2.4</th>
<th>SMT Lead</th>
<th>GB Lead</th>
<th>Ctte. Lead</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 There is a risk that the CCG is unable to: maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients</td>
<td>PW</td>
<td>MA</td>
<td>Quality</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quality and Safety Dashboard (information at CCG level and by main providers)</td>
<td>1. Monthly Quality and Safety Reports to Quality Committee, including reports from the Quality Boards and dashboard. 2. Updates to Quality &amp; Safety re actions and outcomes 3. Quality reports including reports on patient safety and safeguarding issues to the CCG Governing Body. 4. Complaints, Serious Incidents and Serious Case Reviews (SCRs) reported into Quality Committee and SCRs in private section Governing Body.</td>
<td>n/a</td>
<td>984</td>
<td>517</td>
</tr>
<tr>
<td>2. Quality outcome standards, quality schedule, patient safety and relevant targets within service specifications</td>
<td>Quality &amp; Safety approval of service specifications</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3. Contract governance and monitoring processes including CQBs for all key contacts</td>
<td>Minutes of clinical Quality reported to Quality Committee</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4. Review and triangulation of a range of quality information (e.g. Serious Incidents, CQUINs, CQC)</td>
<td>Quality dashboard exception report (Quality Committee minutes would demonstrate the triangulation and Quality decision on whether to implement level 5)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance Process (Standardised process for managing risks and escalating monitoring levels)</td>
<td>Quality &amp; Safety report will demonstrate quality assurance process is used, Quality Committee minutes</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Strategic Objective 2: Principal Risk 2.5</td>
<td>SMT Lead</td>
<td>GB Lead</td>
<td>Ctte.</td>
<td>Risk Status</td>
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<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>2.5 There is a risk that the CCG is unable to: Provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding arrangements, resulting in harm to children and adults.</td>
<td>PW</td>
<td>SCI</td>
<td>Quality</td>
<td>Green</td>
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</table>

<table>
<thead>
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<th>Risk No.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Safeguarding policies and procedures in place</td>
<td>1. Policies approved by Quality Committee in line with agreed timescales for review 2. Internal audit report on compliance against accountability and assurance framework – due 2016 3. NHS England assurance process on compliance against accountability and assurance framework. 4. Annual Safeguarding reports to Quality Committee and Governing Body</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2. Mandatory training within CCG, standards in place with providers</td>
<td>1. Training compliance reported to Governing Body bi-annual in Workforce report and annual in Safeguarding report 2. Quarterly reports, including compliance with Safeguarding training to Quality Committee</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3. Safeguarding standards included within contracts</td>
<td>1. Annual Safeguarding reports to Quality Committee and Governing Body 2. Contracts monitored through CCG Annual Safeguarding report</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4. Annual Section 11 Audits scrutinise provider safeguarding arrangements, (policies and procedures, training).</td>
<td>1. Safeguarding Board scrutiny of provider safeguarding audits 2. CCG Annual Safeguarding report</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>5. Provider s11 assessments scrutinised by Safeguarding Board</td>
<td>1. Local Safeguarding Board reports to GB 2. Quality reports including reports on patient safety and safeguarding issues to the private section of the</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>
| CCG Governing Body | 3. Quality Committee scrutiny of CCG audits  
4. Internal Audit report on safeguarding arrangements due 2016 |
|---------------------|--------------------------------------------------------------------------------|
| 6. Active member of the Local Safeguarding Children's Board and Local Safeguarding Adults' Board. Active member of Yorkshire and Humber Safeguarding Network, ensures national policy developments reflected in local commissioning arrangements. | 1. NHSE Assurance Process  
2. Local Safeguarding Board reports to GB | n/a | n/a |
### Strategic Objective 2: Principal Risk 2.6

There is a risk that the CCG is unable to: deliver its strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Engagement of Practices through the Commissioning engagement Scheme</td>
<td>Governing Body Visit notes</td>
<td></td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice Leads meeting Attendance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Register</td>
<td></td>
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<tr>
<td></td>
<td>End of year reports</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Practice Managers Action Group inputs to clinical commissioning and shares information with member practices on behalf of CCG.</td>
<td>PMAG meeting Notes</td>
<td>Develop implementation plan for each priority area.</td>
<td>n/a</td>
<td>End August 2017</td>
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<tr>
<td></td>
<td></td>
<td>Establish clear reporting arrangements as part of formal governance.</td>
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<td></td>
<td></td>
<td>Clarify Practice Management leadership for priority areas.</td>
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<td>Establish clear arrangements for engagement with membership.</td>
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<tr>
<td>3. Monthly joint meeting between the CCG, LMC Executive and the Pennine GP Alliance</td>
<td>Minutes of the meetings</td>
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<tr>
<td></td>
<td>Joint letter to practices about working together</td>
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<tr>
<td>4. High level plan for the implementation of the General Practice Forward View</td>
<td>High level Plan Document submitted to NHSE and shared with Practices.</td>
<td>Development of a detailed plan for the General Practice Forward View</td>
<td>n/a</td>
<td>End Sept '17</td>
</tr>
<tr>
<td>5. GP Members on the Governing Body</td>
<td>Constitution</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>6. CCG is a delegated commissioner of Primary medical services to enable transformation of general practice</td>
<td>MOU with NHS England</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
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<tr>
<td></td>
<td>CCG Constitution</td>
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<tr>
<td></td>
<td>CPMS Committee Terms of Reference</td>
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</table>
Our intentions – Finance & Efficiency

Support delivery of the West Yorkshire STP gap by:

- Delivering the Calderdale STP solutions to reduce the financial gap for Calderdale in 2020/21 from £100m to £56m.
- Further reducing the gap by £11m in 2021/22 to £16m subject to the development of a full business case – Right Care Right Time Right Place programme
- Working with partners across West Yorkshire to create a balanced financial plan for West Yorkshire
### Strategic Objective 3: Principal Risk 3.1

<table>
<thead>
<tr>
<th>Key Controls</th>
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<th>Action to correct gaps/strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Annual review of financial control arrangements by Internal/External audit</td>
<td>1. Annual sign off of financial plan/budget by Governing Body and Finance &amp; Performance Committee (F&amp;P). 2. Regular updates on amendments/changes to plan reported and agreed through F&amp;P Committee, with minutes and actions reported to Governing Body. 3. Partnership Boards with key partners (Calderdale Council, CHFT, SWYPFT), Financial position is standing agenda item for those 4. Integrated Commissioning Executive and Better Care Fund Programme board between CCG and Local Authority. 5. Critical risk reports to the Finance and Performance Committee and Governing Body.</td>
<td>Finance and Performance work plan amended to focus on recovery every month and in depth performance reports only quarterly. Recovery standard item on SMT and all meeting agendas. Action plan has been produced as part of the reporting on the critical risk. Actions monitored through the Partnership Boards and the Finance and Performance Committee.</td>
<td>829 (risk rating: 5 x 4 = 20)</td>
<td>Complete</td>
</tr>
<tr>
<td>2. Development and delivery of short/medium term Financial Recovery plan.</td>
<td>1. Approval by Governing body with updates at every meeting on position. 2. Agreement on principles and approach through GB formal and development sessions. 3. Approval and detailed monitoring through Finance and Performance Committee 4. Monthly CCG Recovery group accountable for producing and delivering schemes for recovery 5. Position reported at each Primary Care leads meeting 6. Partnership board meetings with CHFT, SWYPFT and local authority have updates on financial position so system aware of pressures.</td>
<td>Transformation Board between CCG, GHCCG and CHFT to develop/monitor joint cash releasing savings and ensure a balanced health economy. Joint “System Financial Recovery Plan” being developed System risk assessment being undertaken by NHS E/I. CCG revised internal governance</td>
<td>n/a</td>
<td>Dec 2017</td>
</tr>
</tbody>
</table>
| 3.  5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting to planned community services, reducing financial risk | 1. Delivery on plan is monitored through Govern Body reports.  
2. Right Care, Right Time, Right Place and Care Closer to Home strategies/business cases regularly updated to GB.  
3. Separate meetings for RCRTRP and CC2H monitoring progress. | n/a | n/a |
| 4. Development of Closer to Home model to reduce increasing demand on acute services (CC2H) | 1. Phase 2 of CC2H will include element around changing financial, regular reporting and updates to GB and F&P  
2. Business case being developed that will include section on finances and contribution towards financial sustainability. | n/a | n/a |
## Governing Body Assurance Framework: Strategic Objective 4 (pages 25-26)

### Improving governance

<table>
<thead>
<tr>
<th>Strategic Objective 4: Principal Risk 4.1</th>
<th>SMT Lead</th>
<th>GB Lead</th>
<th>Ctte. Lead</th>
<th>Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Failure to comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.</td>
<td>JS AB Audit</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Key Controls</th>
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<th>Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Compliance with the provisions of the CCG’s Constitution which has been reviewed by a legal firm and approved by NHS England.</td>
<td>Examples of compliance with Constitution (GB mins 13 Oct 16, suspension of standing orders, re-appointment of chair and Governing Body members)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2. Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework.</td>
<td>Committee terms of reference in place (approved by GB 9th April 16, 9 June 16, 13 Oct 16)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3. Annual committees work plans include any statutory and regulatory reporting requirements</td>
<td>Annual work plans for committees in place (standing item on committee agendas)</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4. Rolling programme of policy review to ensure compliance with changes in legislation, national guidance</td>
<td>Policy Review Schedule in place, policies overdue identified.</td>
<td>Introduce policy for identifying risk of a delay in policy review/ amendment and associated mitigating actions.</td>
<td>n/a</td>
<td>Nov ‘17</td>
</tr>
<tr>
<td>5. Review of compliance with statutory duties</td>
<td>Last completed (March ‘17).</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>6. Internal/external audit reviews/reports ensuring CCG compliance to Audit Committee.</td>
<td>External Assurance 2015/16 Annual Governance Statement, Annual Report and Annual Accounts, head of internal audit opinion and external audit letter of assurance.</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>7. Horizon scanning for any regulatory changes / guidance</td>
<td>Report on new Data Protection Regulatory requirements (Governance Assurance Report, Audit Committee, 17 Nov 16), Modern Slavery Act (Safeguarding Vulnerable Adults and Children Annual Report 2016)</td>
<td>n/a</td>
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<tr>
<td>Strategic Objective 4: Principal Risk 4.2</td>
<td>SMT Lead</td>
<td>GB Lead</td>
<td>Ctte. Lead</td>
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<tr>
<td>4.2 Failure to have effective governance and risk management processes in place due to not having the right structures, capacity and capability</td>
<td>MW</td>
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<tr>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Action to correct gaps/ strengthen control and/or assurance</th>
<th>Risk No.</th>
<th>Target date</th>
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</thead>
<tbody>
<tr>
<td>1. Robust governance structure, integrated risk management framework and systems of internal control in place.</td>
<td>Annual Report and Accounts 2016/17</td>
<td>n/a</td>
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<td>2. Process for regular review of governance and risk management part of internal audit annual work plan.</td>
<td>Internal Audit work plan 2016-18 Draft Head of Internal Audit Opinion March 2017</td>
<td>Further session with the Governing Body on risk appetite</td>
<td>n/a</td>
<td>Nov ‘17</td>
</tr>
<tr>
<td>3. Annual Governing Body and committee performance self-assessment (every three years - independent review of Governing Body and committee effectiveness) - identifying development needs and action plans</td>
<td>Development and actions contained within the Annual Governance Statement (AGS)(June ’16); Committee minutes demonstrating development session and action plans including reduction in frequency of meetings(Audit Sept ’16, Remuneration Oct ’16, Finance and Performance, Oct ’16); OD steering Group mins demonstrating oversight of OD programme</td>
<td>Review of governance, capacity and capability requirements as part of transition to new system-wide ways of working</td>
<td>n/a</td>
<td>April ‘18</td>
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<tr>
<td>4. Robust and systematic appraisals for staff and governing body members to identify any development needs.</td>
<td>Appraisal documentation for both Governing Body and staff; compliance schedule; SMT minutes demonstrating review of completion; training needs analysis completed and reviewed at the OD steering group.</td>
<td>SMT to review the appraisal completion and reporting</td>
<td>n/a</td>
<td>Sept/Oct 2017</td>
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</table>

Learning and Development to complete a training needs analysis for review by the OD steering group | n/a | Nov 2017 |
## Governing Body Assurance Framework: Corrective Action Plan

<table>
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<tr>
<th>Key Control Ref:</th>
<th>Action Required</th>
<th>SMT Lead</th>
<th>Mar 17</th>
<th>Apr 17</th>
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<tr>
<td>1.1(1)</td>
<td>HWB Minutes to Governing Body</td>
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<td>Single plan for Calderdale to be presented to the membership to approve the strategic direction being sent out</td>
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<td>SMT in June, GB in Sept 2017</td>
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<td>BCF Plan to be updated once national guidance issued</td>
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<td>Develop a view of how the development of an ACO would mitigate against this risk</td>
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<td>b) Establish clear reporting arrangements as part of formal governance</td>
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<td>Transformation Board between CCCG, GHCCG and CHFT to develop/monitor joint</td>
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<td>Nov 17</td>
<td>Dec 17</td>
<td>Jan 18</td>
<td>Feb 18</td>
<td>Mar 18</td>
<td>Apr 18</td>
<td>Update</td>
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<td></td>
<td>needs analysis for review by SMT People.</td>
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</tbody>
</table>
**Name of Meeting**: Governing Body  
**Meeting Date**: 12 October 2017

**Title of Report**: High Level Risk Log and Report  
**Risk Cycle**: 3 2017-18  17 Aug – 4 Sep 2017

**Agenda Item No.**: 12

**Report Author**: Robert Gibson, Risk, Health & Safety Manager  
**Public / Private Item**: Public Item

**GB / Clinical Lead**: Matt Walsh, Chief Officer  
**Responsible Officer**: Judith Salter, Head of Corporate Affairs and Governance

**Executive Summary**

- This paper presents the high level risk report at the end of the third review cycle of 2017-18.
- The Calderdale Clinical Commissioning Group Risk Register currently contains a total of 34 with no risks marked for closure.
- Of these open risks, there are:
  - 2 CRITICAL risks (scoring 20); and 5 SERIOUS risks (scoring 15-16)

**Previous consideration**

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<thead>
<tr>
<th>Name of meeting</th>
<th>Quality / Finance &amp; Performance Committees</th>
<th>Meeting Date</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>28/09/2017</td>
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<table>
<thead>
<tr>
<th>Name of meeting</th>
<th>Senior Management Team</th>
<th>Meeting Date</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>11/09/2017</td>
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**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 3 of 2017-18. This is following a review of their respective risks at the Quality and Finance & Performance Committee meetings on 28 September 2017.

**Decision**

☐  Assurance  ☒  Discussion  ☐  Other

**Implications**

- **Quality & Safety implications** (including Equality & Diversity considerations e.g. EqIA): No quality & safety implications
- **Public / Patient / Other Engagement**: Engagement not required
- **Resources / Finance implications** (including Staffing/Workforce considerations): No resources / finance implications

<table>
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<tr>
<th>Strategic Objectives</th>
<th>Risk</th>
<th>Conflicts of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving the agreed strategic direction for Calderdale; Improving Governance</td>
<td>As set out in the report and accompanying appendices</td>
<td>None identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal / Constitutional Implications</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Risk is managed in line with the CCG’s Integrated Risk Management Framework.</td>
<td></td>
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</table>
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 3

2.1 Risk Cycle 3 commenced on 17 August 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 11 September 2017.

2.2 All risks were submitted to either the Finance and Performance or the Quality Committee for review at their meetings on 28 September 2017.

2.3 There were no risks rated 15 (Serious) or above relating to Primary Medical Services in Risk Cycle 3.

2.4 The CCG Risk Register for Risk Cycle 3 has now been archived and Risk Cycle 4 will commence on 23 October.

Risk Register Summary: Risk Cycle 3

2.5 At the end of Risk Cycle 3, the CCG had 34 risks on the Corporate Risk register. There are no risks marked for closure this risk cycle (27 open risks at the last risk cycle).

2.6 15 of the CCG’s 34 open risks (44%) related to quality and clinical matters. The remaining 19 open risks (56%) related to finance, performance or corporate matters.

High Level Risks

2.7 There were 2 critical risks (scoring 20 or 25) on the CCG Risk Register during Risk Cycle 3; there were also the 2 risks as at the end of risk cycle 2.

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 (critical risk report attached – updated September 2017) (Q)</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 (updated critical risk report attached – updated September 2017) (F&amp;P)</td>
<td>The system will not deliver the NHS Constitution 4-hour A&amp;E (Accident and Emergency) 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 NHS England with assurance on the stability and resilience of the system</td>
<td>20</td>
</tr>
</tbody>
</table>
2.7 There are 5 open risks rated as Serious (with a score of 15 or 16) during the current risk cycle (the same number as at the end of the last risk cycle) these are detailed below.

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).

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>1069 (Q)</td>
<td>As a result of the implementation of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT) there is a risk that patient safety will be compromised due to: 1) a lack of or delayed information received in GP practice following attendance at the hospital 2) difficulties in booking fast track appointments in a timely manner 3) difficulties in reconciling medications following attendance at the hospital 4) all of the above having a negative impact on access to primary care. 5) the problems with booking impacting on delivery of timely treatment</td>
<td>16</td>
<td>New risk</td>
</tr>
<tr>
<td>1024 (F&amp;P)</td>
<td>The risk is that the CCG may not have the appropriate QIPP (Quality, Innovation, Productivity and Prevention) schemes in place to ensure that its contribution to the system model is affordable going forward.</td>
<td>16</td>
<td>Static for 1 risk cycle</td>
</tr>
<tr>
<td>1023 (F&amp;P)</td>
<td>The CCG will fail to deliver its 2017/18 planned in-year deficit of £3.13m and therefore fail to deliver a planned £2.7m cumulative surplus.</td>
<td>16</td>
<td>Static for 1 risk cycle</td>
</tr>
<tr>
<td>849 (F&amp;P)</td>
<td>The main acute and community contract with 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 4 risk cycles</td>
</tr>
<tr>
<td>515 (F&amp;P)</td>
<td>There is a risk that the Continuing Healthcare/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 3 risk cycles</td>
</tr>
</tbody>
</table>

The 1 open risk rated as Serious at the end of risk cycle 2 which is no longer a serious risk is:
<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Summary</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>Decreased to 8 due to an overall improving picture</td>
</tr>
</tbody>
</table>

F&P – Finance, performance, corporate  
Q - Quality

3. **Recommendations**

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 3 of 2017-18. This is following a review of their respective risks at the Quality and Finance & Performance Committee meetings on 28 September 2017.

4. **Appendices**

Appendix 1: High Level Risk Log Risk Cycle 3 as at 15 September 2017

Appendix 2: CCG Risk Dashboard Cycle 3 2017-18

Appendix 3: Critical risk reports for risk 709

Appendix 4: Critical risk reports for risk 62
Risk register serious & critical risks for risk cycle 3 as at 15.09.17

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Date Created</th>
<th>Risk Type</th>
<th>Risk Category</th>
<th>Risk Rating</th>
<th>Risk Score</th>
<th>Target Risk Rating</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>709</td>
<td>17/08/2015</td>
<td>Quality</td>
<td>Q - Quality of Care</td>
<td>4 (I4xL1)</td>
<td>8</td>
<td>4 (I4xL1)</td>
<td>Matt Walsh</td>
<td>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 services outside hospital, and (b) health and social care systems and processes are not currently optimised, resulting in a poor patient experience; additional pressure on the current acute bed base and the system being benchmarked as a national outlier.</td>
<td>(a) DTCC Action Group established under the A&amp;E Delivery Board governance structure to provide oversight of improvement in systems, processes and performance. (b) TDC Plan based on 8 high impact changes agreed at A&amp;EDB (c) Critical risk report generated, oversight by SMF, shared with F&amp;P and GB (d) All A&amp;EDB members have taken the Plan and video through their exec boards (e) Re-assessment of 8 high impact changes, and refreshed action plan developed</td>
<td>None identified</td>
<td>(a) Minutes from DTCC Group standing item at A&amp;EDB (b) Performance reviewed at BCF Board meetings and HNB as part of quarterly updates</td>
<td>(c) Reportable DTCC position sustaining below 3.5% threshold showing positive improvement trajectory - particularly delays associated with social care interventions</td>
<td>None identified</td>
<td>Static - B Archive(s)</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>13/06/2015</td>
<td>Finance</td>
<td>F&amp;P - Performance</td>
<td>4 (I4xL1)</td>
<td>8</td>
<td>4 (I4xL2)</td>
<td>Matt Walsh</td>
<td>There is a risk that 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 NHS with assurance on the stability and resilience of the system improvement programme.</td>
<td>(a) Standards for non-delivery of monthly performance set within 2016-17 CHFT contract. (b) Daily STIPRE and A&amp;E performance data monitored. (c) Action plan developed for Delayed Transfers for Care to support improved flow. (d) Strategic direction of Care Close to Home is shift from unplanned hospital admissions. (e) A&amp;E Delivery Board have referenced work in line with national expectations and test performance and mitigating actions.</td>
<td>F&amp;P response rate and satisfaction included in Quality Dashboard reviewed monthly in Quality Committee</td>
<td>(a) Hospital Services Board developing future models of urgent and emergency care - sustainable delivery remains challenging - links to new guidance on A&amp;E Streaming (b) System did not deliver the constitutional target for 2015/16 and 16/17 - loss of £0.25m quality premium funding to the system (c) Additional risk that the system will not deliver this due to delivery trajectory agreed between CHFT and NHSI that will not deliver the standard for 16-17. (d) Development of new community urgent care offers</td>
<td>(a) Performance dashboard shared weekly, with monthly scrutiny at A&amp;E Delivery Board (b) Performance reviewed at F&amp;P and GB (c) CHFT have re-established the task and finish group to improve Friends and Family Test response rates (d) CHFT working towards improvement in system-wide learning from serious incidents.</td>
<td>(a) A&amp;EDB have developed a Delivery Plan in order to improve performance, and it monitored by exception at each meeting of the Board. (b) CHFT performance is in upper quintile (best) in West Yorkshire and nationally</td>
<td>(a) For 17/18, whilst the target was delivered for April (95.09%), the May position deteriorated (85.11%). June position was 92.03, July 93.45. (c) was therefore no delivered. (b) and therefore the risk for this Constitutional target remains at 5*4. (c) EPR had a negative impact on Q1 performance.</td>
<td>Static - 4 Archive(s)</td>
</tr>
<tr>
<td>1069</td>
<td>10/08/2017</td>
<td>Quality</td>
<td>Q - Quality of Care</td>
<td>2 (I2xL1)</td>
<td>2</td>
<td>1 (I2xL1)</td>
<td>Penny Woodhead</td>
<td>As a result of the implementation of the Electronic Patient Record (EPR) at CHFT there is a risk that patient safety will be compromised due to: 1) a lack of or delayed information received in OP practice following attendance at the hospital 2) difficulties in booking fast track appointments in a timely manner 3) difficulties in reconciling medications following attendance at the hospital 4) all of the above having a negative impact on access to primary care. 5) the problems with booking impacting on delivery of timely treatment</td>
<td>(a) Impact of the implementation of EPR is a standing item on the agenda for Clinical Quality Board. Contract Management Board and A&amp;E Delivery Board. (b) GP requested to log all incidents relating to EPR (c) Incidents monitored by the Quality Team/risk teams at the CCG and reported back to CHFT to take action as appropriate. (d) Planned CCG “go see” visits to observe EPR working and report back to Quality Committee</td>
<td>Further assurance is needed from CHFT in relation to the quality of discharge information and mitigating actions to ensure timely appointments are made. Clear timed action plan for recovery.</td>
<td>(a) Standing item on agenda for formal meetings with CHFT (b) Continue to report into Quality Committee on a monthly basis until further assurance is reached.</td>
<td>None identified at present Paper presented at CHFT Board September 2017</td>
<td>Lack of assurance and understanding of the issues and actions to resolve with timescales resulting in inability to monitor progress.</td>
<td>New - Open</td>
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<td>Risk ID</td>
<td>Date Created</td>
<td>Risk Type</td>
<td>Risk Category</td>
<td>Risk Rating</td>
<td>Target Risk Rating</td>
<td>Risk Score</td>
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<td>Senior Manager</td>
<td>Principal Risk</td>
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<tr>
<td>1024</td>
<td>20/06/2017</td>
<td>Finance</td>
<td>F&amp;P - Financial</td>
<td>10 [I4xL4]</td>
<td>4 [I4xL1]</td>
<td>Neil</td>
<td>Smurthwaite</td>
<td>1</td>
<td>The risk is that Calderdale CCG may not have the appropriate QIPP schemes in place to ensure that its contribution to 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>a) Monthly QIPP tracker reporting to Recovery Operational Group, SMT Recovery, F&amp;P committee and Governing Body. b) Clinical engagement in QIPP programmes c) Medium term financial planning process in place d) Financial and contracting reporting and reporting in place through Senior Management Team, Finance and Performance Committee, and Governing Body e) Financial recovery plan being developed</td>
<td>a) Currently there is a QIPP gap on each releasing schemes in 17/18 of £3.4m (in terms of budget) - if this is not achieved the CCG is at a significant risk of not delivering its financial targets. The QIPP tracker is currently being reviewed and updated to quantify the gap in schemes. b) Controls not fully embedded and effective - these have improved through the QIPP meetings c) QIPP plans need further development to ensure granularity - plans have improved in terms of development and reporting d) Work underway in identifying measurement of schemes - significant improvements have been made through QIPP meetings e) QIPP meetings not fully achieved.</td>
<td>a) Internal audit reports b) Finance, contracting and QIPP reports c) Area Team assurance role</td>
<td>Area Team Assurance process - additional support being provided by NHS England to support plan in 17/18, particularly around QIPP opportunities. CCG successful in gaining some Stage 2 QIPP support from the local NHS England team - particularly looking at local system working and outcomes Right Care rating as &quot;Green&quot;</td>
<td>none</td>
<td>Static - 1 Archive(s)</td>
</tr>
<tr>
<td>1023</td>
<td>20/06/2017</td>
<td>Finance</td>
<td>F&amp;P - Financial</td>
<td>10 [I4xL4]</td>
<td>8 [I4xL2]</td>
<td>Neil</td>
<td>Smurthwaite</td>
<td>1</td>
<td>The CCG will fail to deliver our 17/18 planned financial surplus and therefore fail to deliver a planned £2.7m cumulative surplus. The 17/18 financial plan included a number of pressures/risk which have been mitigated to ensure delivery. These risks include activity pressures 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.</td>
<td>The 2017/18 financial plan has been approved by Governing Body. A Quality Innovation Productivity and Prevention (QIPP) plan has been agreed at £1.5bn and there's 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 &amp; Performance Committee and Governing Body and also to NHS England. The financial plan includes a £1.5m contingency budget to manage in year risk.</td>
<td>The CCG is aware of acute cost pressures in the first few months of the year. This is as the CCG needs to undertake against contract value to achieve QIPP targets. Current info suggest the contract trading as planned and therefore creates a pressure to the CCG. The CCG has a £1.5m contingency to help mitigate risk, predicated on full delivery of budget. 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 £2.5m.</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>Financial Plan assured by Area Team. Significant assurance received on internal audit financial transactions report reviewed by Audit Committee from past audit reports and in year audit review plan. Deep dive by NHS England recognised level of risk and the move to a reduced surplus position.</td>
<td>None at this stage</td>
<td>Static - 1 Archive(s)</td>
</tr>
<tr>
<td>849</td>
<td>22/06/2016</td>
<td>Finance</td>
<td>F&amp;P - Contracting</td>
<td>10 [I4xL4]</td>
<td>6 [I2xL3]</td>
<td>Martin</td>
<td>Puryear</td>
<td>1</td>
<td>There is a risk that the main acute contract with Calderdale and Huddersfield NHS Foundation Trust (CHFT) does not undertake against the plan to the levels built into the financial plan due to high levels of demand and potential under-delivery of QIPP schemes. The contract position at the end of Month 3 is showing an under-trade of £26bn, however, this is inclusive of a large estimate due to EPR issues and there has been a material increase in the number of patients waiting. Data Quality issues following EPR continue to make it difficult to fully understand the current position.</td>
<td>The contract position is discussed at the monthly Contract Management Group and bi-monthly Partnership Board with CHFT and at the Recovery meeting. A Transformation Group also meets monthly. System pressures have been discussed at the monthly A&amp;E Delivery Board. Analysis has been undertaken in relation to key pressure areas. The 2017/18 Commissioning Engagement Scheme will focus on managing demand and reducing variation.</td>
<td>Responses to queries and issues continue to take a long time and a large proportion remains outstanding. Analysis can only be undertaken two months after the activity taking place due to delays in the availability of S105 data in line with the national timetable. There is no robust agreed understanding of the expected impact of QIPP and CIP on the contract.</td>
<td>The monthly contract position is reported to the Finance and Performance Committee. Minutes are taken at all meetings. The contract position is presented at the Recovery Group and actions are taken to address specific issues identified. The Transformation Group has agreed that task &amp; finish groups will be set up to jointly understand the expected impact of QIPP and CIP schemes. A system recovery plan is in development.</td>
<td>Ongoing work on thresholds to support demand management. The task &amp; finish group has concluded and the impact of the new model on the contract has been jointly worked through.</td>
<td>The impact of M&amp;A in terms of cost reduction to the CCG and cost out of the system is yet to be fully understood.</td>
<td>Static - 4 Archive(s)</td>
</tr>
<tr>
<td>Risk ID</td>
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<td>Risk Rating</td>
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<tr>
<td>515</td>
<td>26/11/2014</td>
<td>Finance</td>
<td>F&amp;P - Performance</td>
<td>4 (I4xL4)</td>
<td>4 (I2xL2)</td>
<td>Martin Pursey</td>
<td>There is a risk that the CHC/Specialist Care team (responsible for CHC/learning disabilities/mental health/children/personal health budgets/appeals/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>a) Regular update and notification of pressures by Head of Commissioning Continuing Care to the Head of Contracting as part of line management processes.</td>
<td>b) Process continues to rationalise workload by identification of key priorities and reallocation of workloads</td>
<td>c) Process within the team to identify and escalating concerns to the manager</td>
<td>d) Limited capacity to cope with increasing workload</td>
<td>e) Limited capacity to manage the increasing number of very complex cases</td>
<td>f) Limited capacity to cope with crisis situations that require immediate attention such as nursing homes.</td>
<td>g) No capacity and limited skills to support the personal health budget offer</td>
<td>h) Unable to recruit to 2 posts due to CCG financial position.</td>
</tr>
</tbody>
</table>
Risks Report Summary

CCG: NHS Calderdale CCG
Archive Deadline: 02/10/2017
New Risks: 7
Total Risks: 34
Old Risks: 27
Marked for Closure: 0
Calderdale CCG Risk Dashboard 12 October 2017

Open Risks | Cycle 2 Jun - July | Cycle 3 Aug - Sep |
---|---|---|
CCG | 36 | 34 |
F&P | 25 | 18 |
Quality | 11 | 12 |
CPMS | 0 | 4 |

**Movement of CCG Risks during Cycle 3**

- **New**: 7
- **Marked for Closure**: 0
- **Risk Score Increasing**: 1
- **Risk Score Static (for 1 cycle)**: 9
- **Risk Score Static (for 2 or more cycles)**: 14
- **Risk Score Decreasing**: 3
- **Total Risks (including those marked for closure)**: 34

**Number of open risks by category**

- **F&P - Performance**: Cycle 3 4, 5, 6
- **F&P - Contracting**: Cycle 3 3, 4, 5, 6
- **F&P - Financial**: Cycle 3 3, 4, 5, 6
- **F&P - Corporate**: Cycle 3 1, 2, 3, 4, 5
- **F&P - Service Improvement**: Cycle 3 1, 2, 3, 4, 5
- **Q - Quality Improvement**: Cycle 3 1, 2, 3, 4, 5
- **Q - Quality of Care**: Cycle 3 1, 2, 3, 4, 5
- **Q - Medicines Management**: Cycle 3 1, 2, 3, 4, 5
- **CPMS - Quality of Care**: Cycle 3 1, 2, 3, 4, 5
- **CPMS - Financial**: Cycle 3 1, 2, 3, 4, 5

**Total Number of Open Risks**

- **Risk Cycle**: 1 32, 2 34, 3 32, 4 32, 5 30, 6 30

**Static Risk Scores**

- **Number of Cycles Risk has been Static in Score**:
  - 1: 9
  - 2: 2
  - 3: 3
  - 4: 3
  - 6: 3
  - 8: 2
  - 12: 1
# Critical Risk report

**Risk ID:** 709  
**Risk Type:** Quality  
**Risk Category:** Q – Quality of Care

**Date:** 20th September 2016  
(Last Reviewed 29 September 2017)

<p>| | | |</p>
<table>
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</thead>
</table>
| **1** | Current risk score  
(Likelihood) x (Impact) = z | 5 x 4 = 20 |
| **2** | Previous risk score  
(Likelihood) x (Impact) = z | 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 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 2015/16 the Calderdale system was an outlier nationally for reportable (formal) DTOC (Delayed Transfer of Care). Following actions by the A&E Delivery Board (A&EDB) the system was reporting sustainable performance for 2016/17 under the 3.5% target set by NHSE (% of delayed days of all occupied bed days). Performance remained stabled into Q1.  
For non-reportable delays, data shared at the September 2017 Finance and Performance Committee meeting showed a significant increase in the rate of discharges and a significant decrease in the number of non-reportable delays. |
| **5** | Assessment of the issues | Whilst we have significantly improved our performance as a system relating to formally reported Delayed Transfers of Care, we have an issue locally around the discharge of patients who, whilst not technically delayed, are ready to leave hospital after their period of acute care. We are now seeing an improvement in performance related to non-reportable delays. |
| **6** | Future actions | 1. A formal TOC (Transfer of Care) Improvement Plan was approved by the Governing Body in August and the A&E Delivery Board (A&EDB) in July. We have completed a re-assessment of our status against the 8 High Impact Changes and this was shared with the A&EDB in May 17. An action plan has being developed for the next 12 months.  
2. WYAZ (West Yorkshire Acceleration Zone) funding was |
targeted at increasing assessment and homecare capacity. Calderdale Council have also commissioned additional home care capacity.

3. iBCF (Improved Better Care Fund) funding has been 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 has begun 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 Governing Body received an update at the August meeting and will receive a further update at the October meeting. Following which the risk assessment score will be formally refreshed.

<table>
<thead>
<tr>
<th>7</th>
<th>Identified gaps</th>
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<tbody>
<tr>
<td>1.</td>
<td>Impact of proposed NHS England target for reportable delays which will potentially place iBCF funding at risk.</td>
</tr>
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</table>

**Relevant data:** (attach as necessary)

**Risk Owner:** Debbie Graham, Head of Service Improvement

**Senior Manager:** Matt Walsh, Chief Officer

**Date review completed:** 29.9.17
# Critical Risk report

**Risk ID:** 62  
**Risk Type:** Finance & Performance  
**Risk Category:** F&P – Performance  
**Date:** 20th December 2016  
(last reviewed 29 September 2017)

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| **1** | Current risk score  
(Likelihood) x (Impact) = z |
|   | 5 x 4 = 20 |
| **2** | Previous risk score  
(Likelihood) x (Impact) = z |
|   | 4 x 4 = 16 |
| **3** | Risk description |
|   | There is a risk that the system will not deliver the NHS Constitution 4-hour Accident and Emergency (A&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 NHS England with assurance on the stability and resilience of the system. |
| **4** | Current position (include any relevant data as attachments) |
|   | For 2016/17: performance did not achieve the 95% target (performance was 94.1%). The risk for 2016/17 therefore materialised.  
For 2017/18 the following performance has been noted:  
• April – 95.1%  
• May – 85.1% (reduced performance was identified as EPR-Electronic Patient Record related)  
• June – 92.03%  
• July – 93.59%  
• Aug – 93.45%  
This means that Q1 performance was not delivered (90.58%) and the Q2 position is challenging (92.64% Year to date -YTD) and therefore the risk for this Constitutional target remains at 5x4. |
<p>| <strong>5</strong> | 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. |
| <strong>6</strong> | Future actions |
|   | 1. The system has been able to access non-recurrent West Yorkshire A&amp;E Acceleration Zone funding in the early part of 2017/18 which has continued to be utilized to improve capacity and access into; A&amp;E/primary care streaming services and social work assessment and home-care capacity. |</p>
<table>
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<tr>
<th>2.</th>
<th>Commissioners worked with CHFT and Local Care Direct in order to trial a new primary care offer at the front-end of A&amp;E – which commenced December 2017. 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&amp;E Streaming.</th>
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<tr>
<td>3.</td>
<td>The A&amp;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 done in both Calderdale and Greater Huddersfield.</td>
</tr>
<tr>
<td>4.</td>
<td>The A&amp;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.</td>
</tr>
<tr>
<td>5.</td>
<td>The system has continued to plan for each Bank Holiday, assessing risk and gaining assurance from each partner organisation. Learning is identified every month by the Board.</td>
</tr>
<tr>
<td>6.</td>
<td>CHFT remains one of the highest performing Trusts nationally.</td>
</tr>
<tr>
<td>7.</td>
<td>The A&amp;E Delivery Board has recognized the negative impact on A&amp;E performance associated with EPR cutover, and this is visible in the performance data.</td>
</tr>
<tr>
<td>8.</td>
<td>iBCF (Improved Better Care Fund) funds have been targeted locally to support delivery of flow and activities that support delivery of the 4 hour target.</td>
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| 7 Identified gaps | 1. Assurance on delivery of Q2  
2. 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.  
3. Local model of community urgent care, linked to work to develop proposed urgent care centres and A&E streaming models. |

**Relevant data:** A&E performance data is shared daily by CHFT to commissioners and is available on request.

**Risk Owner:** Debbie Graham, Head of Service Improvement

**Senior Manager:** Matt Walsh, Chief Officer

**Date review completed:** 29.09.17
Minutes of the Audit Committee Meeting
held on 18 May 2017, 2.00pm
Saville Meeting Room at Dean Clough

FINAL MINUTES

Present

David Longstaff (DL) Lay Member (CCG Deputy Chair) (Chair)
Kate Smyth (KS) Lay Member (Patient and Public Involvement)
Caroline Taylor (CT) GP Member
Jackie Bird (JB) Registered Nurse

In attendance

John Mallalieu (JM) Lay Advisor (Finance, Performance and External Relations)
Neil Smurthwaite (NS) Chief Finance Officer/Deputy Chief Officer
Judith Salter (JS) Corporate and Governance Manager
Andrew O’Connor (AOC) Corporate and Governance Officer (Minutes)
Lesley Stokey (LS) Head of Finance
Jonathan Hodgson (JH) Internal Audit Manager, Audit Yorkshire
Tim Cutler (TC) Manager, Public Sector Audit, KPMG
Liz O’Reilly (LO’R) Local Counter Fraud Specialist, Audit Yorkshire
Rob Gibson (RG) Risk and Health & Safety Manager (for item 4, minute no. 08/17)
Sam Byrnes (SB) Senior Information Governance Officer (for item 6, minute no.10/17)
Penny Woodhead (PW) Head of Quality (for item 7c, minute 11/17 d)

04/17 APOLOGIES FOR ABSENCE

Apologies were received from Helen Kemp-Taylor (Head of Internal Audit, Audit Yorkshire) and Martin Pursey (Head of Contracting and Procurement)

05/17 DECLARATIONS OF INTEREST

DL invited the committee members to declare any interests relevant to items on the agenda.

DL declared a direct professional interest in agenda item 14 (appendix 1k), minute no. 20/17 – ‘Contracting Report’ explaining that he had signed off a number of the tender waivers in question. The Chair advised the committee that he would take part in the item but not make comment on these specific waivers. It was agreed no further action was required.

The Register of Interests can be obtained from the CCG’s website https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG’s headquarters.
06/17  MINUTES OF THE AUDIT COMMITTEE

a) 19 January 2017

DECISION:

The minutes of the Audit Committee meeting were RECEIVED and ADOPTED as a correct record.

b) 11 May 2017

DECISION:

The minutes of the Audit Committee meeting were RECEIVED and ADOPTED as a correct record subject to the following amendment(s):

Minutes Heading
To read: “11 May 2017”

In attendance

“Lay Member” to read “Lay Advisor”

Appendix 1 – Heading
To read “2016/17”

Appendix 1 – Table

“Outstanding” at row 4 to be marked complete

07/17  ACTIONS AND MATTERS ARISING

The actions from the previous meeting were noted to have been completed. There were no matter arising.

08/17  RISK MANAGEMENT ANNUAL REPORT 2016/17

RG in presenting the report highlighted the following:

- The Audit Committee had determined to no longer receive the Risk Register at its meeting on 22 September 2017 and to instead receive assurance on the effectiveness of the CCG’s risk management process biannually.
- NHS England (NHSE) had assessed the CCG’s risk management framework (as set out in a detailed description as part of the CCG’s Annual Governance Statement) as being consistent with their knowledge, experience and understanding of the CCG and its risks.
- Having requested in December 2016 that the Governing Body Assurance Framework (GBAF) be amended to better reflect the CCG’s operational landscape, the Governing Body had approved an updated GBAF at its meeting in April 2017.
- Internal Audit had reviewed the GBAF as part of their wider review of governance and risk at the CCG. An opinion of “significant assurance” had been provided with a single recommendation.
- Following the Audit Committee’s decision to no longer receive the Risk Register, the CCG’s risk cycle had been amended to enable a more timely review of the register by the relevant committees and Governing Body.
Following the closure of Yorkshire and Humber Commissioning Support (YHCS) at the end of 2015/16, Wakefield CCG had taken on responsibility for hosting the Risk Register.

- In March 2016, Calderdale CCG had appointed a Risk, Health and Safety Manager, bringing risk and incident management services in-house.
- In 2017/18, further work would be undertaken with the CCG’s Governing Body concerning risk appetite alongside the ongoing reviews of the CCG’s risk management arrangements and GBAF. An online GBAF system with links to the Corporate Risk Register would also be developed.
- Additional information concerning open risks during 2016/17 was noted to have been provided as appendices to the report.

Comments and questions were invited.

The following points were noted:

- During the year, the committee had appropriately shifted its focus to assurance in line with its remit of eliminating duplication with activity taking place in other committees.

**DECISION:**

The Audit Committee **NOTED** the CCG’s Annual Risk Management Report for 2016/17.

**09/17 GOVERNANCE ASSURANCE REPORT, QUARTER 4, 2016/17**

JS in presenting the report highlighted the following key points:

**a) Freedom of Information Requests**

There had been an improvement in compliance and a reduction in the number of Freedom of Information (FOI) request breaches in Quarters 3 and 4. Work undertaken within the CCG’s Corporate Governance Team to build resilience in support of the CCG’s FOI function had enabled the team to manage occasions of short notice absence and leave during the periods in question. Details of the exemptions that had been applied in Quarters 3 and 4 were presented to the committee as set out at 2.2 in the report.

Comments and questions were invited.

JS/AOC confirmed that FOI requests received came from a wide range of sources and there were no identified trends. AOC commented that the CCG received regular requests from private sector firms working in the health sector, including those specialising in health information and data.

**b) Management of Conflicts of interest**

Additional statutory guidance had been published in March 2017 for the wider NHS concerning the management of conflicts of interest. This guidance made the distinction between staff working in a decision making capacity and those that did not. This distinction was noted to reflect the position the committee had taken with regard to the publication of the CCG’s staff register in 2016.

The six monthly update of the CCG’s Registers of Interest for Staff, Governing Body and Committees and CCG Member’s had been completed on the 22 February 2017.
It was reported that, in the absence of an Audit Committee meeting in March, the updated registers had been reviewed and signed off by the Audit Committee Chair between meetings prior to publication. It was proposed that the authority for the future approval of updated registers be delegated by the committee to the Chair in his role as Conflicts of Interest Guardian. The committee were advised that this change would ensure registers were published promptly whilst also enabling the committee to focus its attention on receiving assurance concerning the CCG’s processes and arrangements for managing conflicts of interest, including its registers. It was noted that the committee would also receive further assurance from the Annual Internal Audit Report.

Comments and questions were invited.

The committee agreed that the proposal was logical but wanted to be assured that appropriate governance arrangements in place. The Committee was conscious that the Chair should not be in the position of assuring themselves concerning the approval of the registers. This was noted. JS commented that the committee received an additional level of assurance in the Annual Internal Audit Report.

DECISION:

The Audit Committee AGREED that the authority for the approving of all of the CCG’s Registers of Interest be delegated to the Chair of the Audit Committee in their role as Conflict of Interest Guardian.

c) Declaration of Interests – Online Portal

The Committee was updated on the Declaration of Interest Portal which had been developed with colleagues at Greater Huddersfield CCG and The Health Informatics Service (THIS). The benefits and advantages of the system, as set out in the report, were highlighted to the committee. The portal was scheduled to be rolled out to staff in May 2017.

Comments and questions were invited.

JS confirmed that the portal complied with all current statutory guidance and requirements.

d) Non-Compliance with Standings Orders

The CCG’s Prime Financial Policies were reported to require the Chief Finance Officer/Deputy Chief Officer to prepare and submit budgets for approval by the CCG Governing Body prior to the start of the financial year. In March 2017, the CCG was not in a position to recommend its budgets for 2017/18 and 2018/19 for approval due to ongoing work on recovery. Consequently, the item was deferred until its April 2017 meeting with the support of the Audit Committee Chair.

e) Corporate Incidents and Claims

RG reported the following:

- There had been 15 incidents reported across Quarters 3 and 4 including three Health and Safety related incidents and 12 relating to Information Governance.
- The most frequent type of incident related to 3rd parties sending personal information by post, email or fax (eight incidents).
- Those involved in an incident were contacted by the CCG.
- Incidents were followed up by the CCG’s Information Governance Team.
- Clinical incidents reported by GP Surgeries were reported to the Quality Committee
on a six monthly basis for assurance.
- All 26 practices had access to and were using DATIX.
- Incidents originating at Calderdale and Huddersfield NHS Foundation Trust (CHFT) were passed to the Trust’s Patient Complaints Team.
- Quarterly DATIX incident reports were presented to the Practice Managers Action Group for dissemination with patient safety bulletins written and cascaded to all surgeries when recurring themes could be identified.

Comments and questions were invited.

CT explained that there were issues around GP practices expectations regarding feedback when they have reported an incident. She felt this impacted on the overall reporting of incidents. RG provided the committee with examples of the actions taken to inform practices of the outcomes of reported incidents. In response to a suggestion, RG agreed to look at the introduction of an option on DATIX which practices could select if they wished to receive feedback. JS advised the committee that RG would be following up on issues previously identified to establish whether changes have been put in place as result of advice and guidance.

f) Business Continuity and Emergency Planning Resilience and Response

RG reported on exercise “Mondas” which took place on 27 January 2017. It was noted to have benefited the three CCGs involved during the international ransomware attack that affected the NHS between the 12th and 15th May 2017.

Comments and questions were invited.

RG confirmed that the CCG and Calderdale and Huddersfield NHS Trusts (CHFT) had not been significantly affected by the cyber incident.

g) Tour de Yorkshire

RG reported that the providers had supplied assurance concerning their plans for the event and that it had gone ahead without incident.

DECISION:

The Audit Committee RECEIVED the Quarter 4 Governance Assurance Report.

ACTION:

a) RG to explore possible introduction of a feedback request option on DATIX.  

10/17  ANNUAL SENIOR INFORMATION RISK OWNER REPORT (SIRO)

NS in presenting the Annual Senior Information Risk Owner’s Report advised the committee that the content built on information that had been submitted throughout the year. Furthermore, that it provided assurance regarding organisational compliance with the Data Protection (DP) and Freedom of Information (FOI) Acts. The following key points were then highlighted:

- One Serious Incident Requiring Investigation (SIRI) had occurred during the year.
- The CCG had scored 98% on the Information Toolkit which represented an improvement and a very positive outcome.

Comments and questions were invited.

In response to a question, SB confirmed that further work was being undertaken to
embed Privacy Impact Assessments in the CCG’s financial recovery processes and that these were now part of the Equality Impact Assessment (EQIA) checklist.

In response to a question, SB confirmed that issues concerning deactivation of leavers IT accounts were the result of both CCG and THIS processes and that work in 2017/18 would be undertaken to address this.

**DECISION:**

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

**11/17 COMMITTEE ANNUAL REPORTS:**

**a) Finance and Performance Committee**

JM in presenting the committee’s Annual Report highlighted:

- positive changes regarding the way in which the committee delivered its business (set out at 2.6);
- improvements to how the committee received information and reports (set out at 4.7);
- the ongoing challenge presented by Quality, Innovation, Productivity and Prevention (QIPP) targets (set out at 4.6);
- changes within QIPP programme and Monitoring Group (now the Recovery Operational Group) (set out at 4.6);
- that the self-assessment had recognised and reflected the positive progress and that further work was still required.

Comments and questions were invited.

**b) Commissioning Primary Medical Services**

JM in presenting the committee’s Annual Report highlighted:

- a change to the Terms of Reference enabling the committee to approve policies in respect of all areas of its responsibilities (as set out at 3.3);
- changes to the Terms of Reference regarding formalisation the role of the committee in respect of reviewing the principal risks in the Governing Body Assurance Framework (GBAF) relating to the commissioning of primary medical services and other risks within its remit (as set out at 3.3);
- the importance of connecting the committee with the assurance provided by other CCG committees, in particular Finance and Performance and Quality (as set out at 5.1);
- that the committee’s workload would remain at a similar level for a time but might increase in response to Accountable Care Agenda

Comments and questions were invited.

JM confirmed that the committee had become better at recognising and managing conflicts of interest. Furthermore, that the committee had a sensible approach to this aspect of committee business.
JM confirmed that meetings were attended by the public, but that numbers had tailed off toward the end of the year.

c) Remuneration Committee

KS in presenting the report highlighted the following:

- HR policies that required no or only minor amendment were now being reviewed and approved via a formal electronic process enabling a better use of committee time and CCG resource (as set out at 6.4)
- the committee now only received a single set of summary minutes (as reflected in the proposed change to the Terms of Reference)
- a proposed change to the Terms of Reference delegating decision making authority to the Remuneration Committee concerning appropriate levels of remuneration, fees and other allowances (as set out at 4.0)

Comments and questions were invited.

JM noted that it was important that the committee had the right level of HR support and advice going forward.

KP identified that the attendance table at Appendix 2 should read “Registered Nurse / Secondary Care Specialist”.

d) Quality Committee

PW in presenting the report highlighted the following:

- the committee’s Annual Report provided examples of the activities undertaken during the year covering patient safety, effectiveness and experience;
- revisions to strengthen the Quality Dashboard;
- reductions in the frequency of reports in areas where significant assurance had been provided;
- development of the Primary Care Dashboard and receipt of this by the committee
- changes to the timing of meeting to enable members to attend;
- ongoing work to enable the committee to fulfil its responsibilities around assurance of the CCG’s Individual Funding Request (IFR) process and approval of its commissioning policies following review;
- the committee requiring GP Leads attending meetings with managers to present reports and proposals.

Comments and questions were invited.

PW assured the committee that the impact of the Individual Funding Request (IFR) responsibilities should not have an overly adverse impact on the committee’s workload; although, that this would need to be monitored.

DECISION:

The Audit Committee RECEIVED the Committee Annual Reports.

12/17 AUDIT COMMITTEE SELF-ASSESSMENT

DL presented the Audit Committee’s Annual Report inviting comments.

TC noted that the comments relating to the work of either Internal or External Audit
could be addressed during a scheduled private session.

It was confirmed that there would be a committees/self-assessment related item at a future Governing Body Workshop.

DL advised the committee that he would circulate a link to online training resources produced by Internal Audit.

DECISION:

The Audit Committee reviewed the results of the self-assessment and IDENTIFIED development areas and actions to be taken forward in 2017/18.

ACTION:

a) Internal and External Audit issues arising from the committee’s self-assessment to be addressed as part of the committee’s next private session

13/17 AUDIT COMMITTEE DRAFT ANNUAL REPORT

DL in presenting the committee’s draft annual report highlighted the following positives concerning the committee’s work during the year:

- the decision to reduce the number of committee meetings in response to the significant level of assurance received
- work to meet the revised requirements relating to conflicts of interest
- establishment of the CCG’s Auditor Panel

DECISION:

The Audit Committee APPROVED the content of the annual report, subject to amendment following the review of the committee self-assessment findings and review of the Quality, Finance and Performance, Commissioning Primary Medical Services and Remuneration Committee Annual Reports.

14/17 HEAD OF INTERNAL AUDIT OPINION 2016/17 AND DRAFT INTERNAL AUDIT ANNUAL REPORT

JH in presenting the report advised the committee that an opinion of “significant assurance” had been provided with very little negative commentary. He made the following points:

- all reports, including three in draft awaiting sign of by managers, provided “significant assurance”;
- a number of “significant assurances” provided were of a very high level;
- Internal Audit would be introducing a higher assurance rating;
- a summary of Internal Audit’s work in-year was set out at section 3;
- a summary of activity against the 2016/17 work plan was set out in section 4;
- 13 days had been deferred to 2017/18;
- 8 days had been allocated to facilitate work relating to Local Security Management in-year.

Comments and questions were invited.

JH confirmed that recommendations made in the reports were followed up with the relevant managers to ensure that they had been actioned and were included in internal
audit progress reports submitted to the committee.

DECISION:

The Audit Committee RECEIVED the Head of Internal Audit Opinion 2016/17 and Draft Internal Audit Annual Report.

15/17 EXTERNAL AUDIT ISA 260 REPORT

TC in presenting the ISA 260 Report advised the committee that very little was outstanding to date and that the work of the CCG’s Finance Team should be recognised. He went on to focus on the following as unique to the 2016/17 report:

Financial Statement Audit

- an “unqualified opinion” with no unadjusted audit difference and only a small number of presentational changes had been provided;
- the Letter of Representation on the Accounts was outstanding but would be signed in the near future;
- a final review the CCG’s Annual Report and Accounts and Annual Governance Statement would be undertaken in due course;
- there was nothing to note with regard to the regularity of transactions;
- there were no issues to raise concerning NHS Shared Business Services (SBS), NHS Business Services Authority (BSA) or IBM Electronic Staff Record reports (ESR);
- Capita and NHS Digital had been issued with an “adverse opinion” and “qualified opinion” respectively for the reasons outlined in the report;
- work had been undertaken to address risks associated with accounting for delegated primary care co-commissioning expenditure in-year and the intention was to further reflect during the debrief process and to look at national best practice to mitigate the risk;
- work addressing risks posed by secondary healthcare agreements had proved positive with only a small number of disputes;
- areas of judgement and estimation in the accounts were noted as set out in the report;
- audit fees were noted as set out in the report;
- a fee variation would be submitted for approval relating to the additional work that was required due to the absence of third party assurance concerning internal controls at Capita.

Value for Money

- work undertaken regarding the identified financial sustainability risks were noted as set out in the report
- the committee were advised that the information provided assurance that the CCG had robust arrangements in place for meeting the financial challenge

TC concluded:

- no recommendations had been raised as part of the 2016/17 audit
- any unadjusted audit differences were mainly presentational in their nature and set out at Appendix 2
- external audit were satisfied that the inconsistencies relating to whole Government Accounts were appropriate and would report these to the National Audit Office as required
- the statement of audit independence could be found at pp20- 21.

Comments and questions were invited.
Positive comment was made concerning the new systems utilised during the audit and the intention to review the process undertaken was confirmed.

NS assured the committee that the risk concerning Capita and NHSD reports was the same for all CCGs.

DECISION:

The Audit Committee NOTED the content of the External Audit ISA 260 Report.

16/17 ANNUAL REPORT AND ACCOUNTS

Annual Report

JS in presenting the Annual Report highlighted a number of completed or anticipated revisions for the committee’s information:

- Audit Committee attendance figures would be updated following the meeting (p78);
- new tables had been inserted with minor amendment (p92);
- the Chief Finance Officer/Deputy Chief Officer title would be amended following the meeting (p92);
- a disclosure concerning the remuneration of the Chair had been inserted at section 8, “Pay Multiplies2 (p93). The wording inserted had been agreed with External Audit and a further amendment of “and this was considered reasonable” proposed.
- Gender profile data and definitions had been amended (p95);
- information concerning the names of consultants been removed on advice from External Audit (p98);
- consultancy costs had been amended (p98);
- sickness absence information would be updated (p95).

JS concluded that, subject to the advised changes and outstanding queries, the Annual Report would be signed off by the Chief Officer and Chief Finance Officer/Deputy Chief Officer for submission to NHS England (NHSE).

DL concluded that the Annual Report reflected well the extent of the work undertaken by the CCG over 12 months.

Annual Accounts

LS in presenting the Annual Accounts highlighted the following changes:

- a statement had been inserted disclosing the CCG’s estimation of prescribing costs (p6, 1.7.2);
- Central Manchester University had been added as a body of the Department of Health with which the CCG had material transactions in-year (p32).

Comments and questions were invited.

- LS confirmed that Leeds Teaching Hospital had also been added to as a body of the Department of Health with which the CCG had material transactions during in-year (p32);
- DL noted that he should be described as the Audit Lay Member for both Calderdale and Greater Huddersfield CCGs (p32).

DECISION:

The Audit Committee APPROVED the CCG’s Annual Report, Accounts and Annual Governance Statement 2016/17.
DL concluded the item confirming that the Annual Report, Accounts and Annual Governance Statement would be signed off by the Chief Officer and Chief Finance Officer/Deputy Chief Officer and submitted by the required deadline.

17/17 LETTER OF REPRESENTATION ON THE ACCOUNTS

NS explained that the letter would be signed as part of signing off the Annual Report and Accounts.

DECISION:

The Audit Committee NOTED the letter of representation on the accounts.

18/17 INTERNAL AUDIT

Internal Audit Progress Report

JH presented the progress report as circulated and invited questions and comments.

In response to a question, LS confirmed that the Finance Team had a new structure in place to address the recommendation concerning the review and authorisation of control accounts, reconciliations, journals, budget virements and credit notes. IC advised that External Audit could provide assurance for those cases where the item had been reviewed and authorised by the same person.

Internal Audit Draft Work Plan 2017/18

JH in presenting the Draft Work Plan 2017/18 explained that, the plan had been agreed with broad objectives to provide flexibility. The CCG’s Recovery agenda was also noted to run throughout and across activities. He went on to highlight that the work of other CCGs would be drawn on via an open and transparent approach to the sharing of information and best practice. He also explained that there was an intention to assign specialist auditors to audit areas rather than to individual CCGs.

The committee welcomed the agreement to share information and best practice across CCGs.

In response to a question, NS confirmed that the flexibility in the work plan would allow the CCG to ensure that the work requested contributed to the CCG’s priorities and direction of travel.

JH went on to explain that he would like to link each audit area to the Governing Body Assurance Framework (GBAF). Contingency days were also noted to be built into the plan.

Counter Fraud Progress Report

LO’R in presenting the Counter Fraud Progress Report highlighted the following:

- there had been no reports of fraud as a result of the National Fraud Initiative
2016/17;
- mandatory fraud training was at 85% with follow up sessions set to take place
- an information breach (as set out at 4) reported by the Corporate and Governance Manager;
- NHS Protect would be called the NHS Counter Fraud Authority from 1 April 2017.

**Counter Fraud Annual Report 2016/17**

LO’R in presenting the Annual Report 2016/17 explained that the activity undertaken during the year was set out against the four NHS Protect principles. Comments and questions were invited.

Comments and questions were invited,
- LO’R confirmed that to be rated as “green” in terms of compliance against standards, a case would have had to have arisen during the year.

**Counter Fraud Draft Work Plan 2017/18**

LO’R in presenting the Draft Work Plan explained the content was set out against the four NHS Protect principles. The overall number of days allocated in the plan was reported to be set at 18 (10% fewer than in 2016/17). The committee was asked to note that additional days could be required should the CCG be subject to an assessment.

Comments and questions were invited,
- LO’R confirmed that gaps and potential areas for improvement had been assessed and actions put in place.
- LO’R confirmed that information concerning fraud in other areas was taken into account when assessing risks.

**Local Security Management (LSM) Annual Report 2016/17**

The committee confirmed and noted that the approval of LSM Work Plan had been aligned with the committee’s other work plans. Also, that as the work plan for 2016/17 had only been agreed late in 2016, the activity to be reported to date would be limited.

JH in presenting the Annual Report highlighted that work undertaken had been set out against the four NHS Protect principles. Comments and questions were invited.

In discussion the committee:
- agreed to incorporate the LSM and Counter Fraud in-year progress reporting and Annual Reports.

**DECISION:**

The Audit Committee:

1. **RECEIVED** the above Progress and Annual Reports
2. **APPROVED** the above Work Plans for 2017/18
3. **AGREED** to incorporate the Internal Audit, LSM and Counter Fraud in-year progress reporting and Annual Reports.

19/17 REVIEW OF AUDIT COMMITTEE WORK PLAN – 2017/18

DL presented the Audit Committee Work Plan 2017/18 for comments.

In discussion, the following was concluded:

- Line 16 – there would be no Annual Audit Letter for 2017/18;
- Lines 13, 14 and 15 – may require amendment in light of the committee’s decision to explore the possible incorporation of the Local Security Management and Counter Fraud in-year progress reporting and Annual Reports.

TC advised the committee that it may need to consider how it assesses External Audit Performance.

**DECISION:**

The Audit Committee **APPROVED** the Audit Committee Work Plan 2017/18 subject to the above amendments.

20/17 CONTRACTING REPORT:

BP advised the committee that the report and appendices provided assurance that the CCG was following its agreed processes for contracts, tenders waivers.

**Contracting Report**

- Two tenders (Assistance Technology and Weight Management Service – Tier 3) had been completed and contracts awarded.
- A contract below the value of £50k for IT Services including Printing, Landlines and Telephony had been awarded.
- Procurement for a Medicine Optimisation Contacts was scheduled to commence at the end of May.

Comments and questions were invited.

**Waivers**

- Waiver documentation was noted to have been provided at Appendix 1a-1m.
- The number of waivers received by the committee was reported to be a consequence of year-end.
- The waivers relating to Intermediate Care contracts were noted to be for two years but that the contracts only ran for 12 months.
- The GP Local Enhanced Services Contract was noted to be under review and that the waiver granted was for 12 months with the possibility of it ending earlier.
- The Eclipse Analytics waiver was noted to relate to a two year contract Medicines Management Contract.

**Contract Report**

BP advised the committee that, as per its request, the information being reported was by exemption. She provided assurance that the major contracts were all completed and that those outstanding were mainly community contracts which had not been returned.
Questions and comments were invited.

- BP assured the committee that all the contracts were agreed.
- NS explained to the committee that the CCG in respect of its waivers operated better than in other places. Furthermore, the processes Calderdale CCG had in place ensured the reasons for the waivers being granted were appropriate.

**DECISION:**

The Audit Committee **NOTED** the contents of the report, appendices and progress to date.

**21/17 ITEMS FOR GOVERNING BODY AND/OR OTHER COMMITTEES**

**DECISION:**

The Audit Committee **AGREED** the following as being for the attention of the Governing Body and other committees:

a) Approval of Annual Report, Accounts and Annual Governance Statement  
b) Standardisation of approach to Committee Self-Assessment

**22/17 DATE AND TIME OF THE NEXT MEETING :**

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

Audit Committee  
21 September 2017, 2.30pm to 4.30pm,  
Saville Meeting Room, Dean Clough

**23/17 REFLECTIONS ON THE MEETING**

The meeting was agreed to have been positive.
<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>Governance Assurance Report – Business Continuity and EPRR</td>
<td>09/17</td>
<td>a) RG to explore possible introduction of a feedback request option on DATIX.</td>
<td>RG</td>
<td>COMPLETE</td>
<td>Sept 17</td>
</tr>
<tr>
<td>Audit Committee Self-Assessment</td>
<td>12/17</td>
<td>b) Internal and External Audit issues arising from the committee’s self-assessment to be addressed as part of next private session</td>
<td>DL/AOC</td>
<td>COMPLETE</td>
<td>Sept 17</td>
</tr>
</tbody>
</table>
Minutes of the Finance and Performance Meeting
held on 27 July 2017, 3pm,
in Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present
Neil Smurthwaite  (NS)  Chief Finance Officer/Deputy Chief Officer
John Mallalieu  (JM)  Lay Member to the Governing Body
Dr Alan Brook  (AB)  GP Member Governing Body and CCG Chair

In attendance:
Lesley Stokey  (LS)  Head of Finance
Debbie Graham  (DG)  Head of Service Improvement
Debbie Robinson  (DR)  Head of Primary Care Quality and Improvement
Yvonne Hoorman  (YH)  Principle Contracts Manager
Matthew Bleach  (MB)  Business Intelligence Analyst
Shabana Bari  (SB)  Business Intelligence Analyst
Zoe Akesson  (ZA)  Corporate Services – minute taking
Dr Farrukh Javid  (FJ)  GP Governing Body
Rhona Radley  (RR)  Service Improvement Manager
Rob Gibson  (RG)  Risk Manager
Sarah Antemes  (SA)  Head of Commissioning for Continuing Care/Funded Nursing Care

Observing:
Dr Rob Atkinson  (RA)  Secondary Care Specialist

284/17 APOLOGIES FOR ABSENCE

Apologies were received from Penny Woodhead (PW) (Head of Quality), Tim Shields (TS) (Head of Performance), Martin Pursey (MP) (Head of Contracting and Procurement), Dr Nigel Taylor (GP Member Governing Body and Meeting Chair), Dr Steven Cleasby (SC) (GP Member Governing Body), Matt Walsh (MW) (Chief Officer).

285/17 DECLARATIONS OF INTEREST

The Committee members did not declare any interests relevant to items on the agenda.

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.

286/17 MINUTES OF THE FINANCE AND PERFORMANCE MEETING 29 June 2017

DECISION:

The minutes of the 29 June 2017 meeting were RECEIVED and ADOPTED as a correct record, subject to the following amendment;

Item 275/17 action to articulate what the conversation was regarding. The action was amended to read;

‘To seek assurance that a conversation has happened with the Cancer Laryngectomy Society about the current volume of work they are delivering’
to enable us to learn about the consequences of the decision’.

287/17 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:

250/17 Risk Register (reflecting on how the decline of A & E performance is impacting on patient safety and experience) PW and DG to action for next risk cycle following discussion at A and E Delivery Board. Action was carried forward.

260/17 (a) The Full Business Case is to be delivered to CHFT’s Governing Body on 03/08/17. Calderdale CCG received a copy on 27/07/17. The Committee asked for assurance around the key assumptions prior to it being discussed at the next CCG Governing Body meeting. NS assured the Committee that the assumptions and activity in the business case were broadly in line with the assumptions in Calderdale CCG’s financial plan however these are to be revisited to provide assurance to the Committee. To take to August’s meeting for debate. Action carried forward.

275/17 – Recovery Report - assurance that a conversation has happened with the Cancer Laryngectomy Society. DG to follow-up. Action carried forward.

276/17 - Performance Report - action to bring back findings from A and E data and trends of patients referred for cancer treatment. TS to bring back next time. Action carried forward.

277/17 (b) - SpaMedica activity - fact finding exercise continues in order to establish how SpaMedica is able to access CCG as a choice. The Committee accepted this response however there was still a need to understand why the CCG is accepting the £200k overtrade and the Committee wanted to know what action was required to close the loop hole. MP to bring back next time. Action carried forward.

288/17 FINANCE REPORT

The paper was noted by the Committee. LS highlighted the key messages.

The CCG was forecasted to meet its planned drawdown of £3.13m however there was a significant risk to achieving this. In month 3 the CCG was showing an unmitigated risk of £2.4m to reflect the level of uncertainty in relation to QIPP delivery and potential contract overtrades.

The QIPP target was £11.5m. Part of the process with NHSE is to attach some risk to that and it was thought useful to share this with the Committee. There was risk adjustments attached to various QIPP schemes. With a projected delivery against the £11.5m, the overall QIPP risk is £5.1m

This month the CCG was asked by NHSE to send a report on what it is doing to address the QIPP gap. There was a section in the report around stretch QIPP schemes which included;

- Health optimisation
- Procedures of limited clinical value, looking at how our existing schemes align with the overall opportunity
- Menu of opportunities working on MSK and frailty
- Accessing national QIPP support has helped identify areas to target such as Continuing Health Care and MSK pathways
- Right Care opportunities in planned care, emergency care and prescribing
- Looking at BCF and iBCF to understand how areas contribute to managing
risk in the health sector.

The Committee was helped to understand the statement of ‘procedures of limited clinical value’, which was raised by FJ.

Following a discussion on QIPP stretch and understanding the risk against the initiatives, the Committee sought assurance on the CCG’s risk assessment process. NS explained it is discussed at the Recovery Operational Group (ROGr) and taken through the CCG’s internal process. It was included in the report so that the Committee had more oversight and agreement on the CCG’s risk assessment. The CCG has been asked by both NHSE and NHSI to provide a system recovery plan of how it will bridge the gap. Hopefully by September / October there will be a plan in place that can mitigate these risks, recognising the part year affect.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.

289/17 RECOVERY REPORT

NS updated the Committee on 2 key pieces of work happening over the next 2 months that will enable the CCG to give assurance of where it is around risk and mitigation. They were not included in the recovery report as the information was not available at the time the report was submitted.

North of England Commissioning Support (NECS) - NHS England has provided an 80 day consultancy to each CCG to help delivery of their QIPP savings. Calderdale CCG was grouped with North Kirklees and Greater Huddersfield to ensure synergies, economies of scale and maximisation of the consultancy days. The work is being jointly undertaken with Calderdale and Huddersfield NHS Foundation Trust. The first is a high level piece of work with 2 senior NHS officials to see how we work as a system. The second is involving work around outpatients as both CHFT and both CCGs have recognised an opportunity for savings in this area. The 80 day specification has been completed. It will be brought to Finance and Performance Committee for information and hopefully concluded by the end of September.

STP Financial Strategy - York Health Economics Consortium has been commissioned by the West Yorkshire and Harrogate STP to undertake some modelling work to assist with the development of the STP financial strategy. Work will take place across a Greater Huddersfield and Calderdale footprint involving both CCGs, both Councils and the acute hospital. Two clinicians Dr Farrukh Javed and Dr Alan Brook have also been asked to be involved. This work is very time limited and outputs will be shared at the Healthy Future’s workshop in October. With regards to the STP lead process it was highlighted that Farrukh was not a formal member of this committee and that the invited attendee status needed to be changed in order for him to report back for the duration of STP works.

System Risk Reserve - The Committee was informed of 2 changes that will impact on the CCG’s QIPP target. A letter was received from Paul Bauman, Director of Finance for NHS England (NHSE) explaining a change to Category M drugs. Following the recent price reduction for Pregablin, the price difference which would have benefited the CCG’s QIPP target will now be retained by NHSE. Secondly, the acute trust is required to retain part of its CQUIN as a risk reserve. The CCG has received some guidance from NHSE around compliance with this requirement and will feedback through the finance and contracting
The main focus at ROGr in June was to look at ways of reducing the £2.4M QIPP gap. The stretch opportunities were received by the Committee for consideration. The Committee was asked if they were comfortable with the risks that had been noted moving towards a stretch opportunity rather than the proposed target.

The Committee was asked to agree to maintain the stretch ambitions based on an understanding of the risk mitigation. RR assured the Committee that all the size and scale in the stretch targets were NICE compliant. It was noted that there was no indication of how critical the risks are. RR agreed it would be useful to add a RAG rating column.

DR highlighted that following the recent changes, in Category M prescribing, the group can no longer work on the assumption of a £0.5m opportunity in relation to Pregablin. In light of this, ROGr would be challenged at changing the volume of drugs in order to save money on prescribing. Prescribing was put on the agenda for discussion at the Joint Practice Leads and Practice Managers meeting on 20/09/17.

The Committee felt it could ENDORSE the journey towards continuing to develop plans to tackle the £2.4m shortfall and in doing so recognises services will change and will be prioritised due to opportunity and potential.

ACTION:

a) To add RAG rating column to the stretch table to show risk status.
b) To liaise with Judith Salter with regards to changing the invited attendee status of Finance and Performance Committee to include Dr Farrukh Javid

290/17 CONTINUING HEALTHCARE COMMISSIONING PRINCIPLES POLICY

The policy was received by the Committee. It had previously been to Quality Committee where it was supported. The reason behind the policy was to provide guidelines for making decisions that would help when negotiating with families and individuals. SA reassured the Committee that although this decision making currently happens the policy would establish a process to ensure resource allocation is a consideration when deciding on a package of care and that the same principles are applied to decision making.

Discussions followed around the cost of care at home, how the policy would help to balance what the alternatives are and deliver the best quality of care at the most cost effective place. The policy could also be used at discharge and help with fast track and end of life conversations.

It was noted that there was not a premium over and above residential care in the policy however the Committee AGREED the wording that care home actual cost should not generally exceed. NS highlighted that for governance and internal assurance processes costs do need to be clearly documented to evidence the decision.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided. The
Committee SUPPORTED the recommendation subject to the following;

- To remove the sentence around other CCGs capping at 10%, as our policy does not do this.

- To provide an explanation in the document around the consultation process, which took place in 2015, clarifying why their contribution is still relevant and that it is clear and applicable for this decision.

- To check wording of point 6.1.7 with regards to the Human Rights Act 1998 to ensure it is appropriate and complies with other policies.

- It was noted that the F & P cover sheet recommendations should have read ‘to support the recommendation for the policy’. In light of this, once the amendments have been made the policy can be sent the Governing Body for approval. Papers are to be backdated to 31/04/17.

291/17 CONTRACT REPORT

The report was received by the meeting. YH updated the committee on the key messages.

The contract position for CHFT had shifted from an over-trade of £150k to an under-trade of £31k mainly due to a decrease in outpatient activity which was closely related to EPR issues. The position includes an estimate for EPR related issues which is still being worked through. Discussions were taking place with regards to timescales for corrections to be made.

Referral demand had seen a large decrease in April due to temporary closure of EPR and has subsequently seen an increase in May. Year to date GP referrals were down by approximately 6% (512) largely related to a reduction in Trauma & Orthopaedics and General Medicine.

Data quality of referrals and waiting list data was still in question but continuing to request updates on regular basis to enable contacting to consider the real impact of EPR.

Further to the action from last month, Quest for Quality in care homes and how delivery would be in the future was discussed. YH updated the Committee that early discussions are being held to fully integrate community services provided to care homes which will involve reviewing the whole pathway, including the Quest Team, Psychiatric Liaison Service and Psychologist. It was clarified that the action required was to understand the original baseline of the service prior to the expansion to all care homes and understand performance compared to this.

The risk around the wheelchair provider not agreeing to extend the contract was raised. Greater Huddersfield CCG is leading a piece of work to implement proposed service changes to help manage demand and mitigate risks. Contract extension has not been confirmed and a discussion was to take place at SMT early August with regards to non-recurrent funding.

It was noted that the bidder session for the Joint Commissioned Infrastructure for the Third Sector has taken place and the process had started. MP will be involved in this.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.
**ACTION:**

To include original baseline and clarification on assumptions in next contracting F&P report.

**YH**

**PERFORMANCE REPORT**

The report was received by the Committee. MB highlighted the key messages.

New ambulance standards are to be rolled out across the country, which will impact on what is deemed to be an 8 minute call and influence the rules around the ‘stop the clock’.

Sustaining the 4hr target in A and E has deteriorated in April. Assurance was sought at the A and E Delivery Board on the impact to patients. June’s performance improved to 93.5%. CHFT are still in the top percentile for performance in region.

There was a dip in performance around the diagnostic waiting times. 99 % of patients should wait no less than 6 weeks from their referral however in April this deteriorated to 90.4%. There was an improvement in May to 98% with the expectation of a full recovery in June.

Patients should wait no longer than 2 weeks for their first outpatient appointment following an urgent referral from their GP. During May 85.9% was achieved against a constitutional standard of 93%. The key issues for this were around workforce and capacity. CHFT put an action plan in place to address this, which included additional admin for booking centres, capacity to support some specialities, consultant cover for Dermatology and a deep dive was planned for July to ensure sustainable improvement. It was anticipated that further issues would continue during June but a full recovery is expected by July.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**RISK REGISTER**

The risk register and report was received be the Committee. RG provided an update on the main movement over risk cycle 2 (19 June - 10 July). There were currently 36 risks, 18 of which were Finance and Performance open risks and 7 risks after closure.

Following review of the register the Committee asked for risk ID 849 to be reworded as ‘GPs and other referrals’.

The committee asked for risk ID 1024 to be reworded as it was not clear if this should be CCCG or ‘CCCG and the system’ to ensure the system model is affordable going forward. Following discussion, the Committee AGREED it was both CCCG and the system that need to take ownership of the whole system’s affordability.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided. The Committee asked for the following amendments to be made:
ACTION:

To amend risk ID 849 to read;
‘….and increase demand in terms of GPs and other referrals’  
RG

To amend the risk ID 1024 to read;
‘The risk is that Calderdale CCG may not have the appropriate QIPP schemes in place to ensure that its contribution to the system model is affordable going forwards. This may result in non-achievement of control total through non achievement of QIPP targets’.  
RG

294/17  WORK PLAN

The work plan was reviewed and no action was required.

295/17  BCF

The Better Care Fund quarterly update was received by the Committee.

DG informed the meeting that the BCF guidance had been published and the CCG was working towards identifying a plan to be submitted on 11/09/17. The CCG had received clarity around the iBCF allocation for Calderdale and the conditions by which it has to be allocated. The CCG made a submission on 21/07/17 that gave a high level view of where the money will be spent in Calderdale. All CCGs have to agree the plan. The A & E Delivery Board is also actively being sighted on proposals in order for it to help fit with system pressures.

It was noted that the BCF Board has now been consumed into the Integrated Commissioning Executive (ICE) meeting, which is chaired by Dr S Cleasby. The BCF Operational group will continue to provide support at an operational delivery level reporting to ICE.

DG informed the Committee that the plan would not be available for the Health and Wellbeing Board (HWBB) on 17/08/17. It has been proposed that the HWBB’s Chair has sight of it so it is retrospectively presented. DG suggested it may not be necessary to call an extraordinary meeting to present the plan as this could happen at the next Finance and Performance Committee on 31/08/17.

NS gave the Committee further assurance around the 4 funding streams. The CCG is currently working with the council looking at spend in these categories.

The DTOC deep dive has been completed.

Social Care has been asked to share their data on demand for home care, which will be included in the A and E dashboard going forwards.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.

296/17  IMPROVEMENT AND ASSESSMENT FRAMEWORK

The result was announced on 21/07/17. Calderdale CCG had gone done categories to ‘requires improvement’, which was heavily weighted towards financial performance in year. MW gave a video message to staff on the result. TS did a piece of work for SMT around actions to help improve the position,
which will be brought back to the next F & P Committee.

ACTION:

To present actions around improving the Assessment Framework rating at the next meeting.  

297/17  RECOVERY SCHEMES

Covered under item 289/17

298/17  KEY MESSAGES

Matters for the Governing Body
- Finance and recovery information

Matters for the Senior Management Team
- Continuing Healthcare Commissioning Principles
- Deep dive on DTOC
- Continued focus on QIPP

Matters for Local Medical Committee
- Referrals
- Threshold work

Matters for Primary Medical Services Committee - nothing to report

Matters for CHFT Partnership Board - nothing to report

299/17  MINUTES FROM THE A & E DELIVERY BOARD 13/06/17

The minutes were received by the meeting. DG added that the A & E Delivery Board is part way through developing an action plan, which will bring together national and regional assumptions on delivery.

300/17  ANY OTHER BUSINESS

It was noted that Primary Medical Services Committee should be included under key messages for future agendas.

301/17  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  
31 August 2017, 3.00 – 5.00pm  
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>Recovery Update</td>
<td>246/17(b)</td>
<td>Recovery Recommendations to be brought forward to Governing Body - taking recommendations through.</td>
<td>All</td>
<td>Closed</td>
<td>27/07/17</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>c/fwd</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 – Dr Helen Davies and Dr Nigel Taylor to pick up taking through cancer network.</td>
<td>MW</td>
<td>Closed</td>
<td>27/07/17</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 - to bring back to F &amp; P for debate in August.</td>
<td>NS/LS</td>
<td>In progress</td>
<td>31/08/17</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>Closed</td>
<td>29/06/17</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>Closed</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- on the agenda and covered under the recovery report</td>
<td>SMT</td>
<td>Closed</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>Closed</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. In progress, as part of medicines management review work that is ongoing. Action closed.</td>
<td>LS/HD</td>
<td>Closed</td>
<td>27/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) To seek assurance that a conversation has happened with the</td>
<td>DG</td>
<td>In progress</td>
<td>31/08/17</td>
</tr>
</tbody>
</table>
| **Performance Report** 276/17 | 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. | TS | In progress | 31/08/17 |
| --- | --- | --- | --- | --- |
| **Contracting Report** 277/17 | a) To clarify how QUEST and its delivery will be reviewed in the future – included in the contracting report.  
   b) To provide an update on SpaMedica activity – fact finding exercise continues, further update at next meeting. | MP | Closed | 31/08/17 |
| **RCRTRP** 279/17 | To send presentation slides to JM – actioned. | Jen Mulcahy | Closed | 27/07/17 |
| **Key Messages** 280/17 | To inform the relevant admin support of F & P items for referral to GB, SMT, LMC and CHFT Partnership Board – actioned. | ZA | Closed | 27/07/17 |
| **AOB** 282/17 | a) To check the IG rules around the length of time a recording can be retained – at present it is 20 years for minutes of committees. The minutes are then to be archived nationally. The same rule would apply to audio recordings of committee meetings.  
   b) To seek advice on chairing arrangements | ZA | Closed | 27/07/17 |
| **Recovery Report** 289/17 | a) To add RAG rating to stretch table  
   b) To speak to Judith Salter re changes to the invited attendee status of F & P to include FJ | RR | Open | 31/08/17 |
| **Contract Report** 291/17 | a) To include original baseline and clarification on assumptions in next contracting F&P report | YH | Open | 31/08/17 |
| **Risk Register** 293/17 | b) To amend risk ID849 to read;  
   ‘and increase demand in terms of GPs and other referrals’  
   c) To amend risk ID1024 to read;  
   ‘The risk is that Calderdale CCG may not have the appropriate QIPP schemes in place to ensure that its contribution to the | RG | Open | 31/08/17 |
system model is affordable going forwards. This may result in non-achievement of control total through non-achievement of QIPP targets'.

| Improvement and Assessment Framework | 296/17 | To present actions around improving the Assessment Framework rating at the next meeting | TS | Open | 31/08/17 |
Minutes of the Finance and Performance Meeting
held on 31 August 2017, 3pm,
in Shibden Room at F Mill, Dean Clough

FINAL MINUTES

Present
Matt Walsh (MW) Chief Officer
Dr Nigel Taylor (NT) GP Member Governing Body and Meeting Chair
John Mallalieu (JM) Lay Member to the Governing Body
Dr Alan Brook (AB) GP Member Governing Body and CCG Chair
Dr Steven Cleasby (SC) GP Member Governing Body

In attendance:
Lesley Stokey (LS) Head of Finance
Debbie Graham (DG) Head of Service Improvement
Martin Pursey (MP) Head of Contracting and Procurement Manager
Penny Woodhead (PW) Head of Quality
Tim Shields (TS) Head of Performance
Zoe Akesson (ZA) Corporate Services – minute taker
Dr Farrukh Javid (FJ) GP Member Governing Body
Rob Gibson (RG) Risk Manager

Observing:
Dr Rob Atkinson (RA) Secondary Care Specialist

302/17 APOLOGIES FOR ABSENCE

Apologies were received from Debbie Robinson (DR) Head of Primary Care Quality and Improvement, Neil Smurthwaite (NS) Deputy Chief Officer and Chief Finance Officer

303/17 DECLARATIONS OF INTEREST

The Committee members did not declare any interests relevant to items on the agenda.

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.

304/17 MINUTES OF THE FINANCE AND PERFORMANCE MEETING 27 July 2017

DECISION:

The minutes of the 27 July 2017 meeting were RECEIVED and ADOPTED as a correct record.

305/17 ACTIONS AND MATTERS ARISING

The action log was reviewed and updated from the discussions held in the meeting. All actions were completed apart from the below which were carried forward to next month’s meeting;

277/17 - SpaMedica activity, fact finding exercise continues, further update at next meeting.
The recovery report was RECEIVED by the Committee. DG presented the paper on behalf of Rhona Radley. In discussion, the following areas were highlighted:

**Delegation for areas of recovery:** Following a similar approach to CHFT, the Senior Management Team (SMT) agreed to support leads to move schemes forward. A Critical Friend or Senior Sponsor had been identified for each of the schemes however more work is required by SMT to be clear on what accountability the Critical Friend would have and how different this is to the accountability held by the existing Head of Service/Senior Manager. DG to keep the Committee sighted on this process.

**ACTION:** DG to share leadership roles and names with the Committee

**Health Optimisation:** A conversation is scheduled at the Clinical Development Forum on 07/09/17 on the CCG’s description and vision of Health Optimisation. The first view will be shared at the Recovery Operational Group (ROGr) in September.

**Continuing Health Care (CHC):** New documentation was shared as national benchmarking. LS is confirmed as the Executive Lead for CHC.

**Level of Risk:** DG referred to the RAG rating that was added to the stretch table to show risk status. A discussion ensued about a clear view of what was achievable. A request was made for additional activity around the 17/18 update and consequences for 18/19 to be captured. JM asked for the RAG rating colour to represent a number, which would make the level of risk more meaningful. LS informed the Committee that following the recent QIPP support, NHSE have asked CCGs to start reviewing the level of reported risk and to produce an assessment by month 5. This will be discussed and reviewed at ROGr in September. The first draft of the system recovery plan for the whole CHFT footprint has been received and will come to the F & P meeting in September.

**DECISIONS:**

The Finance and Performance Committee;

a) **CONSIDERED** the recovery plan and **REQUESTED** additional activity around the 17/18 update and consequences for 18/19 to be captured for next meeting.

b) **ACCEPTED** the recommendations from the submitted exception reports.

c) **ENDORSED** recommendations to F & P on stretch opportunities with a caveat to adding numbers to create clarity around the level of risk.

**ACTIONS:**

- LS to bring assessment of risk on QIPP for assurance to the next meeting.
- To add numbers to RAG rating on stretch table
DEVELOPMENT OF BCF – PROCESS UPDATE

DG provided the Committee with an update on the development and governance of the plan to date. The plan, which has to be submitted to NHSE by 11/09/17, will show that the CCG is meeting the conditions around spending the BCF and working towards full integration. It will also include a narrative around the development of the Integrated Commissioning Executive (ICE). It was noted that the target for reportable delays set by NHSE for Calderdale uses a February 2017 baseline. For Calderdale CCG this was an anomaly and in light of this the trajectory will be included in the plan using a baseline average for January – April. DG is developing a narrative to be included in the submission.

The CCG Governing Body sub-group are to sign off the plan on 07/09/17 for formal submission to NHSE on 11/09/17. It will then be presented at ICE and the Health and Wellbeing Board on 21/09/17. DG informed the Committee that the CCG will be required to establish an internal governance process for schemes that change and for changes that will have to be made to the current Section 75 agreement. Quarterly updates will be provided at F&P meetings on future changes. A suggestion was made for ICE to be the governance forum however it was felt that ICE is still being developed and it is not yet confirmed where it sits within the CCG’s governance structure.

DECISION:

The Committee RECEIVED and were ASSURED by the update provided.

Following consideration of the governance arrangements, the Committee AGREED that the Governing Body meeting in October was an important part of the BCF timeline for sign-off if required. If the plan was not ready at this stage, arrangements would be put in place to delegate the sign-off.

FINANCE REPORT

The report was received by the Committee.

LS provided a summary of the current financial position. The forecast provided to NHSE is that the CCCG is delivering the plan but showing an unmitigated risk of £2.5m. The key messages were;

The CCG has a QIPP of £11.5m, with a gap of £2.4m that still has to be allocated. LS will begin an additional piece of work looking at additional QIPP and prescribing to check if there is stretch in these schemes and if so move the budget away from these areas to close the gap.

Prescribing is showing an under trade year to date of £300k. CCCG is waiting for the prescribing forecast report relating to 2017/18 and until the information is received, including the effect of the recent category M prescribing price change, the CCG cannot confirm its YTD spend.

LS explained to the Committee how the potential £5.1m risk of delivery against the £11.5m plan was calculated, assuming prescribing and continuing healthcare delivers. Projected delivery for Acute-CHFT is £4m against a target of £6.7m leaving a risk of £2.7m. The QIPP gap risk delivery is currently at £2.4m against a target of £3.5m until work around the QIPP stretch has happened.

LS explained how the net risk of £2.5m against delivery of the financial plan was calculated. The level of risk includes a potential overtrade from CHFT of £2.7m and an estimated 50% delivery of the QIPP delivery risk of £2.5m equating to an
expenditure risk of £5.2m. Taking into account the £1.6m contingency and £1m of mitigation from emergency threshold and budget reviews leaves an unmitigated net risk of around £2.5m. LS highlighted that by using a contingency to net the risk down another contingency will be required next year.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**309/17 CONTRACT REPORT**

The report was received by the meeting. MP updated the Committee on the key messages.

At the end of month 3, there has been a £560k shift in the CHFT position from under trade to an over trade of £261K. Reasons for this were discussed and it is believed to be based on estimates in relation to EPR. The first 2 months have been blocked out however this will not continue. In light of this the stretch position has deteriorated. It would be good to understand the level of detail in the difference between Calderdale and Greater Huddersfield. Discussion ensued around sending patients to the independent sector and the level of risk attached to this. At present the new EPR system does not provide the depth of coding required therefore an analysis of whether there has been a shift to the independent sector activity cannot take place until EPR has stabilised.

With regards to the national CQUIN scheme, MP highlighted that 1.5% of contractual value is linked to transformational indicators.

Issues around funding and performance for the posture and mobility service continue. Discussions have taken place between the wheelchair provider and CCGs and Greater Huddersfield and North Kirklees had agreed £175k non-recurrent funding. This will be used on priority areas over the next 6 months and to extend the contract by 12 months, which Op Care have formally agreed to. It was noted that some of the contract indicator targets in the wheelchair contract have breached. MP explained the percentages do not give a true picture and going forward working with Op Care, Health Watch and quality colleagues will give a more in depth and balanced view particularly around Children’s wheelchairs. MP assured the Committee that over that last 6-12 months Op Care recognised the lack of funding and ensured thresholds were applied appropriately, eligibility criteria was appropriate and have compared and benchmarked against other CCGs in terms of their criteria and complexity.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**310/17 PERFORMANCE REPORT**

The report was received by the Committee. TS highlighted the key points;

Ambulance response time reporting is due to change from October 2017 in line with development of ARP.

For 2016/17 A&E performance to attain the 4hour target was below the constitutional standard. TS drew the Committee’s attention to the divergence between CRH and HRI performance. A discussion developed about staffing. DG confirmed this was raised and discussed at the A&E Delivery Board. It is believed this is due to patient flow through the hospital rather than rota fulfilment.
For assurance, the Committee will continue to receive minutes from the A&E Delivery Board and TS will review admission rates for both A&E sites. It was noted that CHFT remains regionally one of the best performing trusts.

**ACTION:** TS to look at admission rates via A&E for both sites

Breaches were recorded for both the 2 week and 62 day wait for urgent referrals for cancer. The delays were related to the booking centre and EPR. The review process will be picked up at the next Cancer Group meeting. NT informed the Committee that the last meeting had been cancelled at very short notice due to CHFT representation. The Committee asked for this to be escalated to CHFT to ensure it does not happen again in the future.

**ACTION:** DG to escalate cancellation of Cancer Group with CHFT

Improvement and Assessment Framework (IAF) 2016/17 - Calderdale CCG was rated as ‘requires improvement’. The CCG will plan to improve the indicators it is performance managed on and a response will be collated. To support assurance, a quarterly update on the IAF will be given at future F&P meetings in November, January, April and July.

**ACTION:** To include quarterly update in performance report and add to F&P work plan.

Sustainability and Transformation Partnerships (STP) - the first publication of the progress dashboard was received in July. West Yorkshire STP was rated category 3 ‘making progress’. The Committee was asked to be kept sighted on Calderdale’s position and be mindful of variances in relation to this. Going forwards, TS to report to F&P Committee on an exception basis.

**DECISION:**

The Committee RECEIVED and were ASSURED by the update provided.

**311/17 GOVERNING BODY ASSURANCE FRAMEWORK**

The Governing Body Assurance Framework (GBAF) was received by the Committee for assurance. RG provided an update on the main changes;

- Principal risk 2.3 to be merged with risk 1.5 due to duplication. The risk is regarding not delivering proposed clinical model of hospital and community services.

- Principal risk 1.6 has had more detail added around workforce and estates planning and development of a single communication strategy for Calderdale.

Conversation developed around clinical leads being sighted on risks/actions they are attached to. RG in future will inform clinical leads when the review process in going ahead. RG will do this for the next 6 monthly review for the Governing Body meeting in April 2018. Discussion ensued around the value of having a clinical lead named on the GBAF.

**DECISION:**

The Committee were ASSURED with the changes provided however in relation to point 2.3 it was raised that this could be a long term strategic risk and for it to be given thought ahead of the next 6 monthly review. Overall, the Committee felt
that GBAF is a competent way of assessing where the CCG is strategically and the right conversations around the elements are taking place at both this meeting and Governing Body.

**ACTION:** MW to seek advice from Judith Salter about governance around GBAF

312/17  **WORK PLAN**

The work plan was reviewed and no action was required.

313/17  **KEY MESSAGES**

**Matters for the Governing Body**
- Recovery update
- Wheelchairs contract
- BCF update

**Matters for the Senior Management Team**
- GBAF process
- Wheelchairs contract
- Stretch QIPP – how F & P Committee can help Recovery Operational Group and SMT closing loop, request for clarity and achieving number

**Matters for CHFT Partnership Board**
- Escalate cancellation of the cancer meeting

**Matters for Local Medical Committee**
- None identified

**Matters for Primary Medical Services Committee**
- Extended access investigation and the contingency/numbers via financial report

314/17  **MINUTES FROM THE A & E DELIVERY BOARD 11/07/17**

The minutes were received by the meeting. DG reported there has been no silver call since February, which is a positive sign. Escalation is taking place without the need to arrange a call. The delivery plan is being worked on. Conversation had taken place with Business Intelligence team around measuring indicators. There are three pieces of work ongoing around urgent care in A & E streaming. With the help of clinical leads, Jen Mulcahy is leading on establishing a model of care for urgent care centres, Debbie Robinson and Rhona Radley are leading on internal pieces of work on care urgent care offer in community and the same in Greater Huddersfield.

MP added the national integrated urgent care specification has now been released, which includes a number of expectations for the system.

315/17  **ANY OTHER BUSINESS**

None identified

316/17  **DATE AND TIME OF THE NEXT MEETING**

The Finance and Performance Committee **NOTED** that the next meeting would take place as follows:
<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>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. Actioned</td>
<td>PW/DG</td>
<td>Closed</td>
<td>Due next Risk cycle</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 - to bring back to F &amp; P for debate in August. Included in the financial and recovery report. Actioned.</td>
<td>NS/LS</td>
<td>Closed</td>
<td>31/08/17</td>
</tr>
<tr>
<td>Recovery Report</td>
<td>275/17</td>
<td>To seek assurance that a conversation has happened with the Cancer Laryngectomy Society. Helen Wraith spoke to the Society regarding the withdrawal of the charitable account. The outcome of the conversation was that other funding streams are in place and it was not expected to continue therefore no impact. Actioned</td>
<td>DG</td>
<td>Closed</td>
<td>31/08/17</td>
</tr>
</tbody>
</table>
| Performance Report           | 276/17     | a) To review A & E data and bring back findings to next meeting. Historically it was linked to EPR, data is now more consistent. Actioned  
                              |            | b) To check trend of patients referred for cancer treatment and bring back findings to next meeting. Historically it was low volume however now in expected reach. Actioned | TS       | Closed         | 31/08/17                 |
| Contracting Report           | 277/17     | To provide an update on SpaMedica activity – fact finding exercise continues. Further update at the next meeting. | MP       | C/fwd          | 29/09/17                 |
| Recovery Report              | 289/17     | a) To add RAG rating to stretch table. Actioned  
<pre><code>                          |            | b) To speak to Judith Salter re changes to the invited attendee status of F &amp; P to include FJ as a future attendee and if required as GP member representative. Actioned | RR       | Closed         | 31/08/17                 |
</code></pre>
<table>
<thead>
<tr>
<th>Category</th>
<th>Report No.</th>
<th>Item</th>
<th>Description</th>
<th>Responsible</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Report</td>
<td>291/17</td>
<td>a)</td>
<td>To include original baseline and clarification on assumptions in next contracting F&amp;P report. Outstanding, to be included in next month’s contract report.</td>
<td>YH</td>
<td>C/fwd</td>
<td>29/09/17</td>
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<td></td>
<td></td>
<td>b)</td>
<td>To include original baseline and clarification on assumptions in next contracting F&amp;P report. Outstanding, to be included in next month’s contract report.</td>
<td>YH</td>
<td>C/fwd</td>
<td>29/09/17</td>
</tr>
<tr>
<td>Risk Register</td>
<td>293/17</td>
<td>b)</td>
<td>To amend risk ID849 to read; ‘and increase demand in terms of GPs and other referrals’ Actioned</td>
<td>RG</td>
<td>Closed</td>
<td>31/08/17</td>
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<td></td>
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<td>c)</td>
<td>To amend risk ID1024 to read; ‘The risk is that Calderdale CCG may not have the appropriate QIPP schemes in place to ensure that its contribution to the system model is affordable going forwards. This may result in non-achievement of control total through non-achievement of QIPP targets’. Actioned</td>
<td>RG</td>
<td>Closed</td>
<td>31/08/17</td>
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<tr>
<td>Improvement and Assessment</td>
<td>296/17</td>
<td></td>
<td>To present actions around improving the Assessment Framework rating at the next meeting. Included in August’s performance report. Actioned</td>
<td>TS</td>
<td>Closed</td>
<td>31/08/17</td>
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<tr>
<td>Framework</td>
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<tr>
<td>Recovery</td>
<td>306/17</td>
<td>a)</td>
<td>To share delegation of leadership roles and names with the Committee. Actioned</td>
<td>DG</td>
<td>Closed</td>
<td>19/09/17</td>
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<td></td>
<td></td>
<td>b)</td>
<td>To bring assessment of risk on QIPP for assurance to the next meeting. Actioned</td>
<td>LS</td>
<td>Closed</td>
<td>19/09/17</td>
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<td>c)</td>
<td>To add numbers to RAG rating on stretch table. Actioned</td>
<td>DG</td>
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<td>19/09/17</td>
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<tr>
<td>Performance</td>
<td>310/17</td>
<td>a)</td>
<td>To look at admission rates via A&amp;E for both sites and bring back to next meeting.</td>
<td>TS</td>
<td>Open</td>
<td>29/09/17</td>
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<td>DG</td>
<td>Closed</td>
<td>19/09/17</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TS/ZA</td>
<td>Closed</td>
<td>19/09/17</td>
</tr>
<tr>
<td>GBAF</td>
<td>311/17</td>
<td></td>
<td>To seek advice from Judith Salter about governance around GBAF.</td>
<td>MW</td>
<td>Open</td>
<td>29/09/17</td>
</tr>
</tbody>
</table>
Minutes of the QUALITY COMMITTEE Meeting
held on 27 July 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
Louise Burrows LB  Quality Manager
Dr Helen Davies DG  GP Governing Body Member
Debbie Graham BG  Head of Service Improvement
Ben Leaman BL  Public Health Consultant, Calderdale Council
( representing Caron Walker)
Rhona Radley RR  Senior Service Improvement Manager
Debbie Robinson DR  Head of Primary Care Quality and Improvement
Kate Smyth KS  PPI Governing Body Lay Member
Dr Caroline Taylor CT  GP Governing Body Member

In attendance

Dr Alan Brook ABr  Chair of CCG
Corinne CMD  Mental Health Project Manager, Calderdale CCG (for item 4, min. no. 319/17 only)
Andrew Bottomley AB  Programme Manager, Calderdale CCG, (for item 5, min no. 320/17 only)
Sarah Antemes SA  Head of Commissioning – Continuing Care, Calderdale CCG (for item 7, min no. 322/17 only)
Rob Gibson RG  Risk, Health and Safety Manager, Calderdale CCG (for items 8, 9 and 10, min nos. 323/17, 324/17 and 325/17 only)
Lucy Walker LW  Portfolio Lead, Serious Incident team, Greater Huddersfield CCG (for item 11, min no. 326/17 only)
Gill Poyser-Young GPY  Designated Nurse for Safeguarding Children, Calderdale CCG (for item 14, min no. 329/17 only)
Luke Turnbull LT  Designated Nurse for Safeguarding Adults, Calderdale CCG (for whole meeting)
Hannah Smith HS  Designated Nurse for Children Looked After, Calderdale and Huddersfield NHS Foundation Trust (for item 14, only section relating to CLA report, min no. 329/17)
Georgina King GK  Job Aide to Kate Smyth
Alison Waters AW  Project Support Officer, Quality – Minute taker

316/17 APOLOGIES FOR ABSENCE

Action

Apologies were received from:
Penny Woodhead (PW) (Head of Quality, Calderdale CCG)
Caron Walker (CWa) (Public Health Consultant, Calderdale Council)
Clare Smith (CS) (Infection Prevention and Control, Calderdale Council)

DECLARATIONS OF INTEREST

MA invited the Committee members to declare any interests relevant to items on
the agenda.

No interests were declared.

The Register of Interests can be obtained from the CCG’s website www.calderdaleccg.nhs.uk or from the CCG’s headquarters.

317/17  **MINUTES OF THE Quality Committee meeting held on 29 June 2017**

Members of the Committee reviewed the minutes of the previous meeting and agreed them as a correct record subject to the following amendments:

1) Add Dr Helen Davies to the attendance list
2) Update Ben Leaman’s job title to Public Health Consultant.

**DECISION:**

The minutes of the Quality Committee meeting were **RECEIVED** and **ADOPTED** as a correct record subject to the amendments detailed being made.

**ACTION:**

AW to update minutes of the 29 June 2017 meeting.

318/17  **ACTIONS AND MATTERS ARISING**

The Action Log attached to the minutes of the meeting held on 29 June 2017 had been updated following the meeting. Further updates were provided as follows:

**288/17 Quality and Safety Report and Dashboard**

The Committee to receive an update on incidents resulting from the EPR at a future meeting.

Update – This is included in the Quality dashboard. Close action.

**304/17a Right Care, Right Time, Right Place Quality Impact Assessment and Hospital Standards**

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.

Update – AW to chase for update.

**304/17b Right Care, Right Time, Right Place Quality Impact Assessment and Hospital Standards**

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.

Update – AW to chase for update.

**305/17a Quality and Safety Report and Dashboard**

LB to contact CHFT about their Freedom to Speak up Guardian and get more details about the role etc.

Update – Outstanding. Update to be provided to the next meeting.

**310/17c Infection Prevention and Control Annual report for 2016-17 and HCAI Improvement Plan for 2017-18**

CWa and PW to discuss escalation of Leeds laboratory results sharing software issues.

Update – Outstanding.

**Matters Arising**
A&E Delivery Board receiving primary care information

DR stated that the standards implemented in Calderdale were shared at the A&E Delivery Board. There was not a full debate on what would be included in the dashboard. Work will continue on this.

RCRTRP Quality Impact Assessment Refresh

EB explained that Calderdale and Huddersfield NHS Foundation Trust are doing a further update of the Quality Impact Assessment. This will be reviewed by the CCG’s quality team and brought back to the Committee for further discussion of necessary.

319/17 SPECIALIST MENTAL HEALTH SERVICES FOR ADULT REFUGEES AND ASYLUM SEEKERS AFFECTED BY TRAUMA / TORTURE / SEXUAL VIOLENCE SERVICE SPECIFICATION

CMD and CT in presenting the report said that the need for this specialist mental health service was set out in the health needs assessment undertaken by a public health specialist registrar in 2016. Engagement had been undertaken. The service specification focused on adults but it was expected that this would benefit other members of the family. CT clarified that the service was linked to secondary care mental health services and each service could refer into the other. Any prescribing would be undertaken by referral to the patient’s GP or secondary care provider, as this service will provide counselling.

LT suggested that it would be helpful to include more in the service specification on meeting the needs of people who had been subject to modern day slavery and/or human trafficking. CMD and LT agreed to discuss the wording to be included on this outside the meeting.

CMD added that the equality impact assessment had suggested that a venue for the service should be chosen which was not associated with statutory service provision and the Committee supported this. CMD agreed to add a sentence in section 6 of the service specification to this effect.

DG assured the Committee that the senior management team had had oversight of the service specification during its development and that relevant colleagues in the CCG had had opportunity to comment on the draft specification.

DECISION:

The Committee APPROVED the draft service specification, subject to the amendments relating to the addition of wording around modern day slavery and human trafficking, and the venue used to provide the service.

ACTION:

a) CMD and LT to agree wording to be added to the service specification on people who had been subject to modern day slavery and/or human trafficking. CMD / LT

b) CMD to add a sentence in section 6 requiring that the venue(s) used to provide the service was not associated with statutory service provision. CMD

320/17 IMPROVING OUTCOMES IN ELECTIVE CARE – NEW THRESHOLDS

AB presented the new thresholds documents for knee arthroscopy (management of degenerative meniscal lesions) and management of osteoarthritis of the hip with a cover report. He asked if management of osteoarthritis of the hip AND knee could be combined in the same document as the NICE guidance for these
conditions was the same document and they were managed in the same way. The Committee agreed to this.

In considering the cover report which explained the background and next steps for these documents, the Committee agreed that the sentence at paragraph 2.3 ‘The intention is to improve outcomes, rather than to ration care’ should be amended to show that the purpose of the thresholds was to implement NICE guidance and improve outcomes for patients.

In discussing the management of osteoarthritis of the hip threshold document, members considered the part of x-rays in diagnosis of osteoarthritis and agreed to remove the reference to radiology in the document.

CT commented that it would be useful to have a ‘how to’ guide for doctors using the thresholds.

The Committee next discussed the management of degenerative meniscal lesions thresholds document. AB explained that all guidance from the relevant professional bodies stated that arthroscopies should not be done unless patients had had a locked knee for three months. The thresholds document reflected this guidance. Members discussed the differences between locked, locking and gelling knees. EB asked about the sentence ‘Exceptions should be discussed for young patients with considerable symptoms’ and what constituted ‘young’. AB stated that he would review this and make it clearer. The Committee was otherwise supportive of the document.

DECISION:

The Committee APPROVED the two threshold documents SUBJECT TO the amendments detailed.

ACTION:

a) AB to include management of osteoarthritis of the knee in the management of osteoarthritis of the hip document.

b) AB to update paragraph 2.3 in the cover report to clarify the purpose of the threshold documents.

c) AB to remove the reference to radiology in the management of osteoarthritis of hip (and knee) document.

d) AB to clarify what ‘young’ means in the management of degenerative meniscal lesions thresholds document.

321/17 COMMUNITY REHABILITATION PATHWAY

RR in presenting the report said that Dr Cleasby, the clinical lead had been involved in the development of the pathway and had discussed it with the Committee members as he was not able to attend the meeting. RR explained that she was seeking approval of the care pathway only, and that the model would be developed further with Calderdale and Greater Huddersfield clinicians. The aim of the pathway was to keep people at home, where possible, and for those not able to remain at home to use an intermediate care bed. HD said the pathway looked very good and asked how the rehabilitation in the community would be resourced. RR stated that existing resources would be used where possible and models would be enhanced if needed, and that this would be addressed during the modelling work. The Committee learned that the pathway had been developed in partnership with Calderdale and Huddersfield NHS Foundation Trust (CHFT) and social care, and that it had been approved by the rehabilitation group and all partner governance structures. The Committee

...
agreed that patients would rather be cared for at home as far as possible and approved the pathway.

DECISION:

The Committee **APPROVED** the community rehabilitation pathway.

### 322/17 COMMISSIONING POLICY FOR CONTINUING HEALTHCARE

SA presented the draft Continuing Healthcare Commissioning Principles Policy to the Quality Committee for approval. She explained that there was currently no policy to support the work of the continuing healthcare (CHC) team in were often difficult discussions with individuals. The aim of the policy was to support the CHC team to commission services based on the ‘needs’ not ‘wants’ of an individual. Members acknowledged how difficult it had been for staff in the CHC team to manage without a policy. HD asked how the policy compared nationally and would stand up to challenge, SA explained that the policy was very fair and allowed flexibility to meet individual and exceptional circumstances.

The Committee noted that the policy was based on the Greater Huddersfield CCG Continuing Healthcare Commissioning Principles Policy, which had been through rigorous checking, legally etc. LT commented that when someone lacked capacity to decide where to receive their CHC, there was case law saying that the person could only choose from the options available and that the CCG was prepared to fund.

BL asked about the transition from children to adults, SA explained that funding for children’s CHC was more complex and that while Calderdale Council had tried to develop a policy for funding for children, this had not reached any conclusions. SA suggested that this be picked up through the children and young people work. KS added that SA could speak to Julia Redgrave who was drafting a policy for disability for people of all ages.

EB asked that the glossary be updated and references to Kirklees be updated to Calderdale.

Members held a discussion about the wording in paragraph 6.5.4 ‘cost effective’. LT suggested that the cost of care to the CCG may be more than the ‘most cost effective care’. It was agreed that the words should be changed to ‘lowest cost care’, so paragraph 6.5.4 would read:

*’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 lowest cost care identified (based on CCG agreed standard rates for equivalent levels of need).’* Members agreed this amendment.

DECISION:

The Committee **AGREED** the draft policy, **SUBJECT TO** the amendments described.

**ACTIONS:**

a) SA to update the glossary and remove references to Kirklees

b) SA to update paragraph 6.5.4 of the policy to replace ‘most cost effective care’ with ‘lowest cost care’.

### 323/17 OPERATIONAL RISK REGISTER
RG presented the operation risk register to the Committee for review and approval to refer to Governing Body. He explained that of the 36 risks open in the risk register, 11 related to quality and two of these were due for closure. The report included detailed information on risk 709, a critical risk. Two new quality risks were due to be added to the risk register, including 62 day cancer waits and resources available for the LeDeR programme.

EB requested that two additional risks were added to the risk register – one relating to the implementation of the electronic patient record at Calderdale and Huddersfield NHS Foundation Trust (CHFT), and one relating to serious incident and complaints management at CHFT.

**DECISION:**

The Committee **REVIEWED** and **APPROVED THE REFERRAL** of the risk register to the Governing Body.

**ACTION:**

LB to add two new risks to the risk register relating to the implementation of the electronic patient record, and serious incident and complaints management at Calderdale and Huddersfield NHS Foundation Trust (CHFT).

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**324/17 INCIDENT MANAGEMENT AND REPORTING POLICY**

RG presented the draft incident reporting policy and procedure to the Committee for approval. He explained that the CCG had previously had two policies in place, and he had tried to combine them into one more simple document. The policy would be reviewed again in 2018.

Members discussed serious incident section 5.4 of the policy and agreed that it needed to be clear what type of serious incident was being discussed. EB explained that the serious incident framework may not apply to the CCG. It was agreed that EB, RG and Kathryn Stirk from the serious incident management team would review paragraph 5.4 and update it for clarity, and that the updated section 5.4 should be brought back to the next Quality Committee meeting for approval. The Committee discussed whether the Primary Medical Services Committee (PMSC) had a formal governance role in the governance of the policy and DR agreed to review the terms of reference for the PMSC with RG to check this.

Members decided that the amended wording would be reviewed at their meeting in August for approval.

**DECISION:**

The Committee **REVIEWED** the policy and **REQUESTED** an amendment to be brought to the August meeting.

**ACTION:**

a) EB, RG and Kathryn Stirk to review paragraph 5.4 and update it for clarity.  

b) RG to bring the updated section 5.4 of the policy to the Quality Committee in August 2017.  

c) DR and RG to check the terms of reference for the Primary Medical Services Committee to see if it had a formal governance role in the governance of the policy.
325/17  **GP INCIDENT REPORT**

RG presented the quarter 1 2017-18 GP incident report to the Committee for assurance. The report included information on the incidents which had been reported on the CCG’s Datix system by GP practices. The most common type of incidents were related to patient safety, and specifically to access, appointment, admission, transfer and discharges. The report explained that approximately a quarter of incidents related to discharge information – mainly delays in receiving it; errors in medication or information missing from the summary. The launching of the electronic patient record system at Calderdale and Huddersfield NHS Foundation Trust in May 2017 seems to be the main cause of these issues.

MA commented that a good spread of practices had reported incidents and this was reassuring. Feedback had helped with increasing the number of practices reporting incidents.

**DECISION:**

The Committee RECEIVED and NOTED the report and were ASSURED on GP incident reporting.

326/17  **SERIOUS INCIDENT MANAGEMENT UPDATE**

EB explained that this item should have been marked as ‘private’ as the appendix to the report contained potentially identifiable data. Members were asked not to circulate the report any further and agreed to discuss the report in the private section of the meeting.

327/17  **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 information on stroke self-assessment at Calderdale and Huddersfield NHS Foundation Trust (CHFT) and that the Trust was doing a lot of work to improve stroke services. Members also noted the positive results of the patient experience survey. Most answers were similar to previous years with a few getting slightly worse. However the Trust performed particularly well on the question relating to supporting patients to take their own medications which could be due to the CQUIN indicator focussing on this. Members noted that the action plan resulting from the patient experience survey would be taken to the CCG Patient Experience group for discussion.

Members next discussed the quality and safety dashboard, particularly focussing on the negative impact of the implementation of the electronic patient record (EPR) at CHFT on performance and on other areas of the system. Areas affected included two week cancer waits, referrals back to GPs impacting on practice capacity, medicines reconciliation and ophthalmology letters. MA stated his concern that CHFT did not understand the impact of the EPR problems on other parts of the healthcare system, and that new problems were emerging. LB agreed to circulate the EPR report from CHFT received by the CHFT Clinical Quality Board meeting in July. The report concluded that there was a robust process in place for managing issues arising from the implementation of EPR; however the Committee did not feel that this was the case.

MA requested that a risk be added to the CCG’s risk register about the patient safety implications of the implementation of the EPR.
Members discussed GP reporting of incidents onto Datix and concluded that practices did not report all incidents related to EPR. DG added that incidents which had been reported on to Datix and then passed to CHFT had received little response.

The Committee did not feel confident that CHFT had a grasp of all the issues related to EPR and was not dealing with them or mitigating risks effectively.

After a lengthy discussion, the Committee concluded that:

- They believe there remains significant risk associated with unresolved EPR-related issues.
- Whilst individual practices had identified individual concerns, a number of systematic issues were becoming visible that require further discussion and assurance.
- Whilst the CCG continues to gather intelligence from its DATIX system, many practices continue to take on board messages about supporting the system on EPR implementation and are therefore not currently reporting their concerns.
- There had been a suggestion that the CCG act as the interface point between CHFT and practices using NHS numbers as a way of resolving issues at an individual patient level. However, CCGs are not able to hold patient-identifiable data and so that is not possible.
- There should be a point of contact directly into CHFT for practices so that there can be an effective and speedy resolution to patient level issues.
- There should be further discussion of the issues at the LMC Interface meeting which is due to take place in August.
- The Contract Management Group in August should use the EPR report submitted to the Clinical Quality Board and an updated log of issues to facilitate a discussion to see assurance on progress.
- EPR should be a substantive item on the Clinical Quality Board meeting which is due to take place in September.
- The Committee recognised that CHFT is preparing another communication out to practices which is welcomed, and recognise the effort going into resolving issues. However, the Committee felt that they did not have sufficient assurance on mitigating actions, and that it needed to put additional actions in place to ensure that issues were resolved.

**DECISION:**

The Committee RECEIVED and NOTED the report. Members were NOT ASSURED on the issues relating to the implementation of the electronic patient record at CHFT and AGREED a number of actions to address this.

**ACTION:**

a) LB to circulate the EPR report received from the Trust for CHFT Clinical Quality Board to Quality Committee members

b) DG to email Helen Barker at CHFT setting out the Committee’s concerns and requesting a response

c) Yvonne Hoorman (Contracting) to arrange for EPR to be discussed at the next Contract Management Group

d) DR to arrange for EPR to be discussed at the next LMC interface meeting

e) AW to add EPR to the CHFT Clinical Quality Board agenda for the next meeting for a detailed discussion.
LB in presenting the report said that the report should be closed as some information was potentially identifiable in one section of the report. The report included information on maternity related incidents, the better births work, audits, theatre delays and patient experience work.

LB explained that the report was presented to the Committee following the conclusion of the Maternity Assurance Group which had been convened earlier in the year, and the report would be brought quarterly in the future.

DECISION:
The Committee RECEIVED and were ASSURED by the update provided.

329/17 SAFEGUARDING CHILDREN AND ADULTS INCLUDING CHILDREN LOOKED AFTER ANNUAL REPORT

GPY and LT presented the quarterly safeguarding children and adults report to the Committee for assurance. The report include information on the Safeguarding Boards, the Public Health Early Years Service, children looked after and care leavers, the Mental Capacity Act and Deprivation of Liberties (DoLs) safeguards, safeguarding related forums and events, the PREVENT programme, plus additional work from the safeguarding team.

LT explained that the internal audit of safeguarding had been rated ‘significant assurance’ which was very positive. He added that the ‘back office’ functions for the safeguarding boards had been merged and this was proving successful. Multi-agency safeguarding policies were being developed and template policies for GPs to use if they wished had been produced. Work on DoLs was underway with the continuing healthcare team and whilst it was taking much longer than expected, the high priority case applications were complete or nearly complete.

GPY provided a brief summary of the children’s safeguarding work, highlighting that a number of changes had arisen from the Children and Social Work Act, for example the function of the Safeguarding Board.

HS then presented the Children Looked After Annual Report to the Committee, summarising each section for members. Discussion focussed on the SDQ questionnaire and what GPs were required to action. The Committee agreed that more clarity was required for GPs on whether children needed / had been referred for extra support and whether the GP was required to do anything to support the child. HS and GPY agreed to amend the wording to provide further clarity.

DECISION:
The Committee RECEIVED and were ASSURED by the update provided.

ACTION:
GPY and HS to clarify the wording around the SDQ questionnaire completed by children and what GPs were required to do.

330/17 NATIONAL AUDIT REPORTS

LB presented the quarter 4 national audit reports update to the Committee for decision and assurance. The report included information on the following national audits: Treat as One - Bridging the Gap between Mental and Physical Healthcare in General Hospitals; National COPD Audit Programme: Outcomes from the Clinical Audit of COPD exacerbations admitted to acute units in England.
2014 (Published February 2017); and National Diabetes Foot Care Audit 2014-2016, including key recommendations for commissioners, primary and secondary care.

The report also set out draft processes for national audits and NICE Guidance to be reviewed and used within the CCG with support from providers.

The Committee noted the report for assurance and agreed to send any comments on the draft processes to LB.

**DECISION:**

The Committee RECEIVED and were ASSURED by the report and AGREED to send any comments on the draft processes for national audits and NICE guidance to LB.

**ACTION:**
Committee members to send any comments on the draft processes for national audits and NICE guidance to LB.

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**331/17 HEALTHCARE ASSOCIATED INFECTION ANNUAL REPORT 2016-17 AND IMPROVEMENT PLAN FOR 2017-18**

BL in presenting the report said that the Healthcare Associated Infection Improvement Plan for 2017-18 which had been presented to the Committee needed further development in terms of the system-wide approach needed to reduce E.coli numbers; and that a timescale was required for care home audits. LB added that there was a meeting planned for 10th August 2017 to discuss how E.coli numbers would be addressed. Members requested an update to the next meeting as part of the Quality and Safety report.

BL next explained that the pandemic flu plan included in the report was from the previous year and that work was currently underway to update the plan for the current year. Updates on the plans would be included in the quarterly infection prevention and control assurance report.

**DECISION:**

The Committee RECEIVED and NOTED the report.

**ACTION:**
E.Coli update to be provided in the quality and safety report at the August meeting.

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**332/17 REVIEW OF QUALITY COMMITTEE WORK PLAN 2017-18**

The Committee reviewed the work plan for 2017-18.

**DECISION:**

The Committee RECEIVED and NOTED the work plan.

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**333/17 TRANSFORMING CARE UPDATE**

The Committee received the Transforming Care Update.

**DECISION:**
The Committee RECEIVED and NOTED the Transforming Care Update.

334/17 MINUTES TO RECEIVE

DECISION:

The Committee RECEIVED and NOTED:

a) SWYPFT Clinical Quality Board minutes of 12 May 2017
b) Patient Experience Group minutes of 6 March 2017

335/17 ANY OTHER BUSINESS

None raised.

336/17 MATTERS TO REFER TO THE GOVERNING BODY OR PRIMARY MEDICAL SERVICES COMMITTEE

The Committee agreed the following referrals:

- Governing Body – serious incident management update and the Children Looked After Annual Report
- Primary Medical Services Committee – no referrals.

DECISION:

The Committee AGREED referrals to Governing Body and Primary Medical Services Committee.

337/17 DATE AND TIME OF THE NEXT MEETING:

The Committee NOTED that the next meeting would take place as follows:

Quality Committee Meeting
31 August 2017, 12:30pm to 2:30pm
Shibden room, Calderdale CCG.
## Quality Committee Meeting 27 July 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>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>Complete</td>
<td>On agenda as part of Q&amp;S report. EPR added to risk register and discussed with CHFT.</td>
</tr>
<tr>
<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.</td>
<td>JM</td>
<td>Ongoing</td>
<td>JM awaiting information from CHFT.</td>
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<td></td>
<td></td>
<td>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></td>
<td>Complete</td>
<td>Council advised it was a separate piece of work not impacting on RCRTRP.</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.</td>
<td>LB</td>
<td>Complete</td>
<td>LB spoke to Juliette Cosgrove at CHFT and got details.</td>
</tr>
<tr>
<td>Complaints Annual Report 2016-17</td>
<td>307/17</td>
<td>b) PW and JS to discuss what information should be referred to Governing Body outside of the Committee meeting.</td>
<td>PW / JS</td>
<td>Complete</td>
<td>Went to August GB meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) LB and JS to discuss assurance on provider complaints handling for future complaints reports.</td>
<td>LB / JS</td>
<td>Complete</td>
<td>Will be included in next complaints update.</td>
</tr>
<tr>
<td>Infection Prevention and Control Annual report for 2016-17 and HCAI Improvement Plan for 2017-18</td>
<td>310/17</td>
<td>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</td>
<td>CWa</td>
<td>In progress</td>
<td>CWa had discussions with individuals from CHFT, Community Pharmacy and leads in other WY local authorities</td>
</tr>
</tbody>
</table>
but there remains the issue of funding. CWa has agreed to pull together a meeting of all parties to try and make progress.

c) CWa and PW to discuss escalation of Leeds laboratory results sharing software issues.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Minutes of the Quality Committee meeting held on 29 June 2017</td>
<td>317/17</td>
<td>AW to update minutes of the 29 June 2017 meeting.</td>
<td>Alison Waters</td>
<td>Complete</td>
<td>Completed after July meeting</td>
</tr>
<tr>
<td>Specialist Mental Health Services for Adult Refugees and Asylum Seekers Affected By Trauma / Torture / Sexual Violence Service Specification</td>
<td>319/17</td>
<td>a) CMD and LT to agree wording to be added to the service specification on people who had been subject to modern day slavery and/or human trafficking.</td>
<td>Corinne McDonald</td>
<td>Complete</td>
<td>Specification updated.</td>
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<td></td>
<td></td>
<td>b) CMD to add a sentence in section 6 requiring that the venue(s) used to provide the service was not associated with statutory service provision.</td>
<td>Corinne McDonald</td>
<td>Complete</td>
<td>Specification updated.</td>
</tr>
<tr>
<td>Improving Outcomes in Elective Care –</td>
<td>320/17</td>
<td>a) AB to include management of osteoarthritis of the knee in the management of osteoarthritis of the hip document.</td>
<td>Andrew Bottomley</td>
<td>Complete</td>
<td>Changes made.</td>
</tr>
<tr>
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<tr>
<td>New Thresholds</td>
<td></td>
<td>b) AB to update paragraph 2.3 in the cover report to clarify the purpose of the threshold documents.</td>
<td>Andrew Bottomley</td>
<td>Complete</td>
<td>Paragraph 2.3 felt to be clear after further discussion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) AB to remove the reference to radiology in the management of osteoarthritis of hip (and knee) document.</td>
<td>Andrew Bottomley</td>
<td>Complete</td>
<td>Changes made.</td>
</tr>
<tr>
<td>Commissioning Policy for Continuing Healthcare</td>
<td>322/17</td>
<td>a) SA to update the glossary and remove references to Kirklees</td>
<td>Sarah Antemes</td>
<td>Complete</td>
<td>Reference to Kirklees cannot be removed as EQIA document was done by Kirklees.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) SA to update paragraph 6.5.4 of the policy to replace ‘most cost effective care’ with ‘lowest cost care’.</td>
<td>Sarah Antemes</td>
<td>Complete</td>
<td>Policy updated.</td>
</tr>
<tr>
<td>Operational Risk Register</td>
<td>323/17</td>
<td>LB to add two new risks to the risk register relating to the implementation of the electronic patient record, and serious incident and complaints management at Calderdale and Huddersfield NHS Foundation Trust (CHFT).</td>
<td>Louise Burrows</td>
<td>Complete</td>
<td>Risk Register has been updated.</td>
</tr>
<tr>
<td>Incident Management and Reporting Policy</td>
<td>324/17</td>
<td>a) EB, RG and Kathryn Stirk to review paragraph 5.4 and update it for clarity.</td>
<td>Rob Gibson / Emma Bownas</td>
<td>Complete</td>
<td>Reference to patient safety framework removed from policy following discussion with SI lead - KS.</td>
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<tr>
<td></td>
<td></td>
<td>b) RG to bring the updated section 5.4 of the policy to the Quality Committee in August 2017.</td>
<td>Rob Gibson</td>
<td>Complete</td>
<td>On agenda under Matters Arising</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) DR and RG to check the terms of reference for the Primary Medical Services Committee to see if it had a formal governance role in the governance of the policy.</td>
<td>Debbie Robinson</td>
<td>Complete</td>
<td>PMSC has no formal governance role</td>
</tr>
<tr>
<td>Report Title</td>
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<tr>
<td>Quality and Safety Report and Dashboard</td>
<td>327/17</td>
<td>a) LB to circulate the EPR report received from the Trust for CHFT Clinical Quality Board to Quality Committee members</td>
<td>Louise Burrows</td>
<td>Complete</td>
<td>Completed 27-7-17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) DG to email Helen Barker at CHFT setting out the Committee’s concerns and requesting a response</td>
<td>Debbie Graham</td>
<td>Complete</td>
<td>Completed 27-7-17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Yvonne Hoorman (Contracting) to arrange for EPR to be discussed at the next Contract Management Group</td>
<td>Yvonne Hoorman</td>
<td>In progress</td>
<td>Contract Management group cancelled. On agenda for next meeting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) DR to arrange for EPR to be discussed at the next LMC interface meeting</td>
<td>Debbie Robinson</td>
<td>In progress</td>
<td>On agenda for the LNMC interface meeting in September</td>
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<tr>
<td></td>
<td></td>
<td>e) AW to add EPR to the CHFT Clinical Quality Board agenda for the next meeting for a detailed discussion.</td>
<td>Alison Waters</td>
<td>Complete</td>
<td>On agenda for CQB meeting on 26-9-17</td>
</tr>
<tr>
<td>Safeguarding Children and Adults inc. Children Looked After Annual Report</td>
<td>329/17</td>
<td>GPY and HS to clarify the wording around the SDQ questionnaire completed by children and what GPs were required to do.</td>
<td>Gill Poyser-Young</td>
<td>In progress</td>
<td>Meeting planned for 19-9-17 to complete this.</td>
</tr>
<tr>
<td>National Audit Reports</td>
<td>330/17</td>
<td>Committee members to send any comments on the draft processes for national audits and NICE guidance to LB.</td>
<td>All</td>
<td>Complete</td>
<td>No comments received</td>
</tr>
<tr>
<td>Healthcare Associated Infection Annual Report 2016-17 and Improvement Plan for 2017-18</td>
<td>331/17</td>
<td>E.Coli update to be provided in the quality and safety report at the August meeting.</td>
<td>Louise Burrows</td>
<td>Complete</td>
<td>On agenda</td>
</tr>
</tbody>
</table>
Minutes of the QUALITY COMMITTEE Meeting  
held on 31 August 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>
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</tr>
<tr>
<td>Louise Burrows</td>
<td>LB</td>
<td>Quality Manager</td>
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<tr>
<td>Dr Helen Davies</td>
<td>HD</td>
<td>GP Governing Body Member</td>
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<tr>
<td>Debbie Graham</td>
<td>DG</td>
<td>Head of Service Improvement</td>
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<tr>
<td>Caron Walker</td>
<td>CWa</td>
<td>Public Health Consultant, Calderdale Council</td>
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<tr>
<td>Debbie Robinson</td>
<td>DR</td>
<td>Head of Primary Care Quality and Improvement</td>
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<tr>
<td>Kate Smyth</td>
<td>KS</td>
<td>PPI Governing Body Lay Member</td>
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<tr>
<td>Dr Caroline Taylor</td>
<td>CT</td>
<td>GP Governing Body Member</td>
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<table>
<thead>
<tr>
<th>In attendance</th>
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<tbody>
<tr>
<td>Dr Alan Brook</td>
<td>AB</td>
<td>Governing Body Chair</td>
<td></td>
</tr>
<tr>
<td>Helen Foster</td>
<td>HF</td>
<td>Medicines Management Lead, Calderdale CCG (for item 4, min no. 341/17 and part of item 7, min no. 344/17 only)</td>
<td></td>
</tr>
<tr>
<td>Rob Gibson</td>
<td>RG</td>
<td>Risk, Health and Safety Manager, Calderdale CCG (for item 11, min no. 347/17 only)</td>
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</tr>
<tr>
<td>Georgina King</td>
<td>GK</td>
<td>Job Aide to Kate Smyth</td>
<td></td>
</tr>
<tr>
<td>Alison Waters</td>
<td>AW</td>
<td>Project Support Officer, Quality – Minute taker</td>
<td></td>
</tr>
</tbody>
</table>

338/17 APOLOGIES FOR ABSENCE  

Action  

Apologies were received from:  
Rhona Radley, Senior Service Improvement Manager, Calderdale CCG.  

DECLARATIONS OF INTEREST  

MA invited the Committee members to declare any interests relevant to items on the agenda.  

MA, HD, CT, and AB declared a direct professional interest in agenda item 9 – Primary Care Dashboard. This was because their GP practices were included in the dashboard.  

MA advised that the item was for assurance and not decision; and that it was not a material interest; and as such he/she proposed that he, HD, CT, and AB would take part in the whole item.  

DECISION:  

Agenda item 9: MA, HD, CT and AB 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.
MINUTES OF THE Quality Committee meeting held on 27 July 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.

ACTIONS AND MATTERS ARISING

The Action Log attached to the minutes of the meeting held on 27 July 2017 had been updated following the meeting. Further updates were provided as follows:

304/17a Right Care, Right Time, Right Place Quality Impact Assessment and Hospital Standards
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.
Update – JM awaiting information from CHFT. A paper will come to September Quality Committee. Close action.

310/17b Infection Prevention and Control Annual Report for 2016-17 and HCAI Improvement Plan for 2017-18
CWa to provide an update to the July meeting on the agreement of a local health system plan for avian and pandemic flu management.
Update – CWa is pulling a meeting together of the relevant organisations. An update will be provided in the next quarterly report to the Committee. Close action.

310/17c Infection Prevention and Control Annual report for 2016-17 and HCAI Improvement Plan for 2017-18
CWa and PW to discuss escalation of Leeds laboratory results sharing software issues.
Update – Public Health England are setting up a new IT system which is taking time. The lab is used for non-urgent diagnostic and screening tests. Continue to monitor.

327/17c Quality and Safety Report and Dashboard
Yvonne Hoorman (Contracting) to arrange for EPR to be discussed at the next Contract Management Group
Update – EPR update on agenda and part of Quality and Safety Report and dashboard item. Complete.

327/17d Quality and Safety Report and Dashboard
DR to arrange for EPR to be discussed at the next LMC interface meeting
Update – On agenda for September LMC Interface meeting. Close action.

329/17 Safeguarding Children and Adults Inc. Children Looked After Annual Report
GPY and HS to clarify the wording around the SDQ questionnaire completed by children and what GPs were required to do.
Matters Arising

Incident Management and Reporting Policy

LB explained that she and RG had discussed the draft policy with Kathryn Stirk (KS) from the Serious Incident management team. KS had advised that the policy did not need to refer to STEIS, and the section on the Serious Incident framework was removed. The policy had been published.

341/17 MEDICINES COMMISSIONING STATEMENT – RITUXIMAB WITHOUT METHOTREXATE

HF presented the Medicines Commissioning Statement for Rituximab without methotrexate to the Committee for approval. She explained that the Commissioning Statement had been produced to clarify for providers in what circumstances Rituximab without methotrexate should be used. The use of Rituximab with methotrexate was already covered by NICE guidance. The Committee agreed that the statement would be useful and HF confirmed that the Calderdale CCG logo etc. would be added to the commissioning statement following approval.

DECISION:

The Committee APPROVED the Medicines Commissioning Statement for Rituximab without methotrexate.

342/17 EQUALITY DELIVERY SYSTEM UPDATE

PW presented the Equality Delivery System (EDS2) update report to the Committee for approval for publication. She explained that the EDS2 was required to be published annually by CCGs and described how the CCG had met its statutory requirements in terms of equality.

Members learned that the CCG had tried to increase community engagement on equality objectives over the past few years and this had included establishing an equality panel with providers, involving the voluntary sector. Equality schemes had been put before the panel for consideration and a grading panel then met to agree a grade of performance for the CCG on its equality objectives.

PW added that the report included comments and recommendations from the grading panel, and some information from the CCG around these. The objectives for the coming year were being finalised based on the feedback from the panel.

KS commented that she had attended the panel meetings on behalf of the CCG and that greater representation at the panels across all of the protected characteristics would be helpful.

DECISION:

The Committee APPROVED the EDS2 report for publication.

343/17 BETTER CARE FUND PLAN

DG presented a report on the Better Care Fund (BCF) plan to the Committee for assurance. The report explained that each Health and Wellbeing Board area was required to submit a two year plan to NHS England by 11 September 2017 to explain how the Better Care Fund would be used. Members noted that the BCF Plan provided the legal architecture between Calderdale CCG and Calderdale
Council to deliver the Single Plan for Calderdale. It also aligned to the West Yorkshire Sustainable Transformation Plan (STP), particularly in relation to improving social care sustainability, and enhanced personalised support.

DG explained that the Equality Impact Assessment was initially completed in 2014 and would be refreshed based on engagement feedback.

Members learned that the BCF plan had to focus on improvements in four areas: delayed transfers of care; non-elective admissions (General and Acute); admissions to residential and care homes; and effectiveness of re-ablement.

DG briefly described some of the work underway to address these areas, such as metrics around harm caused by delayed transfers of care for particular patient groups such as the over 75s, and patients with mental health conditions.

Members also agreed that it would be helpful to focus on other areas of big spend for the CCG such as community services, and how these schemes were progressing. HD asked about how any duplication between schemes could be reduced and DG explained that she had an overview of all schemes, but that this could be more formally joined up. She suggested that the Integrated Commissioning Executive (ICE) could refer schemes to the Quality Committee for review and overview.

Members agreed that it would be helpful to receive the draft plan at the September 2017 meeting before it went to the Governing Body in October 2017, and to then receive a quarterly update on the various improvement schemes underway in the CCG in December 2017. The Committee could then decide what information they wished to receive in the future.

DG added that all 34 schemes in the BCF were being reviewed as part of a large scale review of improvement work. Any changes to the BCF plan would have to be signed off through the governance arrangements in the CCG and at the council, then go to an NHS England Board for review and approval.

**DECISION:**

The Committee were **ASSURED** by the information in the report.

**ACTION:** DG to liaise with ICE about referring schemes to Quality Committee for review and overview.
duplicate discharge summaries had been solved, but AB stated that he had received duplicate summaries that morning, so the problem was still ongoing.

Members also discussed the ‘action for GP’ box being ticked on discharge summaries and MA confirmed that CHFT were aware of the issues with this. He added that further clarity was required on who needed to take action in response to this box, as in some cases it was the community team. PW added that any change in practice would need to be agreed and MA suggested that the LMC Interface group would be the best place for this.

The Committee noted that the recovery plan may go to the CHFT Clinical Quality Board but that PW would also request it beforehand.

LB next highlighted the information included in the report on E.coli reduction targets. She explained that Calderdale, Kirklees and Wakefield were working together to develop a plan for this and that Greater Huddersfield CCG was trialling some data capture software. The discussion then focussed on the need for a system-wide conversation in Calderdale about E.coli reduction and avoidability.

Members next discussed CHFT staffing information. LB stated that there were still a very large number of nursing vacancies at CHFT and this was a national issue. Members noted that the focus of the next CHFT Clinical Quality Board would be on workforce. PW added that the discussion would include a focus on ‘amber’ rated wards and persistently low-staffed wards to see what was being done in these areas to improve staffing levels.

Referrals from the Medicines Advisory group to the Quality Committee were included in the report for the first time, as a timely method for the Quality Committee to receive information / understand concerns etc. HF summarised the issues and the Committee focussed on the request from the CCG that GPs provide extra assurance on compliance with a particular safety alert. It was suggested that the Local Medical Committee agree a set of principles for deciding when the CCG should request extra assurance from practices on safety alerts, how this should be done, and any consequences for not doing so. It was agreed that HF should lead this.

The Committee next reviewed the quality and safety dashboard and noted that CHFT was rated red for complaints. Members agreed that this indicator should be moved to ‘enhanced surveillance’. Members also agreed that complaints indicators should be added to the dashboard for South West Yorkshire NHS Foundation Trust (SWYPFT).

DECISION:

The Committee were ASSURED by the information provided.

ACTION:

a) HF to contact the Local Medical Committee about agreeing a set of principles for deciding when the CCG should request extra assurance from practices on safety alerts, how this should be done, and any consequences for not doing so.  

b) AW to amend quality and safety dashboard to move CHFT complaints to ‘enhanced surveillance’ and add complaints indicators to SWYPFT dashboard.

HF

AW
COMMISSIONING FOR QUALITY AND INNOVATION SCHEME QUARTER 1 PERFORMANCE

LB presented the quarter 1 Commissioning for Quality and Innovation Scheme (CQUIN) performance for the CCG’s main providers. Members noted that the indicators in the scheme were set nationally and that there were no local indicators. LB explained that South west Yorkshire Partnership NHS Foundation Trust, BMI Huddersfield, Spire Elland and Yorkshire Ambulance Service had all achieved 100% of their indicators. Calderdale and Huddersfield NHS Foundation Trust (CHFT) had failed indicators 2a and 2b which related to timely identification and treatment of sepsis.

The Committee questioned whether the failure to achieve two CQUIN indicators by CHFT was related to the introduction of the electronic patient record and LB said that it was possible that the screening of patients for sepsis was not being recorded by the system. MA added that he was concerned about the failure to treat identified sepsis within an hour, and wished to raise this issue at the next CHFT Clinical Quality Board, which the Committee agreed to.

DECISION:

The Committee NOTED the information provided and AGREED to raise the failure to achieve CQUIN indicator 2b by CHFT at the next CHFT Clinical Quality Board.

ACTION:

PW to raise the failure to achieve CQUIN indicator 2b at the next CHFT Clinical Quality Board.

PRIMARY CARE DASHBOARD

DR presented the primary care dashboard report to the Committee for assurance. The detailed report included information on care Quality Commission (CQC) inspections, General Practice Outcome Standards, the GP patient survey, Friends and Family Test performance, patient participation groups, quality premiums, enhanced services and patient online.

DR highlighted particular areas of focus for her team, including working with the four GP practices whose patient experience survey result was 10% or more below the national average; support to practices rated as ‘requires improvement’ after their CQC inspections; and the best way to triangulate information about GP practices held by different parts of the CCG. Coverage of enhanced services was discussed in more detail, as was GP online.

In relation to enhanced services, members noted that one practice did not offer the learning disability health check and questioned why this was. DR confirmed that all practices should offer the health check. PW suggested that perhaps the health check was carried out as part of the patient’s usual appointments, but that it would be useful to seek extra assurance from the practice about the service.

Members agreed that any changes to commissioning enhanced services schemes should wait until the review of the schemes was completed.

PW questioned why four practices were not engaging with GP Online and meeting targets. DR explained that she was working on ascertaining the reasons behind this and that while it was not a contractual requirement for practices, using GP Online was consistent with the GP forward view.
CT stated that her practice was one of the four practices not using GP Online and highlighted her conflict of interest again at this point. She explained that the practice had not used GP online due to personnel issues which had now been resolved.

DG agreed to bring further information to the Committee on the four practices which were not meeting GP Online targets.

**DECISION:**

The Committee **RECEIVED** and were **ASSURED** by the information in the report.

**ACTION:**

a) DR to seek assurance form the GP practice not offering the annual health check for patients with a learning disability about how this need was met. DR

b) DR to bring further information to the Committee on the four practices which were not meeting GP Online targets. DR

### 347/17 NATIONAL AUDITS – CLINICAL EFFECTIVENESS AND COMPLIANCE

Louise Burrows presented the national audits and clinical effectiveness and compliance report to the Committee for assurance. The report included information about three national audits undertaken in quarter 1, and a description of provider compliance with NICE guidance. The three national audits included fracture liaison service, maternity services and myocardial ischaemia. In terms of the audit results, members noted that Calderdale does not currently have a fracture liaison service and is looking how to implement this; the audit of maternity services was generally very positive, and the myocardial ischaemia audit suggested that public awareness of heart attack symptoms be raised. The Committee learned that Calderdale and Huddersfield NHS Foundation Trust (CHFT) had provided the CCG quality team with updates on their responses to the audits. A lack of local data had been highlighted, and raised with the Yorkshire and Humber network.

The Committee noted that CHFT was non-compliant with 18 out of 58 new or updated NICE guidelines published in quarter 1. Reasons for non-compliance had been provided for three guidelines and LB highlighted that non-compliance is reviewed in detail at the CHFT Clinical Quality Board.

PW added that NICE had published sets of indicators which could be used when commissioning new services.

The Committee were assured by the process in place within the CCG to manage national audit data and NICE guidance compliance.

**DECISION:**

The Committee **RECEIVED** and were **ASSURED** by the clinical effectiveness and compliance update provided.

### 348/17 REVIEW OF GOVERNING BODY ASSURANCE FRAMEWORK

RG presented the Governing Body Assurance Framework (GBAF) to the Committee for review. The report summarised the changes made during the review cycle and included the updated action plan. RG also explained that the Senior Management Team (SMT) had reviewed the GBAF earlier in August and were satisfied with the changes made. The Committee agreed that clinical leads...
should be contacted again by the risk owner managers prior to the SMT review with a summary of any changes made (or a description of ‘no change’) to provide them with an opportunity for further comment / increased awareness.

**DECISION:**

The Committee **REVIEWED** the Governing Body Assurance Framework.

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349/17 **REVIEW OF QUALITY COMMITTEE WORK PLAN 2017-18**

The Committee reviewed the work plan for 2017-18.

**DECISION:**

The Committee **RECEIVED** and **NOTED** the work plan.

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350/17 **MINUTES TO RECEIVE**

**DECISION:**

The Committee **RECEIVED** and **NOTED**:

a) Medicines Advisory Group minutes of 18 May 2017

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351/17 **ANY OTHER BUSINESS**

None raised.

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352/17 **MATTERS TO REFER TO THE GOVERNING BODY OR PRIMARY MEDICAL SERVICES COMMITTEE**

There were no referrals to the Governing Body or Primary Medical Services Committee.

**DECISION:**

The Committee **AGREED** referrals to Governing Body and Primary Medical Services Committee.

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353/17 **DATE AND TIME OF THE NEXT MEETING:**

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

28 September 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>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control Annual Report for 2016-17 and HCAI</td>
<td>310/17c</td>
<td>CWa and PW to discuss escalation of Leeds laboratory results sharing software issues.</td>
<td>Caron Walker / Penny Woodhead</td>
<td>In progress</td>
<td>Public Health England is setting up a new IT system which is taking time. Continue to monitor.</td>
</tr>
<tr>
<td>Improvement Plan for 2017-18</td>
<td></td>
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</tr>
<tr>
<td>Better Care Fund Plan</td>
<td>343/17</td>
<td>DG to liaise with ICE about referring schemes to Quality Committee for review and overview.</td>
<td>Debbie Graham</td>
<td></td>
<td>September 2017</td>
</tr>
<tr>
<td>Quality and Safety report and Dashboard</td>
<td>344/17a</td>
<td>HF to contact the Local Medical Committee about agreeing a set of principles for deciding when the CCG should request extra assurance from practices on safety alerts, how this should be done, and any consequences for not doing so.</td>
<td>Helen Foster</td>
<td>In progress</td>
<td>HF met with LMC chair to discuss. Further detailed discussions to be held.</td>
</tr>
<tr>
<td>Quality and Safety report and Dashboard</td>
<td>344/17b</td>
<td>AW to amend quality and safety dashboard to move CHFT complaints to 'enhanced surveillance' and add complaints indicators to SWYPFT dashboard.</td>
<td>Alison Waters</td>
<td>Complete</td>
<td>September 2017</td>
</tr>
<tr>
<td>CQUIN scheme quarter 1 performance</td>
<td>345/17</td>
<td>PW to raise the failure to achieve CQUIN indicator 2b at the next CHFT Clinical Quality Board.</td>
<td>Penny Woodhead</td>
<td>CQB meeting will take place on 26-9-17</td>
<td>26 September 2017</td>
</tr>
<tr>
<td>Primary Care Dashboard</td>
<td>346/17a</td>
<td>DR to seek assurance from the GP practice not offering the annual health check for patients with a learning disability about how this need was met.</td>
<td>Debbie Robinson</td>
<td>In progress</td>
<td>TS emailed the practice for assurance. Awaiting response.</td>
</tr>
<tr>
<td>Primary Care Dashboard</td>
<td>346/17b</td>
<td>DR to bring further information to the Committee on the four practices which were not meeting GP Online targets.</td>
<td>Debbie Robinson</td>
<td>In progress</td>
<td>Information requested from IT lead.</td>
</tr>
</tbody>
</table>
Commissioning Primary Medical Services Committee Meeting  
Held on Thursday, 1st June, 2017, 5pm to 5:30pm  
at the Elise Whiteley Innovation Centre, Halifax

FINAL Minutes

Present

John Mallalieu (JM) Lay Member to the Governing Body  
(Chair of the Committee)
Matt Walsh (MW) 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 Steven Cleasby (SC) Governing Body GP Member

In attendance

Martin Pursey (MP) Head of Contacting & Procurement  
(for agenda item 7)
Debbie Robinson (DR) Head of Primary Care Quality & Improvement –  
(for agenda Item 5)
Tracey Robson (TR) Primary Care Quality & Improvement Project  
Officer (Minutes)
Lesley Stokey (LS) Head of Finance (for agenda item 6)
Helen Wright (HW) Director, Healthwatch Calderdale

WELCOME & INTRODUCTIONS

08/17 APOLOGIES FOR ABSENCE AND WELCOME TO NEW GOVERNING BODY MEMBER

Apologies were received from Neil Smurthwaite, Chief Finance Officer/Deputy Chief Officer, Kathryn Hilliam, Head of Primary Care Co-commissioning NHS England and Judith Salter, Corporate & Governance Manager

JM asked that the Committee’s thanks to Dr Caroline Taylor for her for contribution over the past two years be noted and he welcomed Dr Steven Cleasby to the Committee.

09/17 DECLARATIONS OF INTEREST

JM invited the Committee to declare any interests relevant to items on the agenda.

AB and SC declared a direct professional interest in agenda item 5 Primary Care Quality Indicator Report – General Practice High Level Dashboard as the information collated related to the performance indicators of GP Practices in Calderdale.

MW, DR, HW and KS declared an indirect personal interest; this was because they are patients in Calderdale Practices.
DECISION

JM advised that the expertise of the conflicted members and their input into the discussion was beneficial to the Committee and the Committee agreed and as such he proposed that AB, SC, MW, DR, HW and KS take part in the whole item.

AB and SC declared a direct financial interest in agenda item 7 “Alternative Provider Medical Services Contract performance review”.

KS declared an indirect personal interest; this was because she was a patient at a neighbouring practice.

DECISION

In acknowledging the decision had been made at the previous meeting and this item related to assuring performance, 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 AB and SC were invited to stay in the meeting to participate in the discussion and it was agreed that KS would stay in the meeting to inform the discussion.

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 SC to withdraw from the discussion at any point if he felt it appropriate to do so.

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 FEBRUARY 2017

DECISION

That the minutes of the meeting held on 2nd February, 2017 were RECEIVED and ADOPTED as a correct record, subject to the following amendments:-

Minute 06/17-1, 3 and the Decision, A Typical should read Atypical.
Minute 06/17-1 practises should read practices.

ACTIONS AND MATTERS ARISING

Min. 05/17 APMS Contract Learning/development opportunities

DR advised that Primary Care Commissioning (PCC) could provide a half day development session. Following further discussion it was
agreed that development would be helpful to some but not all members of the Committee and that in the first instance the Committee would utilise the wealth of experience and knowledge of colleagues who understood and managed the contracts within the organisation to help its members better understand what the different approaches to contracting might be. DR agreed to liaise with the Committee members to identify their development needs and MP and DR would provide an outline of the training required at its meeting in August.

11/17 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

12/17 PRIMARY CARE QUALITY INDICATOR REPORT – GENERAL PRACTICE HIGH LEVEL DASHBOARD

DR presented the Primary Care Quality Indicator report and the General Practice High Level Dashboard as part of the quality assurance arrangements for General Practice. The report focussed on Quarter 4 2016-17, and highlighted general practice performance, it also highlighted that in some areas there was a significant lag in terms of the availability of data, in particular 3.2 and 3.4. It was also noted that the report had been considered by Quality Committee who had asked that the next report provide clarity in relation to actions taken with specific practices.

The Committee was asked to review the dashboard and consider the format of the report from an assurance point of view and whether any further information would be required for future reports.

In the discussion, the following recommendations were noted:

- It was acknowledged that the report was a starting point for the Committee to build upon and that the sources of the data contained in the report were based on what was currently available and it was recognised there should be caution in its interpretation. DR also advised that the content of the report related to services provided under the CCGs delegated budget.
- More clarity in relation to CQC ratings was required, for example ‘rated good overall but requires improvement’ was not a defined CQC outcome.
- Friends and Family Test; ‘patients would recommend the practice’. Further assurance is to be provided by including response rates.
- Reporting priorities should be agreed; Access was used as an example.
- Include Access Incentive Scheme and Access from a patient perception point of view by using Patient Survey results.
- Report variances in performance in general practice for Diabetes audits/financial prescribing data/ compliance with pathways in high priority areas were used as an example.
- Focus on quality, reporting escalations on an exceptions basis.
A more detailed discussion was had about the recommendations and all agreed that:

- The report should link to the Primary Care/Calderdale Clinical Commissioning Group (CCG) strategies, recognising that some of the metrics would rank as more important as they were aligned to the CCGs strategic intent and may impact what was currently measurable via the dashboard in its current format.
- The inclusion of a strengthened set of metrics/framework in relation to Access would help the Committee understand the wider picture across Calderdale.
- A mechanism be put in place to escalate exception reporting from the Quality Committee to this Committee.

It was acknowledged that other sources of information available, including historical data, would provide a different picture and help develop the dashboard further; however it was recognised that care needed to be taken not to overburden the Committee. The focus should be on its priorities as this would keep the dashboard manageable. Using Appendix 5A, item 11, Enhanced Services as an example, JM suggested that reporting by exception would scale back the need for assurance of completeness versus the pathway analysis, commitment and contribution to strategy included in the report.

JM asked the Committee if they were comfortable with the suggested recommendations. The Committee indicated they were. The Committee also recognised that due to the reporting timeline, data would not be available for its meeting in August and DR advised that it would be the framework that is presented.

Further information to be included in future reports:

- Revisit CQC and Friends and Family Test data as referred to above
- Include Access Incentive Scheme and Access from patient perception point of view using Patient Survey results
- Link the report to the CCG and Primary Care strategies
- Include Access as a priority using strengthened set of metrics/framework that reflect the wider picture across Calderdale
- Scale the report down by reporting by exception, not assurance of completeness
- Put in place a mechanism to escalate exception reporting from the Quality Committee to this Committee.
- As discussed under item 13/17, consider using a precis of the Quality Committee Report for the Primary Care quality Indicator Report.

**DECISION**

The Committee **RECEIVED and NOTED** the Primary Care Quality Indicator Report and the General Practice High Level Dashboard and **AGREED** that further information, as set out above, be included in
LS presented the Finance report. The report provided the Committee with information relating to the final financial position of primary care co-commissioned delegated budget for 2016/17 and the proposed budgets for 2017/18 and advised that the budgets were monitored on a monthly basis by the Finance and Performance Committee.

The Committee was asked to note that it was the first Finance report to be presented to the Committee and were asked to consider the report, and identify any amendments to the format or additions to the content.

JM invited comments from the Committee and the following points/issues were noted.

- AB asked if any contingency had been included in the budget for the reimbursement of sick pay for doctors, he advised that this was part of the new contract, and was perceived as a significant change in general practice. He added that in the past, GPs had indemnified themselves for sickness pay but the new contract had introduced direct reimbursement for practitioners. LS agreed to check whether any monies had been factored into the GMS allocation to cover the reimbursement of sick pay for practitioners and to also understand what the financial exposure might be if no allocation has been included. LS will report back to the next meeting in August.

- SC asked if the GMS/PMS OOH (Out of Hours) uplift of £0.06 per weighted patient was correct. LS explained that GMS had been uplifted by £4.76 per weighted patient, a separate budget line for OOH shows an increase of £0.06p per weighted patient and PMS had seen an uplift of £4.27 per weighted patient, the £0.06 is a deduction for those practices who opt out, which is line with the guidance.

- A risk summary, highlighting actuals and variances will be included in future reports.

- AB asked if the same format approach could be considered in relation to the previous agenda item, the Primary Care Quality Indicator report, e.g. produce a precis of the Quality Committee report and the Finance & Performance Committee report. JM asked that this be considered further.

JM asked the Committee if they were comfortable with the format and the content of the report. The Committee confirmed that, subject to the inclusion of a risk summary, they were happy with the report, adding that it had provided the right level of information and relevant highlights which the Committee needed to be made aware of.
For clarity and taking into consideration the discussions under item 12/17 in relation to the provision of a wider ranging Primary Care Quality indicator report DR asked, from a finance perspective, if the Committee would still wish to see financial information that related solely to the delegated budget. DR pointed out that the new wider Primary Care Quality Indicator report would include primary care information that is funded from the CCG’s budget and this would have a financial reporting impact.

Following further discussion, it was agreed that, although the entire CCG’s budget was not the responsibility of Commissioning Primary Medical Services Committee, in terms of understanding the wider picture of primary care in Calderdale, it would be beneficial to the Committee for the Finance report to include both budgets. LS advised that she would arrange for the CCGs high level primary care budget information to be included in future reports.

**DECISION:**

The Committee **RECEIVED** and **NOTED THE** Finance Report and **AGREED** that the following information would be included in future reports.

a) Risk summary which highlighted actuals and

b) The CCG’s high level primary care budget information which would provide a complete picture of Primary Care spend and activity.

**14/17 APMS CONTRACT PERFORMANCE REVIEW**

Prior to MP presenting the APMS contract performance review, JM reminded the Committee that the decision was made in February 2017 to extend the Park & Calder APMS contract by six months from October 2017 to March 2018, subject to the Committee being assured about its performance, and he advised that the decision would only be revisited should there be areas for concern.

MP reported that overall the general performance of this contract was positive; he referred the Committee to points 4.10 and 4.11 of his report which provided a summary of practice performance and incentivised stretch performance requirements of the Contract. When referring to Key Performance Indicators SD2 and SD5, MP advised that although the provider had not yet provided their reports, this was being rectified and would be included in the next reporting cycle.

The Committee confirmed they were comfortable with the assurance the report provided.
DECISION

The Committee:

1) RECEIVED and NOTED the content of the report and its recommendations
2) CONFIRMED that they had sufficient assurance and confidence to the 6 month extension of contract.
3) MANDATED Officers of the CCG to proceed to implement the extension following due process.

15/17 DATE AND TIME OF NEXT MEETING IN PUBLIC

The Committee NOTED that the next meeting would take place as follows:

Thursday, 3rd August 2017, 4pm – 5.30pm at the Elsie Whitely Innovation Centre, Hopwood Lane, Halifax. HX1 5ER
## Commissioning Primary Medical Services Committee Meeting 1st June 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>
</table>
| **Matters Arising** Min. 05/17 APMS Contract Learning/development opportunities | 10/17 | a) Liaise with committee members to identify learning/development needs and provide an outline of the training required to Committee’s August meeting.  
   b) Committee members to engage with DR to share their learning needs. | Martin Pursey & Debbie Robinson | In progress & on PRIVATE agenda | 03/08/2017 |
| **Primary Care Quality Indicator Report – General Practice High Level Dashboard** | 12/17 | Provide update report to include revisions to format and content as follows:  
   ▪ More clarity re CQC and Friends and Family Test data  
   ▪ Include Access Incentive Scheme and Access from patient perception point of view  
   ▪ Report to be linked to the CCG and Primary Care strategies  
   ▪ Include Access as a priority using strengthened set of metrics/framework to reflect the wider picture across Calderdale  
   ▪ Scale down the report by reporting by exception, not assurance of completeness  
   ▪ Put in place a mechanism to escalate exception reporting from the Quality Committee to this Committee.  
   ▪ Consider using similar format (precis of the Quality Committee and the Finance & Performance Committee report) (raised under 13/17) | Debbie Robinson | On agenda | 03/08/2017 |
| **Finance Report** | 13/17 | a) Check whether monies for the reimbursement of sick pay for practitioners has been factored into the GMS allocation and understand what the financial exposure might be if no allocation has been included. | Lesley Stokey/Neil Smurthwaite | On agenda | 03/08/2017 |
b) Future update reports to include revisions to format and content as follows:
- Include risk summary and CCG primary care budget information resulting in a complete picture of Primary Care spend and activity

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<tr>
<th>Proposal for reinvestment of PMS Premium Funding</th>
<th>06/17 a)</th>
<th>PMS Reinvestment of Premium funding – Incentive Scheme to improve Access; provide update report</th>
<th>Debbie Robinson</th>
<th>Not due yet</th>
<th>05/10/2017</th>
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<td>06/17 b)</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>05/10/2017</td>
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West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups
Minutes of the meeting held in public on Tuesday 4 July 2017
Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF

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<tr>
<th>Members</th>
<th>Initials</th>
<th>Role and organisation</th>
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<tbody>
<tr>
<td>Marie Burnham</td>
<td>MB</td>
<td>Independent Lay Chair</td>
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<tr>
<td>Richard Wilkinson</td>
<td>RW</td>
<td>Lay member</td>
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<tr>
<td>Fatima Khan-Shah</td>
<td>FKS</td>
<td>Lay member</td>
</tr>
<tr>
<td>Dr James Thomas</td>
<td>JT</td>
<td>Clinical Chair, NHS Airedale, Wharfedale and Craven CCG</td>
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<tr>
<td>Dr Andy Withers</td>
<td>AW</td>
<td>Clinical Chair, NHS Bradford Districts CCG</td>
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<tr>
<td>Helen Hirst</td>
<td>HH</td>
<td>Chief Officer, NHS Bradford City &amp; Districts</td>
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<tr>
<td>Dr Alan Brook</td>
<td>ABr</td>
<td>Clinical Chair, NHS Calderdale CCG</td>
</tr>
<tr>
<td>Matt Walsh</td>
<td>MW</td>
<td>Chief Officer, NHS Calderdale CCG</td>
</tr>
<tr>
<td>Dr Steve Ollerton</td>
<td>SO</td>
<td>Clinical Leader, NHS Greater Huddersfield CCG</td>
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<tr>
<td>Carol McKenna</td>
<td>CMc</td>
<td>Chief Officer, NHS Greater Huddersfield CCG</td>
</tr>
<tr>
<td>Dr Alistair Ingram</td>
<td>AI</td>
<td>Clinical Chair, NHS Harrogate &amp; Rural District CCG</td>
</tr>
<tr>
<td>Amanda Bloor</td>
<td>ABI</td>
<td>Chief Officer, NHS Harrogate &amp; Rural District CCG</td>
</tr>
<tr>
<td>Dr Alistair Walling</td>
<td>AWa</td>
<td>GP Clinical Lead, NHS Leeds South &amp; East CCG</td>
</tr>
<tr>
<td>Dr Gordon Sinclair</td>
<td>GS</td>
<td>Clinical Chair, NHS Leeds West CCG</td>
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<tr>
<td>Visseh Pejhan-Sykes</td>
<td>VPS</td>
<td>Chief Finance Officer, NHS Leeds CCGs Partnership (deputy for Philomena Corrigan)</td>
</tr>
<tr>
<td>Dr David Kelly</td>
<td>DK</td>
<td>Clinical Chair, NHS North Kirklees CCG</td>
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<tr>
<td>Richard Parry</td>
<td>RP</td>
<td>Chief Officer, NHS North Kirklees CCG</td>
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<tr>
<td>Dr Phillip Earnshaw</td>
<td>PE</td>
<td>Clinical Chair, NHS Wakefield CCG</td>
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<tr>
<td>Jo Webster</td>
<td>JW</td>
<td>Chief Officer, NHS Wakefield CCG</td>
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**Apologies**

Dr Akram Khan
AK Clinical Chair, NHS Bradford City CCG

Dr Jason Broch
JB Clinical Chair, NHS Leeds North CCG

Philomena Corrigan
PC Chief Executive, NHS Leeds CCGs Partnership

Moira Dumma
MD Director of Commissioning Operations (Y&H), NHS England

**In attendance**

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<tr>
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<tr>
<td>LA</td>
<td>Director of Delivery – West Yorkshire, North Region NHS England</td>
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<tr>
<td>IH</td>
<td>Programme Director, WY&amp;H STP</td>
</tr>
<tr>
<td>JWe</td>
<td>Director of Finance, WY&amp;H STP</td>
</tr>
<tr>
<td>SG</td>
<td>Joint Committee Governance Lead (minutes)</td>
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<tr>
<td>KC</td>
<td>WY&amp;H STP Communication &amp; Engagement Lead</td>
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WY&H Joint Committee of CCGs – 04/07/2017

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For items 03/17 and 04/17

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Position</th>
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<tbody>
<tr>
<td>Rory Deighton</td>
<td>RD</td>
<td>Director, Healthwatch Kirklees</td>
</tr>
<tr>
<td>Dr Graham Venables</td>
<td>GV</td>
<td>Clinical Director, Y&amp;H Clinical Networks</td>
</tr>
<tr>
<td>Jacqui Crossley</td>
<td>JC</td>
<td>Head of Clinical Effectiveness and Governance, Yorkshire Ambulance Services</td>
</tr>
<tr>
<td>Jonathan Booker</td>
<td>JBo</td>
<td>STP Senior analyst</td>
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<tr>
<td>Linda Driver</td>
<td>LD</td>
<td>STP Stroke Project Lead</td>
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25 members of the public attended the meeting.

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<tr>
<th>Item No.</th>
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<tr>
<td>01/17</td>
<td>Welcome, introductions and apologies</td>
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The Chair welcomed everyone to the first meeting in public of the Joint Committee. Apologies were noted. MB said that the Committee brought together the 11 CCGs across WY&H. She emphasised that although the Committee supported the STP, the Committee only included CCGs and did not represent all of the partners involved in the STP.

MB highlighted that the role of the Committee was to make collective decisions on shared priorities across WY&H, and that it was not the business of the Committee to deal with issues in individual places.

Open Forum

Before the start of the formal meeting, there was an opportunity for members of the public to make representations or ask questions about the work of the Joint Committee. A Deputation was received from the campaign group Hands off Huddersfield Royal Infirmary (HRI):

- How do the STP and local plans fit together? Would specialist stroke services be based at HRI? Was consideration being given to the availability of community based services to support stroke patients once they had been discharged?

Members of the public asked questions about:

- Had decisions already been taken to close hyper acute stroke units? The availability of detailed STP financial information and how decisions would be made about finance gaps within the STP? The validity of the evidence collected as part of the stroke engagement exercise and case for change? Who would ultimately make decisions about the configuration of stroke services?

- From the memorandum of understanding for the Joint Committee: what is a Lead commissioner/Contractor? What decisions are delegated to the Joint Committee? What happens when a CCG disagrees with a decision of the Joint Committee?

- The impact of budget reductions across WY&H on plans to close the A&E department at HRI?

MB said that, where appropriate, answers to these questions would be provided as part of the relevant agenda items. If this was not possible, a full written response would be provided. These questions, and the answers to them, would be posted on the Joint Committee webpages following the meeting.

SG/KC
<table>
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<tr>
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<tr>
<td>JW</td>
<td>emphasised that this was a meeting in public, not a public meeting. Local issues should be taken up at place level. WY&amp;H stroke questions would be addressed under the specific agenda items, and there would be a further opportunity for questions later in the meeting.</td>
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<td>02/17</td>
<td>Declarations of Interest</td>
<td>The register of interests of members of the Joint Committee was tabled at the meeting. The Chair reminded Committee members of their obligation to declare any interests they may have on any issues arising at meetings which might conflict with the business of the Committee. No further declarations were made.</td>
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<tr>
<td>03/17</td>
<td>Learning from patients and the public – Stroke</td>
<td>MB emphasised the importance of public engagement in informing and shaping the design of care pathways, and introduced AW, who chaired the stroke Task and Finish Group. AW presented the background to the work and introduced the stroke specialists, including clinical advisors, who were in attendance today. In 2013, the 10 WY CCGs had identified stroke as a priority for West Yorkshire. 3 elements had been highlighted – prevention, discharge and hyper acute stroke units (HASU). At that time, Airedale HASU had been forced to close as it had not been sustainable, and services had transferred to Bradford. This had emphasised the importance of sustainability across WY&amp;H, which became a priority for the STP. There were 3600 admissions a year across WY&amp;H, which was expected to increase by 10%. There were 2 big issues involved with ensuring access to specialist care – workforce and capacity. The case for change recognised the need to further improve and ensure the sustainability of services. Referencing 2 of the questions posed earlier, AW emphasised that no specific recommendation or decisions had yet been taken on the number of HASUs. Although the focus of today was on HASUs, he emphasised the need to address the whole stroke pathway and ensure that the right support services were available close to people’s homes. AW highlighted the need to engage with people to identify their needs. This would then be used to review the existing pathway and develop new clinical models over the coming months. The Committee watched a short video featuring Malcolm and Sue. Malcolm had suffered a stroke, and the video presented the challenges that he and his family had faced. RD then presented the results of a public engagement exercise led by Healthwatch in February and March 2017. Healthwatch had used a variety of methods to engage the public. Feedback from social media indicated that 98,000 people were aware of the engagement exercise. 940 surveys had been returned. 75% of respondents had direct lived experience of stroke, either as a patient or carer. The work had also included consultant-led focus groups and interviews. RD noted the main messages, which included immediate access to tests and treatment, effective discharge and follow up services, the role of voluntary organisations, and the need to join up services and provide ongoing support and review. The importance of prevention work had also been highlighted.</td>
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|         | RD said that the approach to stroke services met the Healthwatch principles of engagement. There had been transparent engagement from the start, with people with lived experience of stroke.  
FKS congratulated Healthwatch on the report and methodology. The quality of engagement had been good. There was a recognised need to engage more effectively with some minority groups, including Eastern European and BME groups.  
JW felt that it was an excellent piece of engagement work. She questioned whether more focus was needed on recognizing the signs of stroke.  
SO highlighted some powerful messages, including the variation in care between weekdays and weekends and that some respondents had been diagnosed but not admitted.  
DK questioned the variation in survey response rates. RD said that there were fewer in Bradford, as similar work had already been done in that area.  
In response to a question from MB, RD said that there had been feedback to everyone who had participated in the engagement.  
Responding to a question from FKS, KC said that engagement colleagues were exploring a variety of options for involving patients in the Task and Finish Group.  
MB invited questions from members of the public:  
- **How could quality stroke support be provided in the community in the light of financial challenges?**  
- **How could Healthwatch be seen as independent?**  
AW responded that the aim of the redesign was to improve quality and outcomes. There may be cost impacts, but the focus was firmly on quality.  
RD said that Healthwatch was an independent charity, funded by local authorities. They had set out to listen to local people, and had no preconceived ‘agenda’.  
**The Joint Committee: Noted** the Stroke Services Engagement Report key findings and next steps.  
**04/17** **Improving stroke outcomes**  
JW presented the report, highlighting three main objectives: improving stroke outcomes, using resources efficiently and effectively and ensuring that stroke services were sustainable and fit for future. The focus of today was on specialist services, but there was a need to cover the whole pathway in future work.  
The case for change recognised that high quality care in the first few hours was critical. There were significant workforce challenges in ensuring high quality services, 24 hours a day, 7 days a week. Clinical outcomes varied across WY&H and there was a need to learn from best practice and experience elsewhere, which indicated that outcomes were better when treatment was provided in specialist centres. Key factors to be taken into account included NICE guidelines and opportunities provided by new technology.  
The case for change highlighted clearly the need to review existing services. There had been extensive engagement with key stakeholders, including the Clinical Senate, patients and the public, providers and Overview and Scrutiny Committees.  |
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<td>The first stage of the NHSE assurance process had been completed. The next steps were to develop an outline business case and report back to the Joint Committee in November. FKS welcomed the case for change. She identified some areas for further focus, including supporting carers/families to travel to specialist centres and prevention support for BME and Eastern European groups. JW acknowledged the need to do more to engage with some populations. DK identified the need for greater consistency of post-stroke support across all places in WY&amp;H. He felt that the Committee had an important role to play in addressing resourcing and workforce issues. JW said that this was a good example of how the STP and Joint Committee could support work across a WY&amp;H footprint. AW added that the Task and Finish Group would be addressing the whole care pathway. HH asked whether the identified risks around workforce and the sustainability of services could be managed within the proposed timeframe. JW responded that the current services were providing safe care, but that there was a need to strengthen resilience. At present, it was planned that options for change would be presented to the Joint Committee in November. ABr noted that only a proportion of patients would benefit from HASU services, and emphasised the importance of effective ambulance care. JC added that the aim was a ‘gold standard’ pathway, with patients receiving the best possible care. MB welcomed the report and the engagement that supported it. FKS added that the Lay Member Reference Group of the WY&amp;H CCGs had been updated on the process so far. MB invited questions from the public: • The finding that outcomes for stroke patients are better from specialist services was questioned, particularly in relation to thrombolysis. • How will you ensure clinically led, evidence based care when dealing with financial challenges? Where is the money coming from? • How will you ensure high quality care at home? • Where will decisions be taken about the reconfiguration of services • A comment was made that the Healthwatch findings supported the ‘basics’ of good care, follow up and local services. GV responded that thrombolysis had limited value, but that some stroke patients did benefit from it. All aspects of stroke care were much better organised in specialist centres and benefitted everyone who came through the service. Critical issues like swallowing, positioning and hydration were dealt with by specialist staff. AW responded that the stroke work was strongly clinically driven and included acute hospital stroke leads. He added that investment in prevention services could reduce the number of strokes. JW invited members of the public to submit any further questions outside of...</td>
<td>JW</td>
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<td>meeting. MB welcomed the interim report and looked forward to firmer proposals on the way forward coming back to the Committee in November.</td>
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<td>The Joint Committee:</td>
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<tr>
<td>• Noted progress to date; • Noted the Engagement Report and Strategic Case for Change; and • Noted the next steps and timelines.</td>
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<td>05/17 The Operation of the Joint Committee</td>
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<td>SG presented the report, which set out the role, membership and purpose of the Joint Committee and how it would operate. The report set out the basis on which the 11 CCGs in WY&amp;H had delegated WY&amp;H-level decisions to the Joint Committee. Appendix A included the Memorandum of Understanding for Collaborative Commissioning and the membership and terms of reference of the Joint Committee. It also covered the quorum for the Committee and the voting arrangements. Appendix B presented the Committee’s workplan. This set out the specific decision areas which had been delegated to the Joint Committee by the CCGs, including stroke, urgent care and cancer services. To ensure appropriate challenge and transparency, the Joint Committee was Chaired by an Independent Lay Chair and also included 2 Lay members from the CCGs. Meetings were held in public and agenda papers, minutes and decision summaries would be posted on the Committee’s webpages. The Committee had set out some principles for involving the public, and would review these as the Committee developed. The Committee workplan was firmly focused on what needed to be done at WY&amp;H level to deliver the outcomes set out in the STP. The Committee’s workplan had been prepared in late 2016 and was very high level. There was now a need to be more specific about the scheduling of decisions that would be coming to the Joint Committee. HH highlighted the need to log and respond to all relevant questions and to post answers on the website. MB noted the need to distinguish clearly between issues at WY&amp;H level for which the Committee was responsible, and work at place level, which should be addressed locally. JW noted the need to engage effectively at local place level and emphasised the ‘3 tests’ which defined work at WY&amp;H level. These were where WY&amp;H – level work was needed to improve outcomes, share best practice of deal with common problems. DK emphasised the need to establish greater clarity about the Committee workplan. MB advised that the Committee needed to appoint a Deputy Chair. She proposed that Gordon Sinclair be appointed for a six months interim period. In response to a question from DK, MB explained that GS had extensive experience of chairing the Collaborative of CCGs over the past 3 years. He would act as Deputy for six months, whilst the 2 CCG Lay members gained experience of the operation of the Committee. GS noted that if he was required to deputise, any conflicts would be identified</td>
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and managed appropriately. He reiterated that the Committee had delegated responsibility for commissioning decisions.

MB invited questions from the public:
- *When would the earlier questions about the MOU be answered? Why were local authorities not represented on the Joint Committee in their role as commissioner?*

JW responded that the CCGs worked closely with local authorities at both place and WY&H level. Answers to all questions would be provided following the meeting.

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The Joint Committee:
- **noted** the Memorandum of Understanding for Collaborative Commissioning including the Committee’s Terms of Reference, membership and Workplan
- **noted** the appointment of the Independent Lay Chair and 2 Lay representatives, and **appointed** Gordon Sinclair as interim Deputy Chair for six months.
- **noted** how the public will be involved and the shared outcomes and targets towards which the Committee is working.
- **noted** the approach to refreshing the Committee’s workplan and **requested** that an updated workplan be brought back to the Committee for approval in November 2017.

**06/17 Any other business**

There was none.

**Next Joint Committee in public** - Tuesday 5th September 2017, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF.