Agenda Item: 2

NHS Calderdale Clinical Commissioning Group

Minutes of the Public Section of the Governing Body Meeting held on Thursday 08 February 2018 at 2pm in Function Room 2 at the Shay Stadium, Halifax

DRAFT MINUTES

Present:	Dr Alan Brook	AB	GP member and Governing Body Chair
	Neil Smurthwaite	NS	Chief Finance Officer / Deputy Chief Officer
	Dr Steven Cleasby	SC	GP Member and Assistant Clinical Chair
	Dr Robert Atkinson	RA	Secondary Care Specialist
	Dr Majid Azeb	MA	GP Member
	Jackie Bird	JB	Registered Nurse
	Farrukh Javid	FJ	GP Member
	John Mallalieu	JM	Lay Member (Finance and Performance)
	Kate Smyth	KS	Lay Member (Patient and Public Involvement - PPI)
	Dr Caroline Taylor	CT	GP Member
	Dr Nigel Taylor	NT	GP Member
Invitees:	Penny Woodhead	PW	Chief Quality and Nursing Officer
	Stuart Smith	SM	Director of Adult and Children's Services, Calderdale Metropolitan Borough Council
In attendance:	Judith Salter	JS	Head of Corporate Affairs and Governance/Board Secretary
	Andrew O'Connor	AOC	Corporate and Governance Officer (Minutes)
	Rhona Radley	RR	Service Improvement Manager (item 7, min no. 07/18)
	Cate Simmons	CS	Lead Nurse – Children (item 7, min no. 07/18)
	Debbie Robinson	DR	Head of Primary Care Quality and Improvement (item 9, min no. 09/18)
	Martin Pursey	MP	Head of Contracting and Procurement (item 9, min no. 09/18)
	Tim Shields	TS	Performance Manager (item 10 c, min no. 10/18)
	Robert Gibson	RG	Risk, Health and Safety Manager (item 11 min no. 11/18)
			Plus 4 members of the public.

01/18 APOLOGIES FOR ABSENCE AND INTRODUCTIONS **Action**

Apologies for absence were received from Matt Walsh (Chief Officer), David Longstaff (Lay Member - Audit and Deputy Chair), Dr Helen Davies (GP Member), Paul Butcher (Director of Public Health, Calderdale Metropolitan Borough Council).

02/17 DECLARATIONS OF INTEREST

GP Governing Body members were declared to have a direct financial interest in item 9 (minute 09/18) as it related to financial investment in General Practice. It was explained that AB would hand over the Chair to JM for this item. It was then proposed that the GPs should take part in the initial discussion on this item, as they were in a position to provide valuable input, particularly in terms of the CCG's strategic commissioning intention for improved access. However, at a suitable juncture, as decided by JM, that they should leave the room to allow the remaining Governing Body members to continue their deliberation and then make

a decision.

The Governing Body was supportive of the proposed arrangements for managing the conflict of interest in relation to Item 9 (Minute 09/18)

There were no further declarations.

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.

03/17 MINUTES

DECISION:

1. The minutes of the public section of the Governing Body meeting held on 14 December 2017 were **RECEIVED** and **ADOPTED** as a correct record subject to the following amendment:

Minute Number 81/17 – Finance, Contracting and Recovery Report

"those that attended an IAPT service" to be amended to read "those that attended an **integrated** IAPT service".

All actions arising from the meeting were noted to have been completed.

04/18 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

05/18 PATIENT STORY

PW introduced a short film on the subject of vascular dementia produced by the West Yorkshire & Harrogate Strategic Transformation Partnership (WY&H STP). It featured a patient's partner and their account of the impact of vascular dementia and the adequacy of care at home and in care homes. The film was not specific to Calderdale but to one of the localities across the partnership.

Following the film, PW noted that the Governing Body had previously discussed the work of carers in other contexts, of which the film provided a further example, before highlighting that the account raised issues concerning service delivery. She raised questions regarding the appropriateness of their admission to an acute setting and the forward planning of support that had taken place at that time.

Comments and questions were invited from the Governing Body.

A conversation followed:

- It was noted that the frailty service in Calderdale and Huddersfield ensured residents returning home from an acute setting did so with a specific and broad package of care in place.
- Early diagnosis was recognised to be key to the implementation of effective, personalised and self-directed care packages and improved outcomes for patients. To this end, the importance of improving dementia awareness was noted.
- The important role played by care homes in providing care for dementia sufferers and potential benefits for carers was recognised.

- The joint work carried out by the Health Sector and Social Services in Calderdale for sufferers of dementia was noted.

PW concluded the item explaining that the Governing Body's comments would be shared with the CCG's Service Improvement Team and its Clinical Leads to advise future discussions and planning.

PW was thanked for bringing the matter forward for discussion.

DECISION:

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

06/17 CHIEF OFFICER'S REPORT

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

Winter

The report recognised the positive impact of partnership working on system performance during the winter period. Since the publication of the meeting paper, an instruction to recommence routine elective surgery from the beginning of February had been received. It was noted that services were getting back to normal; however, significant pressures were continuing and were being addressed by the Accident & Emergency (A&E) Delivery Board.

Right Care, Right Time, Right Place

A High Court Judge had refused permission in relation to the application for a judicial review of Calderdale and Huddersfield NHS Foundation Trust's (CHFT) decision to approve the Full business Case. The claimants had applied for an oral hearing which would take place on the 15 March 2018.

The Secretary of State for Health had written to the Joint Overview and Scrutiny Committee on the 25th January 2018 advising the committee that an Independent Reconfiguration Panel had been asked to undertake an initial assessment of their case. The report was expected to be provided no later than 26th February 2018. The CCG had made the required submissions.

Calderdale Leadership Group – Collective Statement of Purpose

The report provided information on work that was taking place between leaders across Calderdale. A further meeting was taking place on the 9 February 2018.

Voluntary Action Calderdale (VAC)

The report provided information on the positive work and success of VAC's "Molly and Bill" project ("**M**aking **O**ur **L**ives **L**ively and **B**eing **I**nvolved in **L**ocal **L**ife"). The project was launched in autumn 2016 with the aim of providing creative and meaningful activities for care home residents.

Changes to Date Protection Legislation

The new General Data Protection Regulation (GDPR) was due to come into force on the 25 May 2018. The GDPR would replace the existing UK Data Protection Act and required that CCG's designate a Data Protection Officer (DPO). The role

and duties of a DPO were set out 5.3 and 5.4. The Audit Committee had supported the recommendation that the CCG's Head of Corporate Affairs and Governance take on the role of DPO on an interim basis. The parameters underwriting this decision were set out at 5.5. NS reflected positively on the standard of the IG work and provision at the CCG.

Accountable Care Contracts (ACC)

NHS England (NHSE) had announced that it would be launching a further consultation on the contracting arrangements for Accountable Care Organisations (ACOs). A letter from Sarah Wollaston, the Chair of the Parliamentary Health Selected Committee, to the Secretary of State, had been provided for information at Appendix 1.

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

The decision summary from the meeting that had taken place on the 9 January 2018 had been supplied at Appendix 2.

Comments and questions were invited on the items covered in the Chief Officer's report.

- NS confirmed that he believed that CHFT was now getting back to normal and undertaking some inpatient elective care but that there were some ongoing pressures and capacity issues to be managed. He noted that there would be learning across the NHS which should feed into future planning.
- In response to a comment regarding the value of effective winter planning, NS reflected that work undertaken to addresses Delayed Transfers of Care and other trends had contributed to system performance over the winter period, but recognised this was inconsistent across the NHS.
- The CCG's Winter Access to Primary Care Scheme was noted to have performed well as part of the system wide approach to meeting system demand during the winter period. It was suggested that the contribution made across the system should be taken into account when addressing the winter metrics.
- The fact that local hospitals continued to outperform those across the partnership was recognised.

DECISION:

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

07/18 SPECIAL EDUCATIONAL NEEDS AND/OR DISABILITIES (SEND) FOR CHILDREN AND YOUNG PEOPLE

RR in presenting the report explained that the document supplied at Appendix 1 set out the work and approach of the CCG in support of Children and Young People (C&YP) with Special Educational Needs and/or Disabilities (SEND). She explained that the document was not intended to constitute a change to the CCG's Constitution or existing joint arrangements, but to provide a "holding position" while formal strategies and the required documentation were put in place. CS explained that formal documentation was required by the NHS England (NHSE) diagnostic checklist which sought to determine the CCG's compliance with is legal obligations relating to Part 3 of the Children and Families Act 2014.

It was noted that the paper presented for approval would be published on the CCG website.

Comments and questions were invited.

- PW advised the Governing Body that this matter had featured in an earlier Quality and Safety Report and the paper was the outcome of the further work referenced at that time as needing to take place.
- In response to a suggestion it was agreed that the paper should include a link to the local offer so that parents could access guidance and advice on the steps they could take.
- PW advised the Governing Body that C&YP SEND compliance featured on the CCG's risk register. Furthermore, that it had relevance to future joint targeted inspections. In this context, she queried whether the Governing Body would like the Quality Committee to undertake further scrutiny work.
- SS provided positive feedback on performance in several areas but noted that wheelchairs and CAMHS services were potential areas for challenge.
- NS suggested that the information presented could usefully be fed into the CCG''s future commissioning activity.
- In response to a question, RR advised that a meeting would take place with Corporate Governance colleagues with a view to the work being completed in the next six months.
- In response to a question, CS advised that the paper was not intended to report on levels of performance but to confirm how the CCG was meeting its statutory duty. Performance information was noted to be available in the SEND Annual Report which was received by the Quality Committee.

DECISION:

The Governing Body **NOTED** the content of the paper for assurance and **APPROVED** its publication on the website subject to the agreed amendment. **RR/CS**

08/18 PUBLIC SECTOR EQUALITY DUTY

PW presented the Public Sector Equality Duty (PSED) Annual Report 2018. The report provided an annual update of activities undertaken to embed equality across the CCG. The report also contained details of the CCG's compliance with the PSED which the CCG was required to publish annually.

Equality was highlighted to be critical to the CCG's successful commissioning of services that meet the needs of the local population as well as being a matter of pride for the organisation.

The report contained a number of links to further information. Attention was drawn to Section 6 and information concerning work undertaken against the CCG's original Equality Objectives which had been introduced in 2013. Work undertaken to understand the experience of South Asian people accessing diabetes services and patient experience monitoring processes were both highlighted. Significant work was also noted to have taken place around the CCG's Equality Impact Assessment (EIA) processes both in support of the CCG's recovery plan and system recovery.

New objectives had been developed through the CCG's Equality Delivery System (EDS) and subsequently endorsed by the Governing Body in December 2017. Plans in relation to these new objectives were in development. The Equality Health Panel had been established and would play a part in the delivery of

improvements; as would HR colleagues in preparation for the introduction of Workforce Disability Equality Standard.

KS reflected positively on the content of the report and the hard work of the Quality and Engagement Teams. She explained that conversations were taking place with other Public and Patient Involvement (PPI) Lay Members to gather and share best practice. She also suggested that, despite it not being a protected characteristic, poverty should be an important consideration for the CCG in terms of its decisions.

Comments and questions were invited:

- In response to a question, PW explained that some Equality Delivery System Panel members had not been aware of the full range of equality materials available as part of the Right Care, Right Time, Right Place programme. While the CCG had robustly challenged the view and made the panel aware of the full range of materials available, PW explained that, in line with appropriate self-assessment methodology, the panel's original response had been reported.
- In response to a question, it was noted that the Senior Management Team had asked the CCG's HR lead to develop some proposals on how the CCG workforce might better reflect the diversity of the local population.

DECISION:

The Governing Body **APPROVED** the report for publication.

09/18 EXTENSION OF THE IMPROVING ACCESS PILOT

JM in the Chair.

JM reminded the meeting that due to the GP Governing Body Members having a direct financial interest in the item, it had been agreed that they would take part in the initial discussion, but would then, at a suitable juncture, leave the table so that remaining Governing Body members could continue their deliberations and make a decision.

DR in presenting the report sought approval for the extension of the Improving Access Pilot until 31 March 2019. The paper was noted to:

- Set out the CCG's approach to achieving 100% population coverage of access to GP surgeries at evenings and weekends to meet locally determined demand;
- Provide the background to the pilot;
- Provide details of the funding that the CCG was expecting to receive from April 2018 onwards;
- Set out a number of issues for considerations, at 2.5;
- Outline two options, at 3.1 and 3.2;
- Indicate a recommended option, at 3.3.

Questions and comments were invited.

During the discussion, the following points were made:

- The use of NHS England (NHSE) terminology to describe appointment types in future ("pre-bookable" and "same day") was agreed,

- The funding available in 2018/19 was recognised as non-recurrent.

- There was recognition that that a pilot approach had been adopted for several interrelated reasons. These included the need to test an approach with providers, the outputs of which would be used to inform future commissioning intentions; to test concepts and assumptions contained within the emerging Integrated Urgent Care Model (IUMC); to take into account the evolving nature of both the guidance from NHS England (NHSE), and the evolving debate around the IUMC; and to learn from the experience of providers in delivering the service for the first time.

- There was a consensus concerning the need to be clear about the aim of the service and how its impact, both for patients and on the wider system, would be evaluated.

- There was a general agreement that the proposal moved beyond a service pilot.

- From a procurement point of view, the "pilot" proposal was clarified to be a "time limited direct contract award" and that the recommendation asked for the scope and length of that award be extended.

- The extension, as detailed in the report, was noted as allowing innovative ways of working and initial proof of concept, which had not been commissioned previously, to be tested and explored. Furthermore, that this would, if required, result in the development of a service model and the undertaking of a procurement exercise in 2018/19.

At 2.39 pm, the GP Governing Body members left the room.

JM advised the Governing Body that, as the GP members of the Governing Body were conflicted and could not take part in the decision, alternative quoracy arrangements as set out in the CCG's Constitution would need to be implemented. For the purpose of the item, it was noted that the Governing Body would be deemed to be quorate if at least four of the remaining members of the Governing Body were present including either the Registered Nurse or Secondary Care Specialist and either the Chief Officer or the Chief Finance Officer/Deputy Chief Officer

The required members were noted to be in attendance and the meeting proceeded to the deliberation and decision.

Comments and questions were invited.

- PW confirmed that there were no plans for the CCG to undertake any further patient engagement work in the next 12 months and that the outcomes of the original engagement work and the ongoing work being carried out by providers collecting patient experience data would be brought together later in the process when evaluating service impact. She also noted that the conjoint analysis of patient preference referenced earlier took place outside the two to three year timeframe typically applied by the CCG.
- NS confirmed that the funding for 2018/19 was ring fenced for the purpose of delivering extended access.
- In response to a comment, DR confirmed that NHSE had published revised guidance since the meeting papers had been published and that this would need to be taken into account.
- MP summarised that the CCG ultimately needed to be clear about what it wanted to commission and the length of the contract. He reflected that, at this

point in time, it was the unlikely that a procurement process would either be competitive or robust. Furthermore, that the approach that had been taken and proposal put before the Governing Body for decision placed the CCG in a strong position in terms of extended access and the development of the broader IUCM.

DECISION:

The Governing Body **APPROVED** the extension of the time limited direct award contract to the 31 March 2019.

GP Governing Body members re-joined the meeting.

10/18 FINANCE, CONTRACTING AND RECOVERY REPORT

NS in presenting the report highlighted the following key messages:

Finance

- The CCG continued to forecast delivery of an in-year deficit of £3.13m which had been agreed by regulators.
- There continued to be significant risk in the system. The appendices supplied were noted to set out the best and worst case scenarios. The CCG was currently reporting an unmitigated risk of £581k (best case) and £3.6m (worst case).
- Negotiations with the main acute provider regarding year-end position were ongoing.
- The CCG was still forecasting to achieve its expected financial plan for the year. Whilst not underestimating the challenges going forward, this was noted to be an achievement considering the level of risk encountered during the year.
- Pressures arising from prescribing stock shortages were beginning to reduce; NHS England (NHSE) would not be top slicing the Category M saving in 2018/19; and the majority of prescribing Quality Innovation, Productivity and Prevention (QIPP) saving targets had been fully realised but would continue to be a focus for activity going forward.
- Running costs remained on budget and there was no planned reduction or increase in 2018/19. However, the CCG would need to take account of pay awards.

Comments and questions were invited.

- In relation to 1.2.5, NS confirmed that the £2m movement was that referred to in Appendix A. The CCG would be correctly reporting CHC expenditure when completing national benchmarking returns going forward.

Recovery

- A System Recovery Group had been established as part of the governance arrangements for system recovery. NS was noted to be the Chair of the group which had met on one occasion. The group was addressing the affordability gap concerning hospital fees which had been recognised through the Right Care, Right Time, Right Place programme. Above this executive group, a Partnership Transformation Board had been established replacing two system meetings. The Board had also met for the first time.
- A number of contract reviews had been discussed by the CCG's Finance and Performance Committee. The committee's recommendations were set out at 2.4.2.
- National planning guidance had been received a week prior to the meeting.

The CCG's financial plans and proposals would be brought forward through the CCG's governance processes. The CCG was reported as needing to improve its financial position in 2018/19 by £7.4m. As it would not be meeting national business rules, the CCG would be required to submit a further Financial Recovery Plan for scrutiny by regional and national partners.

Contracting

- NS had attended the Place Overview and Scrutiny Meeting on the 7 February 2018 which had received a report concerning Posture and Mobility (wheelchair) Services. He advised the Governing Body that a great deal of learning needed to be taken into account when service proposals were brought through at a future date.

DECISION:

The Governing Body **NOTED** the contents of the report and the financial position.

11/18 QUALITY AND SAFETY REPORT AND QUALITY DASHBOARD

PW in presenting the report highlighted the following:

Ensuring Quality During Winter

- The CCG had not received any specific guidance from NHS England (NHSE) and NHS Improvement (NHSI) concerning the quality response to winter pressures in 2017/18. The CCG had continued to work on the basis of previous guidance, in particular the quality measures set out at 2.3.
- The CCG had been asked to look at ambulance turn-around times and those breaching 60 minutes where harm occurs, reporting them as serious incidents.
- Since the publication of the papers, the CCG had received a request asking for information concerning 12 hour trolley waits.

Serious Incident (SI) Management

- There had been on overall improvements in the quality and timeliness of Serious Incidents Reports but challenges persisted in instances where there complex SI's involving multiple organisations. Dialogue with providers was reported to be very good.

Healthwatch Enter and View Visit

- Health watched had the power to undertake "enter and view" visits with all providers. The visit to the Dales Unit at Calderdale Royal Hospital was reported at 5.0. The Quality Care Commission (CQC) would revisit the South West Yorkshire Partnership NHS Foundation Trust (SWPFT) to undertake it 'well-lead organisation' review and follow-up review in the two to three months following the meeting.

Quality Dashboard

- The Quality Committee had discussed undertaking further work regarding health care associated infection rates, C-difficile in particular. The committee was seeking further assurance that sufficient actions were being taken.

Comments and questions were invited:

- A significant improvement in the percentage of time-to-theatre for patients with a Fractured Neck-of-Femur was noted. PW advised that the Quality Team would continue to monitor performance for at least another three months to ensure the improvement was sustained.
- The Public Health Team was exploring options concerning data access. PW had sought further information and a timeframe for resolution. MA commented that he was not confident all the available data was being extracted.
- In response to a question regarding pressure ulcers, PW advised that she did not think that there was a correlation between occurrences and levels of nursing staff.

DECISION:

The Governing Body **RECEIVED** the report and **NOTED** the actions being taken.

12/18 PERFORMANCE REPORT

In presenting the report, TS highlighted the following key points:

- The overall performance for referral to treatment (RRT) and cancer waiting times (CWT) did not include data from Bradford Teaching Hospitals due to the implementation of Electronic Patient Record (EPR) system. This was noted to account for between 2% and 4 % of activity.
- December's A&E performance was 88.2%. Although below the required standard, system performance exceeded levels achieved regionally and nationally. Calderdale and Huddersfield NHS Foundation Trust (CHFT) was currently rated 12th nationally.
- Calderdale's published delayed transfers for care figures for November were set out at 5.2. These were noted to be positive,
- The underachievement regarding diagnostic waiting times was reported to be due to issues concerning access to CT scans at CHFT.

Comments and questions were invited:

DECISION:

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

13/18 HIGH LEVEL RISK LOG AND REPORT - RISK CYCLE 5 2017-18

RG in presenting the high level risk report for risk cycle 5 highlighted the following points:

- There were 37 open risks on the risk register with four marked for closure, leaving 33 open risks.
- There was one Critical Risk (Risk 62) (scoring 20) and seven serious risks (scoring 15-16).
- All risks had been submitted for review to either Finance and Performance or Quality Committees at their meetings on the 25 January.
- Risk 984 was the only risk that had increased it score during the cycle. The reason was noted to be set out in the report at 2.8.

Questions and comments were invited.

- There was a short discussion regarding Risk 62 relating to A&E performance

given that the CCG's performing well in comparison to other areas. It was noted that the CHFT's risk register included a risk concerning the achievement of an improved trajectory.

- In response to a question, PW confirmed that the rating relating to risk 1069 (Electronic Patient Record) would reduce during cycle 6.

DECISION:

The Governing Body **CONFIRMED** that it was **ASSURE**D that the High Level risk register represents a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 4 of 2017-18. This was following a review of the respective risks at the Quality and Finance & Performance Committee meetings on 25 January 2018.

14/18 COMMITTEE MINUTES

a) The Minutes of the Audit Committee

DECISION:

The Governing Body **RECEIVED** the minutes of the Audit Committee meeting held on 21 September 2017.

b) The Minutes of the Quality Committee held on 30 November 2017 and 21 December 2017

DECISION:

The Governing Body **RECEIVED** the minutes of the Quality Committee meetings held on 30 November 2017 and the 21 December 2017

c) The Minutes of the Commissioning Primary Medical Services Committee meeting held on 5 October 2017.

JM advised the Governing Body that the committee had met once since its meeting October and had undertaken a development session.

DECISION:

a) The Governing Body **RECEIVED** the minutes of the Commissioning Primary Medical Services Committee meeting held on **5 October 2017.**

15/18 MINUTES OF THE WEST YORKSHIRE AND HARROGATE JOINT COMMITTEE OF CCGs MEETING HELD ON THE 7 NOVEMBER 2017.

The Governing Body **RECEIVED** the minutes of the meeting of West Yorkshire and Harrogate Joint Committee of CCGs held on 7 November 2017.

16/18 KEY MESSAGES FOR MEMBER PRACTICES

DECISION:

- Extended Access Decision
- Thanks on the work carried out on managing winter pressures

17/18 DATE AND TIME OF THE NEXT MEETINGS OF THE GOVERNING BODY IN PUBLIC:

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

CCG Governing Body Meeting
8 March 2018, 2.00pm
The Shay Stadium
Halifax

Governing Body Meeting Thursday 8 February 2018 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
SEND for C&YP	07/18	Amend as agreed and upload C&YP with SEND paper to website	RR/CS	**COMPLETE**	08/03/2018
PSED Report 2017/18	08/18	Publish PSED Report 2017/18 on the CCG website	PW	**COMPLETE**	08/03/2018
KEY MESSAGES TO MEMBER PRACTICES	16/18	Communicate Extended Access Decision to Member Practices	Comms DR	**Ongoing**	08/03/2018

Name of Meeting	Governing Body	**Meeting Date**	8 March 2018
Title of Report	**Calderdale Cares**	**Agenda Item No.**	4
Report Author	Matt Walsh	**Public / Private Item**	Public
GB / Clinical Lead	Chief Officer	**Responsible Officer**	Dr Matt Walsh

Executive Summary							
Please include a brief summary of the purpose of the report	The governing body is presented with three related papers under this agenda item. The first is a brief paper describing the CCG context into which the other papers fit. The others are presented as appendices to the first. They are: 1. An introduction to the Calderdale Cares proposal from Calderdale Metropolitan Borough Council (CMBC) written by the CMBC Chief Executive and Director of Public Health, and 2. The paper which was presented to and ratified by CMBC Cabinet on 12th February 2018						
Previous consideration	**Name of meeting**	Calderdale CCG Governing Body Development Session	**Meeting Date**	11/01/2018			
	Name of meeting	Health and Wellbeing Board	**Meeting Date**	21/12/2017			
Recommendation (s)	It is recommended that the Governing Body: 1. **NOTES** the content of this suite of papers 2. **RESOLVES** to commit the CCG to work in partnership with others in the system to begin to map out how the vision might be realised. 3. **RESOLVES** to commit the resources to support the Local Authority to develop a Memorandum of Understanding which will be presented back to the Governing Body for approval in the late spring.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	37T

Implications			
Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)	We will need to maintain a focus upon quality and safety if we agree to progress. We may wish to consider joint priorities and system governance arrangements for Quality.		
Public / Patient / Other Engagement	This proposal moves us beyond engagement and towards true participation and co-creation with localities, communities and individuals.		
Resources / Finance implications (including Staffing/Workforce considerations)	The proposal here carried no specific financial risk. The capacity and resource deployed in support of partnership working is already in place.		
Strategic Objectives (GBAF) (which of the CCG objectives does this relate to?	Strategic Objective no. 1 - Achieving the agreed strategic direction for Calderdale ▪ Integrated	**Risk** (include risk number and a brief description of the risk)	None identified

	commissioning ▪ Tackling the Wider Determinants of health ▪ Care closer to Home ▪ Optimising system working		
Legal / CCG Constitutional Implications	This particular decision exposes us to no additional risk.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	This particular decision holds no specific conflict of interest.

1. Introduction

1.1 The CCG has articulated within its strategic plans over the past 4 years a clear intention to work with the local health and care system to better integrate health and care services for the benefit of the people that we serve. We have said this because when we have engaged and consulted with people they have told us that they want this to happen. They are confused about multiple entry points into care, they are tired of having to tell their story more than once and they are clear that we should work more effectively together to improve health and prevent illness and dependency.

2. Calderdale Cares

Calderdale Cares is a Local Authority led, place based proposal. It calls for a re-alignment and re-integration of Hospital, Mental Health, Social Care, Primary Care and Public Health services. One could see it as a way of addressing the fractures in the way the system is organised which were the unintended consequence of the Health and Social Care Act 2012. The proposal calls for a population based approach to the planning, funding and delivery of Health and Care services in Calderdale. It advocates the application of evidence based design principles and it calls for the integration of the commissioning functions which are the functions responsible for planning and funding Health and Care in Calderdale. The intention behind the proposal is to address the concerns articulated in the introduction.

- To enable easier and faster access to a wider range of joined-up pathways of care where people tell their story once.
- To deliver better outcomes based on what is important to people.
- To deliver more care, closer to home.
- To use technology more effectively to provide novel ways of accessing care and support.

The paper argues that in order to do this we need to act as a whole system. It acknowledges that this is a massive undertaking and will require a different sort of relationship between clinical and professional teams and the people that we are here to serve.

It also argues that in order to be successful we will need to invest in organisational and system development. If we agree to embrace this as an approach, this signals a change in a way of being, not just a change in the way that we do things.

The paper has been considered and adopted by Calderdale Metropolitan Borough Council (CMBC) Cabinet at its meeting on 12th February. It has been approved as an approach by Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board of Governors, and it has the support of the South and West Yorkshire Partnership NHS Foundation Trust board.

At the Cabinet meeting a number of recommendations were accepted;

- To endorse, in principle, the approach to delivering a place-based integrated health and social care system that will enable neighbourhoods to develop at their own pace.

- To endorse, in principle, the alignment of in-scope service budgets.

- To endorse, in principle, the approach to delivering a place-based health and social care system that will enable neighbourhoods to develop at their own pace.

- To ensure shared commitment to reducing inequalities in both access and outcomes;

- To maintain clarity about the boundaries between health and social care in terms of payment and means testing, ensuring that health remains free at the point of access;

- To invite scrutiny to consider and comment on the proposals; and

- To seek to agree a Memorandum of Understanding (MOU) between key partners which sets out the basis for our partnership approach to realise our ambitions for better health and care in Calderdale.

These are the recommendations of the Council's Cabinet. The CCG will need to work with the Council and the whole system to ensure that all our ambitions are aligned.

3. Next Steps

3.1 Should the Governing Body choose to accept the recommendations, the Senior Management Team (SMT) will begin in earnest to work with the Senior Management Team at the Local Authority to describe the governance arrangements which will need to be developed in order to move towards this new set of relationships. It is my view that there is much that could be done within the existing governance and partnership arrangements and that the real question here is not the strength of the governance, but the strength of the belief that this could help us to create something better, and the strength of the will to make that change.

4. Implications

This proposal brings to mind the saying 'be careful what you wish for, it might come true'. The CCG has experienced some considerable challenges over the past four years as we have led and participated in system conversations about approaches to integration, the delivery of Care Closer to Home and the transformation of services. The fact that key partner organisations are now indicating their readiness for an acceleration of work and thinking on integration, the CCG will need to understand and manage the opportunities and risks attendant to this.

The proposal here fits exactly with the ambitions that the CCG has set out in successive strategic plans and is in line with the direction of travel articulated in the West Yorkshire and Harrogate Partnership plan. In fact, should we agree to accept the recommendations here, it will give Calderdale the opportunity to be at the leading edge.

There is a clear recognition within the proposal of the important role that General Practice plays within neighbourhoods and communities, and the philosophy, approaching the development of an integrated model built upon a concept of localities is entirely in line with the thinking and work that the CCG has done with its member practices and is in harmony with the thinking we are beginning to do on Primary Care Home.

If we agree to progress this work in partnership with others in the system we will need to ensure that we retain our clear focus upon quality and safety, understand and manage the opportunities and risks that relate to the financial position of the NHS, further strengthen and align approaches to involvement and participation and manage explicitly the governance and constitutional challenges that will be attendant to integration. At this stage it is not possible to articulate all of those risks. We will learn by doing and by working with partners to understand and share the benefits and risks as a system.

To conclude, as is usual, there are concerns about the approach being advocated here. Some are suggesting that this whole initiative is an attempt to move to a model of care that will necessarily move the system towards a privatised model of care delivery. The Governing Body

will be aware that there are Judicial Review processes operating in relation to potential new contractual models and the fact that the Parliamentary Health Select Committee is reviewing notions of Accountable Care.

This proposal from the council is neither of those things. It is simply a visionary proposal to move to a more integrated approach to the commissioning and delivery of care, focussing upon prevention, participation and the delivery of better outcomes and holding true to the founding principles of the NHS.

5. Recommendations

It is recommended that the Governing Body:

1. **NOTES** the content of this suite of papers
2. **RESOLVES** to commit the CCG to work in partnership with others in the system to begin to map out how the vision might be realised.
3. **RESOLVES** to commit the resources to support the local Authority to develop a Memorandum of Understanding which will be presented back to the Governing Body for approval in the late spring.

6. Appendices

1. Calderdale Cares Introduction
2. Calderdale Metropolitan Borough Council Cabinet Paper - 12th February 2018

Agenda Item 4, Appendix 1

Calderdale MBC

Wards Affected All

Cabinet

12 February 2017

11

Health and Social Care Leadership Approach and Calderdale Cares

Cover Report of Robin Tuddenham, Chief Executive.

Given the present context of intense fiscal challenge, and increasing demand on the Health and Social Care system, there is renewed impetus to establish a clear trajectory for integration of health and social care in every area of England, at each level (Health and Care Partnership, district) by 2020. In response, a range of contracting and organisational forms are emerging that enables the delivery of joined up GP, Hospital, Mental Health and Community Care Services. These include regional approaches, alignment of NHS commissioning and provision, and integration of CCG functions into a local authority as seen in a number of authorities in Greater Manchester and other Councils like North East Lincolnshire.

In Calderdale, there is a strong desire to move towards a place based approach to health and social care, harnessing the contribution of both the statutory and community sectors, ensuring effective governance both clinical and democratically accountable, and defining better the role of the primary and acute system. There is a real opportunity to harness what I describe as the 'collaboration imperative' to develop new relationships, a parity of esteem across the system and a strong sense of place utilising the role of community anchors in early prevention and supporting wider agendas such as inclusive growth. There are important principles which are important to reaffirm; sustaining the NHS as free at the point of delivery, and commitment to what is being described as 'left shift' into the community with a strong focus on the social and wider determinants of health.

This shift seeks to deliver improved access to primary care, effective delivery of services in the community and to support people in their own homes, improved access to mental health oriented around patients' needs, and the ongoing development of evidence based emergency and acute services.

Calderdale Council has produced the paper ***Calderdale Cares: Moving Forward on Health and Social Care***. This reflects a range of discussions within the Council, with Health and Social Care leaders and with local providers. Although not a fixed blueprint, the paper presents a rationale for change, a potential approach to delivering an integrated health and social care system, and highlights the scope of local authority involvement within an integrated system. It also makes recommendations for the Council to consider moving toward integrated Health and Social Care by 2020. The paper has

some clear principles such as defining an agreed approach to neighbourhoods (localities) across the system, more integrated commissioning through the Integrated Commissioning Executive, and clarity of providers at local level through a potential alliance model in future years.

There are many challenges to overcome, a sense of seeing it before, leadership and workforce capacity, economic and political uncertainty, and fiscal pressures leading to a risk of a retreat back to silo working. All of these risks can be overcome. They do not prevent our potential to realise the opportunity for the Calderdale system to write its own script, rooted in communities, within tight resources and with the best chance to create a health and social care system as sustainable as it can possibly be.

Progress so far:

- Discussions have recently taken place at Calderdale Council

- Health and Social Care Leaders have considered the paper in response to the discussion at the last Health and Wellbeing Board with external facilitation. This has sought to consider options both locally and in response to the developing work at a West Yorkshire and Harrogate Health and Care Partnership level.

- The paper was recently presented at Vanguard Board where it was received positively with all partners demonstrating a commitment to move forward, once there is greater clarity on next steps and the position of the Council and partners.

- The Health and Wellbeing Board supports the principles outlined in the paper

Agenda Item 4, Appendix 2

Calderdale MBC

Wards Affected All

Cabinet

12 February 2018

11

Calderdale Cares: Moving Forward on Health and Social Care

Report of the Chief Executive and Director of Public Health

1. Purpose of the report

1.1 In the present climate of fiscal consolidation and growing demand, the government wants to see the integration of health and social care, in all areas of England, by 2020[1]. In response, a range of contracting and organisational forms are emerging across England that sees the alignment of NHS commissioning and provision and integration of CCG functions in a local authority.

1.2 This paper proposes a realignment of community health services, primary care, public health and social care services for children and adults through Calderdale Cares.

1.3 Calderdale Cares is a place-based framework for Health and Social Care in Calderdale that is underpinned by strong collaboration across the statutory and community sector and where organisations work together and share resources to deliver holistic person-centred support at a local level.

1.4 As a leader on "place", the Council is critical to developing a whole system approach where innovative integrated services focus on reduction in health inequalities, and the joint commissioning of preventative services deliver the most improvements to people's health.

[1] Department of Health and Department of Communities and Local Government, 'Better Care Fund, Policy Framework 2016/17', January 2016.

2. Need for a decision

2.1 Cabinet is asked to consider the approach to delivering health and social care integration by 2020 and reach a decision on whether to support it.

3. Recommendation

Cabinet is recommended:

3.1 To endorse, in principle, the approach to delivering a place-based integrated health and social care system that will enable neighbourhoods to develop at their own pace.

3.2 To endorse, in principle, the alignment of in-scope service budgets.

2. Where are we now?

2.1 There is already a successful history of collaboration across Calderdale organisations and their leadership via the Vanguard Programme and Health and Wellbeing Board. Therefore, we should continue to build on the willingness to take joint responsibility for population health and service improvement, whilst reflecting our commitment to having a shared responsibility for the health and care of local people through the triple aim of improved population health, quality of care and financial efficiency.

2.2 The Calderdale Health and Wellbeing Board are currently developing a place-based approach through the Single Plan for Calderdale. The plan outlines a collective vision of a sustainable health & care system for the people of Calderdale that delivers improved health outcomes, reduced health inequalities, greater independence and moves away from the current system that incentivises episodic and fragmented care.

2.3 Within the Council, work is currently underway to develop thinking around integration and to learn from other areas that are at various stages on this journey. Current learning suggests that:

- This is an organisational development, people process, as well as a structural process.
- The role of executive leaders and Elected Members in driving and sponsoring change is critical and needs to be visible throughout.
- Public, staff and stakeholders need to be engaged in co-design.

- The purchaser-provider split incentivises more, not better care.
- Areas must commit to redistributing resources from secondary to community and primary care.
- Integrated models should focus on the needs of the population in place.

2.4 If agreed, the Calderdale Cares proposals will be discussed with the CCG, CHFT, SWYPFT senior leaders. The Chief Executives of these three bodies will put a joint proposal to the meeting of the Health and Wellbeing Board on proposed models of delivery in support of delivering the Single Plan for Calderdale in early 2018.

3. Calderdale Cares Proposal

3.1 Calderdale Cares proposes a vision that remains consistent with public-sector values; but moves from a top-down approach that incentivises fragmented and episodic care, to a locally led whole population system where closely integrated services share resources and work to empower people to take greater ownership of their health and wellbeing in the community.

3.2 Previous public consultations have shown that Calderdale people have concerns about the availability of health and social care services and the quality of those services[2]. Whilst others have felt unable to influence both major decisions about existing services and about their own needs.

3.3 Through a neighbourhood model, Calderdale Cares will introduce locally led integrated services that will continuously engage with the local community and improve outcomes in neighbourhoods through seamless health and social care pathways; shifting demand from more acute services to early intervention and preventative services based in the community; whilst giving Calderdale people a greater opportunity to influence decision making. Neighbourhoods are likely to cover a population of 30000-50000 people. The boundaries will be agreed between the Council and partner organisations.

[2] Calderdale People's Commission, 'Improving Health Together'
https://www.calderdale.gov.uk/v2/sites/default/files/improving-health-together-leaflet.pdf

For the people of Calderdale, this will mean:

- Easier and faster access to a wider range of joined-up pathways of care where people tell their story once.
- Better outcomes based on what is important to people.
- Fewer trips to hospital as more services will be available in the community.
- More advice and guidance to help people make the right choices and manage their own health.
- Better access to local voluntary and community groups.
- More involvement in the design of care services near where people live.
- Support from community and voluntary services when people need them.

For our organisations, this will mean:

- Being part of developing new services that better meet the needs of local people.
- Sharing Risk
- Ongoing engagement and service co-design with service users and the general public
- Delivering integrated services focused on the local needs of individuals, their carers, and their families.
- Developing a flexible workforce aligned to changing patterns in skills and service demand.
- Working with partners to consistently address each of the wider determinants of health.

3.4 To achieve this we need to develop new forms of care to specific cohorts of our population through new organisational forms, such as an alliance model, that work through pooling resources and new forms of commissioning that are aligned with the outcomes set out in the Single Plan for Calderdale (See Appendix 1 -5).

3.5 Calderdale Cares will emphasise improving population health by bringing together multiple interventions across the system through an integrated model that prioritises prevention and addressing the wider determinants of health.

3.6 The neighbourhood model will provide the platform for delivering effective whole population-outcome based services; will ensure that our children have the best start in life; and that Calderdale people live well and age well. To achieve this, integration of health and social care provision will be based around GP practices and the proposed development of an Integrated Wellness Service.

3.7 The Integrated Wellness Service will serve as a holistic approach to addressing the wider determinants of health such as wellbeing, healthy lifestyles, welfare and work/learning skills (See Appendix 3 and 4).

3.8 Calderdale Cares will prioritise the integration of physical and mental health, embedding parity of esteem for physical and mental health conditions across the system and tackling both high rates of mental health conditions among people with long-term physical health problems and a lack of support for wider psychological aspects of physical health and illness.

3.9 A core component for delivering integrated prevention and population needs focused service is the interface between acute hospitals and community based services. Therefore, close effective working relationships between acute hospitals and community based services should be a priority for *Calderdale Cares*.

3.10 Public engagement and scrutiny will form an essential part of Calderdale Cares. We will seek the views of the People Scrutiny Board on the *Calderdale Cares* implementation programme.

We will analyse the wide range of community engagement events that have taken place, including the Council's People's Commission and CCG consultation on hospital and community health services reconfiguration to make sure that the implementation programme for Community Cares takes account of the views of citizens.

Each neighbourhood will be asked to make sure that citizen and service user engagement is central to its activities.

3.11 By 2020, the new care models will be fully assessed and operational; budgets will be aligned and a wide range of services jointly commissioned through Calderdale Cares.

4. Strategy

Stage 1

4.1 The Health and Wellbeing Board's Single Plan for Calderdale is a collective agreement of strategic aims, outcomes, measures and values that informs *Calderdale Cares. It* enshrines a whole system approach, and places the Council at the forefront of a 'place based' approach that emphasises a shift toward locally-led and whole population focused community based support.

4.2 All partners will recognise the potential risks and challenges posed by this including recognition that both the CHFT and SWYPFT may require standardised operating procedures across their larger footprint.

4.3 A full review of borough wide community assets will be undertaken and will form the basis of future models of health and social care.

A scoping exercise will be undertaken, identifying which Council and health services should be aligned.t, this will include a risk analysis and proposals for mitigating those risks.

4.4 In order to reduce duplication and ensure best value for each £ spent, joint commissioning by the Council and the CCG will be undertaken by an enhanced Integrated Commissioning Executive. The broader focus will reflect the whole population outcomes approach to *Calderdale Cares* that will see the allocation of budgets to integrated services on the basis of local need.

4.5 A 'neighbourhoods' model will be established across the health and social care system as a basis for locality working. These areas should cover populations of roughly 50,000 and will manage whole population budgets.

4.6 After a 12-month period, a full review will measure the effectiveness of the new ways of working and identify improvements needed. This review will be considered by the Health and Wellbeing Board.

Stage 2

4.7 By 2020, *Calderdale Cares* will be established as an alliance committed to delivering integrated community health, primary care and social care services with defined outcomes and accountabilities.

4.8 In-scope services will be delivered through local neighbourhoods, all of which will have identified budgets to meet the health needs of their population.

4.9 Governance arrangements for joint commissioning and overseeing service provision will be fully established with continued strategic oversight by the Health and Wellbeing Board, with clear accountabilities for each aspect of delivery.

4.10 The enhanced Integrated Commissioning Executive will play a pivotal role in driving the continued integration process – removing the purchaser/provider split and commissioning the proposed alliance of providers, and regularly monitoring performance in line with pre-determined outcomes.

5. Operational

Stage 1

5.1 Implementation of a common vision for change that will guide the way we will operate, shape our values and behaviors and inform integrated decision making that remains engaged with wider conversations across the West Yorkshire footprint.

5.2 Delivery of a place-based person-centered approach to Health and Social Care against defined whole-population health outcomes, promoting people to live well and age well across the whole of Calderdale.

5.3 Development of effective measures of cost, quality and public satisfaction that link to the Single Plan for Calderdale and are fully deployed across each neighborhood.

5.4 Delivery of a strategy for supporting employees about how their day-to-day work will change and that encourage individuals and groups to take

ownership for their new roles and responsibilities for delivery of an effective preventative/early intervention/self-management service that engenders a culture based on a shared vision and shared principles and lived out in the behaviours of leaders at all levels.

Stage 2

5.5 Delivery of a full system review after 12 months on effectiveness of Calderdale Cares, reviewing agreed measures and responding to recommendations.

6. Governance

Stage 1

6.1 There is no single model of good governance and our collective understanding of what constitutes a suitable arrangement will continue to develop over the coming months. Discussions have considered a number of options, and the favoured approach is detailed in **Appendix 2**. Governance arrangement will be introduced in 2018/19 in "shadow form" with a view to more formal arrangements being introduced from June 2019.

6.2 The Leadership Group (Council Leader and chief executives of Council, CCG, CHFT, SWYPFT) will meet to provide strategic leadership and to ensure productive partnership working.

6.3 The recently formed Single Plan for Calderdale Officer Group will oversee the implementation of decisions of the HWB and the Leadership Group and report to each meeting of the HWB.

6.4 Existing Governance will be reviewed and proposals developed for effective governance that will facilitate establishment of *Calderdale Cares*.

Stage 2

6.5 The Integrated Commissioning Executive will be enhanced, undertaking a broader strategic commissioning role. Its membership will include one

Council Cabinet Member and will commission services that reflect the Calderdale Cares commitment to a whole population integrated system.

6.6 Neighbourhoods will have established mechanisms for engaging with Integrated Commissioning Services with representation from providers, cabinet, and the public

6.7 Governance will be reviewed and proposals prepared to make sure the right governance can be introduced to take forward the next stages of *Calderdale Cares*.

7. Finance

Stage 1

7.1 The Council, the CCG, CHFT and SWYPFT will immediately begin working together to adopt a shared approach to addressing the budget deficit across the whole system.

7.2 Work will begin to identify spend of social care, primary care services and community health with a view to aligning budgets.

Stage 2

7.3 Budgets will be pooled and transferred via ICE to deliver shared health and population outcomes through Calderdale Cares.

8. Next Steps

- Discuss the Cabinet position with the CCG and other health colleagues ensuring linkage with West Yorkshire HWB Chairs' discussions from HWB's Chair meetings and STP footprint.
- Develop a joint strategic outcomes agreement based on the "triple aim" of improved population health, quality of care and financial efficiency.
- Develop a value and behaviours statement to guide the work and as a basis for engaging with staff.
- Review governance arrangements to ensure effective delivery of integrated services.
- Create a project plan for the delivery place based neighbourhood model with details agreed timescales.
- Identify in-scope LA services for alignment with neighbourhood model.

Appendix 1. King's Fund Place-based systems of care design principles.

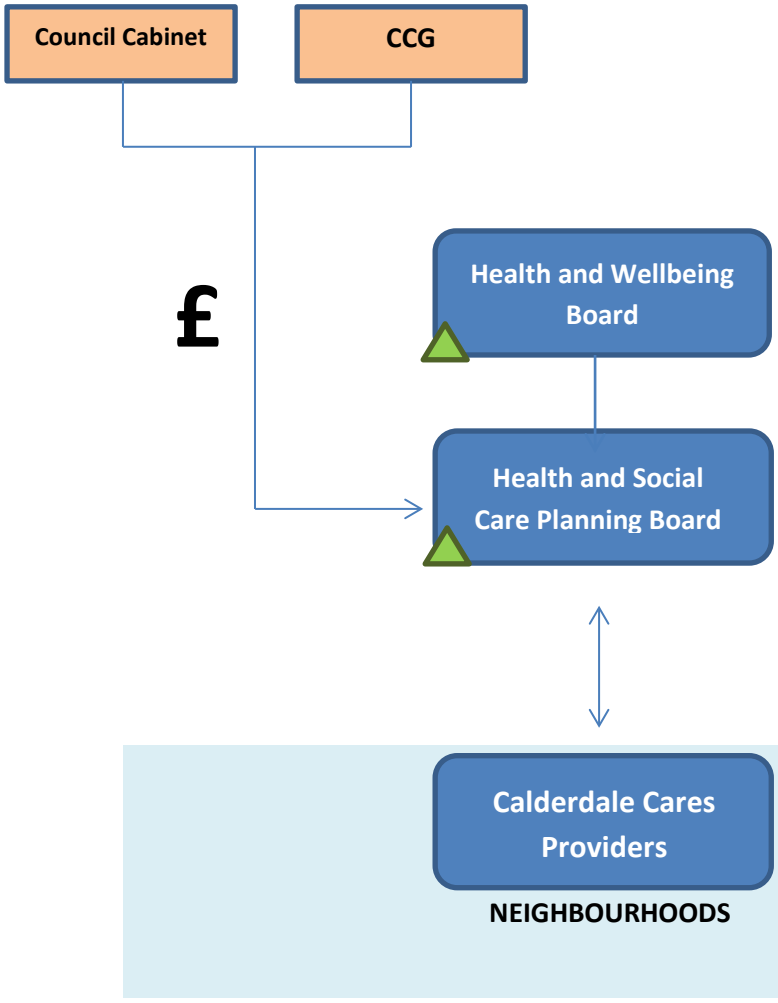
- Define the population group and the system's boundaries
- Identify the right partners and services
- Develop a shared vision and objectives
- Develop an appropriate governance structure
- Identify the right leaders and develop a new form of leadership
- Agree how conflicts will be resolved
- Develop a sustainable financing model
- Create a dedicated team
- Develop a single set of measures

Source: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

KEY:
Proposed Elected Member Position = ▲
Pooled Budget = £

Appendix 2 Potential Structure

These structures are based upon developments in other parts of the country



Health and Wellbeing Board Committee of key partners led by the Council (Chair) – joint strategic needs assessment and place based outcomes strategy for wellbeing system based on defined locality/data. Potential council delegated powers around commissioning/ visible commitment to public engagement.

Health and Social Care Planning Board a joint CMBC/CCG commissioning team with pooled budget rooted in place commissions and monitors Calderdale Cares.

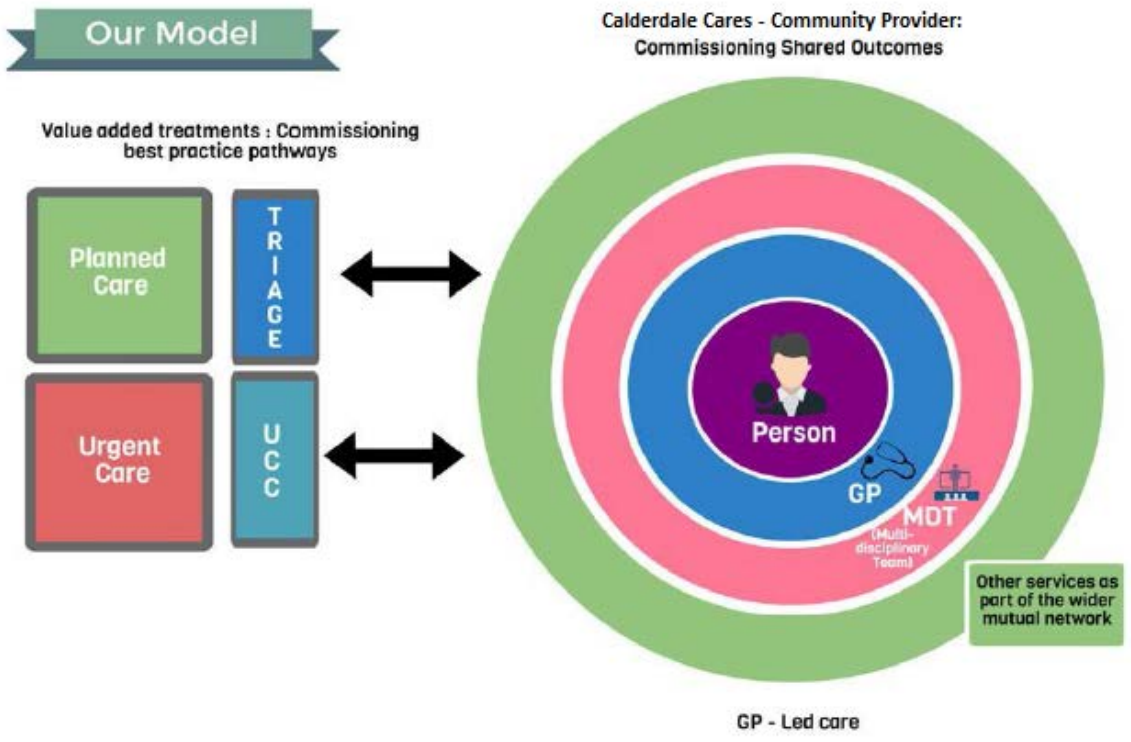
Calderdale Cares Providers - joined up locality hub services within defined localities model.

Budget allocated through a 'population health' based approach targeting needs identified within localities, delivering services focused on prevention and wellbeing.

Appendix 3 Example of a potential Calderdale Cares Model and Patient Pathway

A population with multiple chronic conditions requires care to be provided in an integrated manner as opposed to supplying the predominantly episodic interventions of our fragmented system at present. This potential Calderdale Cares delivery model addresses these imbalances and General Practice takes overall responsibility for the care provided by other services.

Patients can access services via their local GP, a single point of access which ties into a multi-disciplinary team of professionals and services that are able to address needs quickly and efficiently.



The services are summarised below that strive to improve access, continuity and coordination underpinned by more generic population health improvements, system and staff benefits and the empowerment of Calderdale communities.

ii.***Rapid Access Services*** largely delivered on a locality basis and designed to respond to urgent care needs whilst identifying proactively potential onset or exacerbation of illness and ensuring an integrated approach to patient management within a community setting;

iii.***On-going Care Services*** delivered at a GP level predominantly through multi-disciplinary teams (MDTs). These are delivered at scale on a locality through Local Access Hubs effectively forming a mutual network of care with a wider network of community based and voluntary sector services.

iv.***High Care Need Services*** that operate as a 'step up' mechanism for the more vulnerable, complex care patients or patients with increasing acuity that require more enhanced condition management to prevent an admission to hospital and 'stepping down' to On-going Care Services.

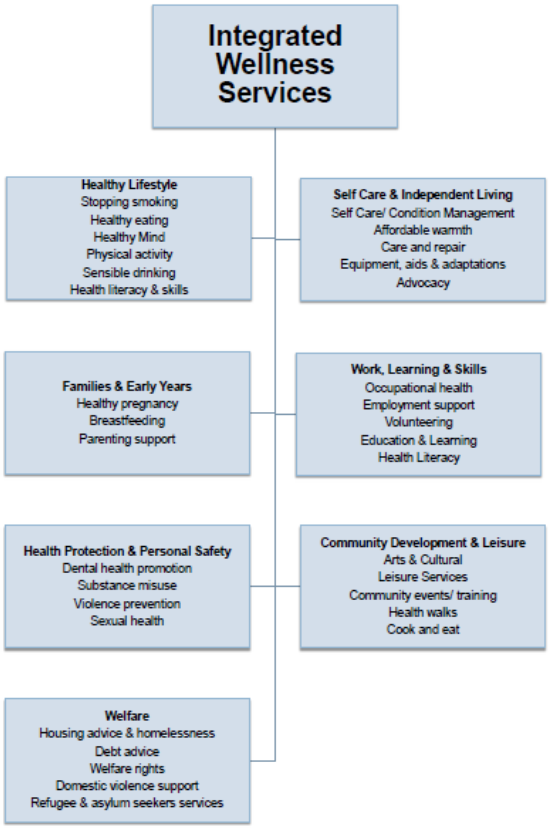
v. ***Integrated Wellness Services*** which is predominantly focused on prevention and population health management would wrap around this model providing a range of services that address the wider determinants of health. **(See Appendix 3).**

(This model is based on the Dudley CCG approach).

Appendix 4 Integrated Wellness Service

An Integrated Wellness Service is defined as *providing support to people to live well, by addressing the factors that influence their health and wellbeing and building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them (Knowsley Council)* .

It moves beyond focussing on single issues and takes a holistic and person-centred approach, addressing the psychosocial determinants of health behaviour. **Source: Knowsley MBC**



Knowsley Integrated Wellness Service: A Whole System Approach

- Single point of access 'hub'.
- Holistic assessment of individuals.
- Hub triages clients based upon need and provides on-going support.
- Service supports community development and builds upon community assets.

Appendix 5. Potential Alliance Organisation Model

A review of the literature highlights a range of MCP models that could be explored – this paper presents a proposed alliance model based on the overview below:

Contractual Alliance Overview

• The four Providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, the alliance would overlay existing contracts

• The Joint Commissioners and Providers come together in a contractual alliance to deliver MCP services under their existing contracts with the commissioners

• Decision making by the four Providers is delegated from each provider to their member(s) who sit on an Alliance Board and bind their organisation

• An overarching robust alliance arrangement which deals with risk and reward sharing is put in place

• Services are delivered by the individual members under their existing contracts

• The joint commissioners (Calderdale MBC/CCG) act as system integrators

Appendix 6. Ten lessons to support the development and implementation of new care models

1. Start by focusing on a specific population

Focusing first on a specific cohort of the population gives teams experience of co-designing services with patients and using data to understand need.

2. Involve primary care from the start

Primary care plays an essential role in delivering coordinated care for patients, families and communities. General practitioners can offer significant insight into the needs of populations and where services can be developed.

3. Go where the energy is

Identifying individuals and teams who already have ideas for and commitment to change can help gain momentum locally.

4. Spend time developing a shared understanding of problems

Ensuring there is a shared understanding of the problems to be solved is a crucial factor in cross-team improvement work and requires that people are bought together at the beginning of any change initiative.

5. Work through and thoroughly test assumptions about how activities will achieve intended results

Developing logic models can help teams think through and articulate links between planned activities and outputs without rushing to implementation.

6. Find opportunities to learn from others and assess suitability of interventions

When looking at learning from elsewhere bring staff together to work through how to adapt the interventions for the local area.

7. Set up an 'engine room' for change

In the absence of formal organisational structures, it is important to put in place a central project team that includes project management, data analysis, communication and administrative expertise. This should include staff who have already worked in the local area to create confidence among stakeholders.

8. Distribute decision making roles

Ensure decision making roles are allocated across organisations and professional groups – not just at the most senior level.

9. Invest in workforce development at all levels

With the creation of new cross-organisational services, investment in developing people is crucial. This is necessary at all levels of the local system and requires a focus on individual skills, team development and training for those in leadership roles.

10. Test, evaluate and adapt for continuous improvement

Giving teams licence to experiment is crucial in order to understand the impact of changes and to help shape plans as they progress. It's important to make sure the people and teams involved are given feedback and supported to alter plans when changes do not go as intended.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	08/03/2018
Title of Report	**Commissioning of Lower Value Medicines and Products In Calderdale**	**Agenda Item No.**	5
Report Author	Helen Foster (Medicines Management Lead)	**Public / Private Item**	Public
GB / Clinical Lead	Dr Nigel Taylor	**Responsible Officer**	Debbie Robinson (Head of Primary Care Quality and Improvement)

Executive Summary							
Please include a brief summary of the purpose of the report	The Clinical Commissioning Group (CCG) consulted the Calderdale population on a proposal to limit the routine availability of a list of lower value medicines and products on prescription. Some of the proposals for the use of these items were revised following the CCG consultation and recommendations have been agreed by the Finance and Performance Committee and are presented to the Governing Body for approval.						
Previous consideration	**Name of meeting**	Quality Committee	**Meeting Date**	25/01/2018			
	Name of meeting	Finance and Performance	**Meeting Date**	25/01/2018			
Recommendation (s)	It is recommended that the Governing Body: 1) **ACCEPTS** the assurance of the Quality Committee on the Equality Impact Assessment. 2) **APPROVES** the Finance and Performance Committee recommendations regarding changes to the routine availability of a number of lower value medicines and products on prescription.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications	
Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)	EQIA received and approved at Quality Committee on 25/01/2018.
Public / Patient / Other Engagement	Calderdale CCG has conducted an eight week consultation with its population to inform its decisions regarding limiting the availability of a list of lower priority medicines and products on prescription. The final consultation report will be published on the CCG website together with a CCG response once a decision has been made by the Governing Body.

Resources / Finance implications (including Staffing/Workforce considerations)		Implementation of the recommendations will impact on Calderdale health professionals and require capacity within the internal and external medicines management teams, communications and engagement teams.	
Strategic Objectives (which of the CCG GBAF objectives does this relate to)	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value	**Risk** (include link to risks)	None identified.
Legal / Constitutional Implications	The CCG has a legal obligation to monitor the equality impact of changes as result of decision making.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Conflicts will be managed in line with the CCG's policy for the management of conflicts of interest.

1. Introduction

1.1 Austerity measures are having an increasing impact on the financial positions of many public sector organisations, including the NHS. Calderdale Clinical Commissioning Group (CCG) must address a funding gap of nearly £13 million in 2018/19. In order to meet this significant shortfall we have been reviewing everything we invest and spend in local health and care services including the money we spend on prescribing.

1.2 The CCG is required to commission or fund certain treatments by NICE[1] and this, along with updated national and local good practice treatment guidelines and the introduction of new medicines, results in a growth year-on-year in prescribing both in primary and secondary care. Some treatments can be reviewed with a view to stopping local funding allowing continued investment in more effective and useful medicines, whilst still meeting the reasonable requirements of the population.

1.3 The CCG engagement with the public *'It's our NHS and we are not going to waste it'* in 2017 provided support to a CCG consultation on stopping the prescribing of certain lower value medicines and products as a way of reducing the spend on prescribing and supporting the CCG with achieving financial balance.

1.4 Certain medicines and products were identified for review: sunscreens, baby milks, eflornithine and other cosmetic products, multivitamins and vitamin D, emollients for mild dry skin, branded prescriptions on patient request (where not clinically indicated or cost effective) and Infacol or Colief for infant colic. Calderdale CCG currently spends in excess of £400,000 per annum prescribing these treatments.

1.5 These treatments have been identified using the PrescQIPP[2] drop list, or are otherwise subject to national controls by the Advisory Committee for Borderline Substances (ACBS). Some work has been completed on a number of treatments of limited clinical value locally and commissioning statements are in place for a number of these, which have restricted their availability on the NHS.

1.6 The Quality Committee has previously agreed that the CCG should consult the Calderdale population on a proposal to limit the routine availability of a list of lower priority medicines and products on prescription and has received Quality Impact Assessments (QIA) and Equality Impact Assessments (EQIA) for the proposed changes.

1.7 The CCG consulted the Calderdale population on these proposals and the consultation report has been received at Quality Committee.

1.8 The EQIA has been updated following the consultation and has been received and approved at Quality Committee.

2. Engagement

2.1 The key overarching themes from the consultation were:

- There was a general agreement across all products that the CCG needed to prevent an impact on people who have a low income.

[1] National Institute of Health and Care Excellence

2 PrescQIPP is an NHS funded not for profit community interest company which produces evidence based resources and tools for primary care commissioners

- Children, young people and frail elderly were considered as potentially being most impacted by these decisions and measures should be in place to ensure they are protected.
- There was a common theme that GPs should use clinical judgement on a case by case basis and that a blanket ban may be an extreme way of managing NHS funding.
- People want to see more prevention, more information and greater communication to people to ensure impact is reduced.
- Some people were surprised that a range of these products were available on prescription to start with and wanted more information about the logic behind this.
- People want to see treatments available for medical reasons only. If there was a medical reason the majority of people feel that products should be prescribed.
- In addition to the above point, if the treatment is required as part of a broader medical condition such as cancer for example; that any products required during this period should be on prescription.
- There was a lot of evidence to suggest that people may not fully understand or have read clearly who would and would not be impacted. (This conclusion has been drawn following analysis of a range of comments included in the report in relation to whether or not prescriptions would continue for particular conditions. An example of this was comments from people with eczema and psoriasis being concerned about their continued need to get these on prescription as a mainstay of their treatment. Section 4 details actions we are proposing to mitigate this risk).

3. CCG consideration of over-arching themes

3.1 The CCG's overarching response to the concerns (noted in section 2) is that the proposals largely concern self- care rather than treating a diagnosed health condition. All products are widely available from pharmacies, shops and supermarkets with the exception of eflornithine which is a prescription only medicine.

3.2 Where a medical reason exists for these products to be supplied on prescription, exemptions have been defined where it is appropriate for them to continue. Otherwise there is no anticipated health impact if patients do not use these products. Where a patient has a clinical condition requiring treatment their clinician will be able to prescribe alternative treatments.

3.3 Following the consultation, the Equality Impact Assessment (EQIA) has been updated to include the overarching themes from consultation, and the equality themes and impacts. The update includes mitigation; the CCG's response to issues identified, have been included in the refreshed EQIA.

3.4 The actions and mitigation sections were fully revised to address the concerns raised within the consultation. This included noting where a concern raised had been reviewed and was clinically incorrect, but where we identified the need to improve and provide more clarity through our communications to patients/public and/or what would be in place to mitigate the concerns.

For example concerns regarding access to baby milks addressed by refining our recommendation to allow other specialist milks to continue on prescription but noting that vouchers for baby milk are available to low income families.

3.5 The EQIA was assured on 25 January 2018 by the Quality Committee.

The key equality issues for individual recommendations are presented in section 4, alongside mitigating actions following consultation.

4. Detail

4.1 The following recommendations were agreed by the Quality Committee and the Finance and Performance Committee.

4.1.1 Sunscreens

- Proposal: stop prescribing sunscreens
- 69% (761 people) agreed or strongly agreed
- **Recommendation**: stop routine prescribing of sunscreens. Allow prescribing for ACBS (Advisory Committee for Borderline Substances) defined conditions only.
- Rationale: effective sunscreens are readily available for purchase, that are suitable for the majority of people.
- Equality issues: Ethnicity **-** 15 (53.5%) people from Asian / Asian British backgrounds felt this proposal would have an impact on them or their households. There is no clinical reason why this should be an equality issue, it does demonstrate the need to improve communication.
- CCG mitigation: continued availability for ACBS conditions.

4.1.2 Eflornithine

- Proposal: stop prescribing eflornithine cream for unwanted facial hair
- 67% (736 people) agreed or strongly agreed
- **Recommendation**: stop routine prescribing of eflornithine cream.
- Rationale: Low evidence for effectiveness of this product means it should not be routinely prescribed at NHS expense. More effective treatments are available if clinically indicated for hirsutism due to medical conditions such as Polycystic Ovary Syndrome (PCOS).
- Equality issues: 17.5% (21) of Asian / Asian British respondents felt this proposal would have an impact on them or their households
- CCG mitigation: more effective treatments are available for hirsutism due to medical conditions.

4.1.3 Antifungal nail paints

- Proposal: stop prescribing antifungal nail paint
- 62% (679 people) agreed or strongly agreed. Comments suggested in some cases public had not noted that more effective treatments would continue to be available from the GP for more severe nail infections.
- **Recommendation**: stop routine prescribing of antifungal nail paints

- Rationale: Low evidence for effectiveness of these products means should not be prescribed at NHS expense. More effective prescription treatments are available if clinically indicated.

- Equality issues**:** Disability: 19.6% (42) of all the disabled respondents either disagreed/strongly disagreed with the proposal. With 6.5% (14) of these respondents feeling this would impact on them or their families

- CCG mitigation: more effective treatments will continue to be available from GP practices if clinically indicated.

4.1.4 **Multivitamins and vitamin D**

- Proposal: stop prescribing multivitamins and vitamins except for deficiency states and post bariatric surgery
- 62% (682 people) agreed or strongly agreed. Comments suggested the public hadn't noted prescribing would continue for deficiency and post bariatric surgery.

- **Recommendation**: stop routine prescribing of vitamins except for diagnosed deficiencies and post bariatric surgery.

- Rationale**:** no evidence for vitamins in improving health outcomes outside deficiency states or where deficiency is predictable (i.e. post bariatric surgery)

- Equality issues: ethnicity: 28% of Asian/Asian British respondents felt there would be impact vs 11% of all respondents. No clinical reason identified. Some comments were received the about impact in low income.

- CCG mitigation: healthy start vitamins are available free of charge for young children and in pregnancy for low income families. Communications materials will be clear about continued use for specific patient groups.

4.1.5 **Emollients for dry skin**

- Proposal: stop prescribing emollients except for diagnosed skin conditions eczema and psoriasis.
- 48% (526 people) of respondents agreed or strongly agreed 39.3% (434 people) didn't agree/strongly disagreed with proposal. Many comments suggest the public had not noted that prescribing would continue for patients with diagnosed skin conditions eczema and psoriasis. Some comments about use for foot care in diabetes, lymphoedema, skin cancer and in elderly with fragile skin at risk of ulceration.
- **Recommendation**: stop routine prescribing of emollients except for eczema, psoriasis, diabetic footcare, lymphoedema and to prevent skin ulceration in fragile patients.
- Rationale: mild dry skin is not a medical condition and most people buy their own products.
- Equality issues: carers, disabled and Asian respondents had higher level of disagreement with proposal, issues around low income.

- CCG mitigation: many of the comments demonstrated that respondents did not know that prescribing would continue for diagnosed skin conditions of eczema and psoriasis.

- Following the comments from the consultation additional indications were added i.e. foot care in diabetes, lymphoedema and for fragile skin at risk of ulceration. Communications materials will be clear about continued use for specific patient groups.

4.1.6 **Infant feeds**

- Proposal: stop prescribing infant feeds except for diagnosed Cow's Milk Protein Allergy (CMPA) and specialist metabolic disorders
- 47% (517) of people agreed or strongly agreed, 32% (359 people) did not agree, 21% (233 people) did not know.
- Comments - need for Nutriprem and Neocate for premature babies, also generally cost an issue but vouchers available for low income families
- **Recommendation**: stop routine prescribing of infant feeds except for diagnosed CMPA, specialist metabolic disorders and for premature and other infants on recommendation of paediatric dietitian/paediatrician where feeds are not readily available
- Rationale: Most families purchase infant milks which are readily available from pharmacies and supermarkets. Vouchers for infant milks are available for low income families.
- Equality issues: children requiring specialist feeds only available on prescription or much more expensive noted as a concern.
- CCG mitigation: the wording of recommendation was amended to include continued prescribing of specialist products in recommendation. Also vouchers for infant feeds are available for low income families. Communications materials will be clear about continued use for specific patient groups.

4.1.7 **Infant colic treatments**

- Proposal: stop prescribing infant colic treatments (no exclusions)
- 45% (490) of people agreed or strongly agreed, 31% (339 people) did not agree, 24% (259 people) did not know
- Concerns around low income families and stress from infant colic
- **Recommendation**: stop routine prescribing of infant colic treatments (no exclusions)
- Rationale: poor evidence of efficacy, these products are not recommended in routine management of colic
- Equality issues: concerns re children in low income families.
- CCG mitigation: some work will be required to ensure appropriate advice is being given by local health professionals re managing infant colic, this will include liaising with Health Visitors to ensure consistent implementation.

4.1.8 **No routine prescribing of branded products**

- Proposal: To not routinely fund prescribing of branded products unless there is a clinical reason (e.g. allergy to ingredient)
- 73% (816) people agreed or strongly agreed
- Concerns from people who are on medicines that need to be branded (some epileptic medicines), people who have had problems with side effects

- **Recommendation**: stop routine prescribing of branded products without clinical reason or where more cost-effective by brand
- Rationale: no need for routine branded prescribing for majority of products (prescribers aware of exceptions to this)
- Equality issues: 21.7% of disabled people disagreed with the proposal, 24.2% Asian/Asian British disagreed with proposal. There is no clinical reason why this should be an equality issue, it does demonstrate the need to improve communication.
- CCG mitigation: prescribers have a high level of awareness already of situations where branded prescribing is clinically required. The medicines management team and the external practice pharmacy team will support practices with identifying such prescribing. Communications materials will be clear about continued use for specific patient groups.

5. Next Steps

5.1 Subject to governing body approval of the recommendations:

- A communications and implementation plan will be launched to ensure that the public, patients, local prescribers and other health professionals and other stakeholders are aware of the CCG recommendations. This will include the use of social media to proactively share these changes with the public. The action plan for public facing communications is provided at (Appendix 1).

- A number of resources will be available to support the implementation of the new commissioning policies.

- The CCG medicines management team and the external practice pharmacy team will support practices in implementing the recommendations. Patients currently receiving these medicines and products will be identified and use reviewed in line with the recommendations. Patients who are affected by the change in CCG policy will be informed either by letter, phone or face to face as appropriate.

- The impact of these changes on Calderdale patients will be monitored in a number of ways:

  i. Reduction in prescribing of these items will be monitored on a quarterly basis.
  ii. Patient experience will be captured through any formal complaints to the CCG which will be reviewed.
  iii. Feedback will be sought from GP practices on the change in practice and impact on both patients and health professionals as a result.

- The consultation report will be published on the Calderdale CCG website.

6. Recommendations

6.1 It is recommended that the Governing Body:

1) **ACCEPTS** the assurance of the Quality Committee on the Equality Impact Assessment.

2) **APPROVES** the Finance and Performance Committee recommendations regarding changes to the routine availability of a number of lower value medicines and products on prescription.

7. Appendices

Appendix 1: Action plan for public facing communications

Appendix 1

Action plan for public facing communications

Should the Governing Body decide to approve the recommendations to cease the routine prescribing of the medicines of lower clinical value identified in this report and branded medicines in Calderdale, the following communications actions will be taken:

Channel	Action	Notes	Effective from
CCG Website	Front page news post	Notifying the public of the decision, explaining what will change and the reasoning behind the recommendation.	09/03/2018
CCG Website	Dedicated web page	Containing in-depth information as to the recommended changes to prescribing in Calderdale and the reasoning behind the recommendation. • This page will also contain a list of frequently asked questions designed to help members of the public to understand the proposed changes, and a number of resources including: • 'Advice for patients' information sheet on medicines of lower clinical value and branded medication that is no-longer available on prescription in Calderdale. • Web links to supporting information re: voucher schemes	Week commencing 12/03/2018
GP practices	Toolkit of resources	Calderdale CCG's member GP practices will receive a toolkit of information aimed to inform members of the public of the proposed changes, and to help GPs have informed conversations with affected patients and advise them of possible alternative products and treatments available elsewhere. This toolkit of resources will include: • Printable versions of the 'Advice for patients' information sheet on medicines of lower clinical value and branded medication that is no-longer available on prescription in Calderdale. • Frequently asked questions documents for GPs and clinical prescribers • Printable posters for GP practices informing members of the public of changes to services and the wider aims of the Everyone's NHS programme. • Digital waiting room screens advising members of the public of the changes to prescribing and signposting where to go for more information.	Week commencing 12/03/2018

Social media	Information for the public	This campaign will appear on the CCG's Twitter (www.twitter.com/calderdaleccg) and Facebook (www.facebook.com/nhscalderdaleccg) pages, and will consist of a number of messages and graphics from the CCG's communications team.	Week commencing 12/03/2018

The information given above represents the base level of communications actions pending the decisions of the Governing Body on Thursday 8 March 2018. More resources and information may be produced based on feedback from the public, clinical prescribers and stakeholders as required in order to ensure effective communication with all target audiences.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	8 March 2018
Title of Report	**West Yorkshire & Harrogate Joint Committee of CCGs - Annual Work Plan & Memorandum of Understanding**	**Agenda Item No.**	6
Report Author	Stephen Gregg – WY&H Joint Committee Governance Lead	**Public / Private Item**	Public
GB / Clinical Lead	Alan Brook, Chair	**Responsible Officer**	Matt Walsh, Chief Officer

Executive Summary				
Please include a brief summary of the purpose of the report	The purpose of this paper is two-fold: To seek Governing Body endorsement of: ▪ The amendment of the Memorandum of Understanding for Collaborative Commissioning between CCGs ('the MoU') enabling the continuation of the current Joint Committee voting arrangements following the merger of the 3 Leeds CCGs on 1st April 2018. ▪ The refreshed work plan of the West Yorkshire and Harrogate (WY&H) Joint Committee of Clinical Commissioning Groups (CCGs).			
Previous consideration	**Name of meeting**	WY&H CCGs Joint Committee development session	**Meeting Date**	06/02/2018
	Name of meeting		**Meeting Date**	36T
Recommendation (s)	It is recommended that the Governing Body: 1. **NOTES** that administrative changes will be made to the MoU to reflect that the merged Leeds CCG will be a party to the MoU from 1st April 2018. 2. **ENDORSES** the recommendations that an amendment to the MoU be made to ensure the continuation of current voting arrangements (i.e. 3 votes for the newly merged Leeds CCG), and that these arrangements are reviewed after 12 months. 3. **ENDORSES** the West Yorkshire and Harrogate Joint Committee refreshed Annual Work Plan.			

Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	36T

Implications	
Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)	Quality and Safety implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.
Public / Patient / Other Engagement	Public and patient engagement implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.
Resources / Finance implications (including Staffing/Workforce considerations)	Resource and finance implications form a key element of the work plan and 'critical path' for all Joint Committee decisions.

Strategic Objectives (GBAF) (which of the CCG objectives does this relate to?	**Strategic objective no.1 &2:** *Risk 1.4* We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint. *Risk 2.2*: 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.	**Risk** (include risk number and a brief description of the risk)	Robust, transparent voting arrangements are needed to minimise the risk of Joint Committee decisions being challenged.
Legal / CCG Constitutional Implications	Amendments to the Joint Committee's work plan and to the MoU must be approved by the CCG membership.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Conflicts of interest will be managed in line with the CCG statutory guidance on the management of conflicts of interest.

1. Purpose

1.1 The purpose of this paper is two-fold:

To seek Governing Body endorsement of:

- The amendment of the Memorandum of Understanding for Collaborative Commissioning between CCGs ('the MoU') enabling the continuation of the current Joint Committee voting arrangements following the merger of the 3 Leeds CCGs on 1st April 2018.

- The refreshed work plan of the West Yorkshire and Harrogate (WY&H) Joint Committee of Clinical Commissioning Groups (CCGs).

2. Detail

2.1 The WY&H CCGs established the Joint Committee to take commissioning decisions to support the aims and objectives of the WY&H Sustainability and Transformation Plan (STP). To enable this, the CCGs delegated authority to the Joint Committee to take certain decisions on their behalf.

2.2 The service areas delegated to the Joint Committee are set out in a high level work plan agreed by each of the CCGs in 2017. The work plan includes: Cancer, Stroke, Mental Health, Urgent and Emergency Care and clinical thresholds (now known as Standardisation of Commissioning Policies/elective care) and was approved by Calderdale CCG member practices in February 2017.

2.3 A Memorandum of Understanding (MoU) agreed by each CCG formalises the role of the Joint Committee.

2.4 Joint Committee voting arrangements

The MoU sets out the framework for the CCGs to work together across West Yorkshire and Harrogate. It was agreed by the 11 CCGs in May 2017 and established the Joint Committee of CCGs and its Terms of Reference.

2.5 From 1st April 2018, the 3 Leeds CCGs who are parties to the current MoU will merge to form a single CCG, with a combined registered population of over 878,000. Clause 13.2 of the MoU allows that statutory successor bodies of one or more CCGs, including merged bodies, shall be deemed to be parties to the MoU without the need for the formal agreement of the remaining parties. However, the merger has an impact on the voting arrangements for the Committee.

2.6 Following the merger of the 3 Leeds CCGs, there will be 9 parties represented on the Joint Committee. Under the arrangements set out in the MoU, the 878,000 registered population of Leeds would be represented by one vote, as opposed to the 3 which it currently has through the individual CCGs.

2.7 At its development session on 6th February 2018, members of the Joint Committee considered possible future voting arrangements. In view of the changes taking place across the WY&H health and care system, a pragmatic, transitional approach was discussed. It was recommended that the 'status quo' be maintained of 3 votes for Leeds.

2.8 Although the recommendation is to maintain the voting 'status quo', this represents a technical change in the voting arrangements. Legal advice has confirmed that this requires the MoU to be amended and the new arrangements presented to all CCG memberships for approval.

2.9 Should CCG memberships approve the proposed arrangements, a variation agreement to the MoU will be drafted for signature by each CCG. It is proposed that this process is completed by the time of the Joint Committee meeting in public on 6 June 2018. This will be the first meeting of the Joint Committee after the Leeds CCGs merge.

2.10 It is proposed that the transitional voting arrangements are reviewed after 12 months.

2.11 Matters delegated to the Joint Committee – the work plan

The MoU requires the work plan to be reviewed within the first six months of the operation of the Joint Committee, which first met in public in July 2017. The aim is to ensure that the decisions delegated to the Committee are clear, and that matters in the work plan comply with the approach set out in the MoU. The MoU requires each CCG to ensure that all matters in the Joint Committee work plan are properly and lawfully delegated. Changes to the work plan must be agreed by the membership of each CCG.

2.12 Following consultation with STP programme Senior Responsible Officers (SROs) the work plan has been reviewed. The current agreed work plan is attached at Appendix 1 (column 1), alongside the refreshed work plan (column 2). The refreshed work plan covers all of the service areas in the current work plan, but seeks to clarify the scope of the decisions that it is proposed are delegated to the Joint Committee.

2.13 CCGs are now being asked to seek the agreement of their memberships to the work plan by 11 May 2018, to enable it to be presented to the Joint Committee at its meeting in public on 6 June 2018.

2.14 Matters not formally delegated to the Joint Committee

As well as making decisions on matters which are formally delegated to it, the Joint Committee can also make recommendations to individual CCGs where a WY&H approach is beneficial. A recent example was the recommendation on atrial fibrillation. A flow chart showing the different ways in which the Committee can deal with WY&H issues is attached at Appendix 2.

3.0 Recommendations

3.1 It is recommended that the Governing Body:

4. **NOTES** that administrative changes will be made to the MoU to reflect that the merged Leeds CCG will be a party to the MoU from 1st April 2018.

5. **ENDORSES** the recommendations that an amendment to the MoU be made to ensure the continuation of current voting arrangements (i.e. 3 votes for the newly merged Leeds CCG), and that these arrangements are reviewed after 12 months.

6. **ENDORSES** the West Yorkshire and Harrogate Joint Committee refreshed Annual Work Plan.

4.0 Next Steps

4.1 Subject to the endorsement of the above recommendations by the Governing Body; the CCG members will be asked to:

- Approve the proposed MoU amendments and refreshed work plan.
- Delegate authority to the Chief Officer to finalise and sign the MOU on behalf of the CCG

5.0 Appendices

Appendix 1: West Yorkshire and Harrogate Joint Committee of CCGs – Refreshed work plan 5 December 2017

Appendix 2: West Yorkshire and Harrogate Joint Committee of CCGs – enabling agile decision making.

Appendix 1

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Joint Committee of CCGs – Refreshed work plan 5 December 2017

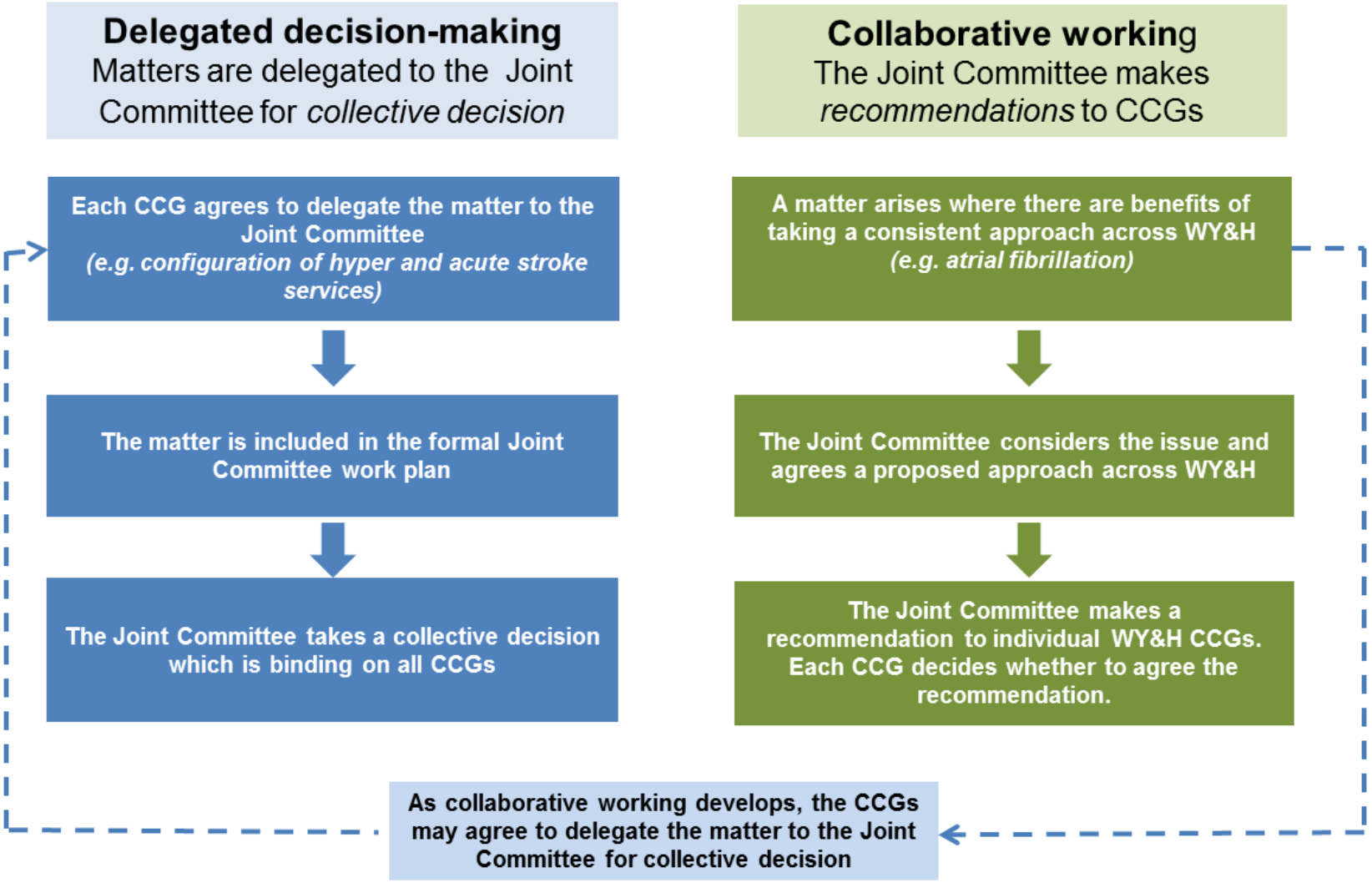
Agreed work plan (December 2016)	*Refreshed work plan (December 2017)*
Cancer • Commit to local action plans to deliver Recovery Package & risk stratified post-treatment pathways by 2020 • Consider option appraisal for service model for strategic diagnostic growth. Where appropriate consider approval for public consultation. • Agree preferred model for service model for strategic diagnostic growth. • Agree to pilot new strategic approaches to commissioning and provision of cancer care	***Cancer – West Yorkshire and Harrogate*** • *Agree new strategic approaches to the commissioning and provision of cancer care, building on the 'Commissioning for Outcomes' work.*
Mental health • West Yorkshire plan developed for provision of children young people inpatient units integrated with local pathways. Seeking to eliminate inappropriate placements. • West Yorkshire plan developed for low/medium secure services and associated pathways. • Bed management proposal developed to support reduction in out of area placements. • Proposal developed for standard approach to commissioning acute mental health services across West Yorkshire.	***Mental health – West Yorkshire and Harrogate*** • *Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds across West Yorkshire and Harrogate.* • *Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services to ensure risk and benefit can be clearly understood and managed across West Yorkshire and Harrogate.* • *Agree plan for the provision of children and young people inpatient units, integrated with local pathways.*

Agreed work plan (December 2016)	*Refreshed work plan (December 2017)*
Stroke • Agree Stage 2 NHSE Assurance – Outline Business Case sign off (subject to Stage 1 NHSE approval to proceed). Approval to proceed to Formal Consultation. • Stage 3 Assurance – Formal Consultation completed (Subject to NHSE Stage 2 approval). • Consider outcome of consultation. Agree recommendations (Subject to NHSE Stage 1 and 2 approvals) • Stage 4 Assurance – Delivery Plan prepared and signed off	***Stroke - West Yorkshire and Harrogate*** *Agree configuration of Hyper Acute and Acute stroke services* • *Review and approve outline business case. Decide on readiness to consult.* • *Review outcomes of consultation.* • *Approve full business case* • *Consider and approve commissioning approach and approve delivery plan.*
Urgent and emergency care • Agree future arrangements for NHS 111 and WY Urgent Care Services. • Agree business case for the Clinical Advice Service. • Urgent emergency care technology work stream – Agree business case for direct booking licenses and acute trust telehealth. • Consider recommendations for reconfiguration of services, priority pathways and wider STP work • Agree significant improvements in the development of the clinical advice service which supports NHS 111, 999 and out-of-hours calls • Consider ongoing benefits realisation work & return on investment working with YHEC and the AHSN	***Urgent and emergency care - West Yorkshire and Harrogate*** *Integrated urgent care services:* • *Agree the specification and business case (incorporating future arrangements for NHS 111 and GP out of hours services).* • *Agree the commissioning and procurement process to deliver services from 2019 onwards*

Agreed work plan (December 2016)	*Refreshed work plan (December 2017)*
Standardising commissioning policies • Quarterly rolling process of development, agreement and implementation of commissioning policies. Covering: pre-surgery optimisation; clinical thresholds and procedures of low clinical value; eliminating unnecessary follow-ups; efficient prescribing. Proposed policies will have been considered through the Clinical Forum.	***Elective care and standardising commissioning policies – West Yorkshire and Harrogate*** *Develop and agree West Yorkshire and Harrogate commissioning policies, including:* • *Pre-surgery optimisation (supporting healthier choices);* • *Clinical thresholds and procedures of low clinical value;* • *Eliminating unnecessary follow-ups;* • *Efficient prescribing.*

Appendix 2

WY&H Joint Committee - enabling agile decision-making



NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	8 March 2018
Title of Report	**Appointment Governing Body Chair and Assistant Clinical Chair**	**Agenda Item No.**	7
Report Author	Judith Salter, Head of Corporate Affairs and Governance	**Public / Private Item**	Public
GB / Clinical Lead	Dr Alan Brook, Chair	**Responsible Officer**	Dr Matt Walsh, Chief Officer

Executive Summary							
Please include a brief summary of the purpose of the report	▪ To ask the Governing Body to appoint a new Chair. ▪ Dependent upon the outcome of the above, to ask the Governing Body to appoint the Assistant Clinical Chair.						
Previous consideration	**Name of meeting**	n/a	**Meeting Date**	37T			
	Name of meeting	n/a	**Meeting Date**	37T			
Recommendation (s)	It is recommended that the Governing Body: 1. **APPOINTS** Dr Steven Cleasby as Chair of the Governing Body for a period of three years. Subject to the outcome of the above, it is recommended that the Governing Body: 2. **APPOINTS** Dr Majid Azeb as Assistant Clinical Chair of the Governing Body						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	37T

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	Improving Governance	**Risk** (include risk number and a brief description of the risk)	None identified
Legal / CCG Constitutional Implications	NHS (Clinical Commissioning Group)Regulations (2012); Calderdale CCG Constitution and Standing Orders v.4	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Two GP Governing Body members will have a conflict of interest which will be managed in line with the CCG's policy on the management of conflicts of interest.

1. Introduction

The purpose of this paper is;

1.1 To ask the Governing Body to appoint a new Chair of the Governing Body, in line with the CCG's Constitution.

1.2 Dependent upon the outcome of the decision above, to ask the Governing Body to appoint the Assistant Clinical Chair of the Governing Body.

2.0 Background

2.1 The CCG's Governing Body comprises the following voting members:

- 7 GP members elected by the member practices (including the Chair)
- Chief Officer and Chief Finance Officer/Deputy Chief Officer
- 3 Lay Members (including the Deputy Chair)
- Registered Nurse and Secondary Care Specialist

2.2 Dr Alan Brook has notified the CCG that he intends to retire from being a member of the Governing Body, and therefore Chair, from the end of April 2018.

2.3 In line with the CCG's Constitution and Standing Orders, the Governing Body Chair must be drawn from one of the GP Governing Body members and is appointed by the Governing Body. The tenure period is for three years with an option for another three years.

2.4 The role of the Chair, as set out in the CCG's Constitution[1], is to:

- lead the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities;
- build and develop the CCG's Governing Body and its individual members;
- ensure that the CCG has proper constitutional and governance arrangements in place;
- ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
- support the accountable officer in discharging the responsibilities of the organisation;
- contribute to building a shared vision of the aims, values and culture of the organisation;
- lead and influence the achievement of clinical and organisational change to enable the CCG to deliver its commissioning intentions;
- oversee governance and particularly ensuring that the Governing Body and the wider CCG behaves with the utmost transparency and responsiveness at all times;
- ensure that public and patients' views are heard and their expectations understood and, as far as possible, met;
- ensure that the organisation is able to account to its local patients, stakeholders and NHS England;
- ensure that the CCG builds and maintains effective relationships, particularly with Calderdale Health and Wellbeing Board.

[1] NHS Calderdale CCG Constitution 2017 v.4, 7.4.1 – 7.4.2; Standing Orders 2.2.1

2.5 The Chair of Calderdale CCG Governing Body is also the lead clinician of the CCG. As such they should have the respect of the CCG's member practices and also have the following responsibilities:

- lead the CCG ensuring it is able to discharge its functions;
- be the senior clinical voice of the CCG in interactions with stakeholders including NHS England.

2.6 Following a call for expressions of interest and nominations, Dr Steven Cleasby has been nominated by Dr Caroline Taylor and seconded by Dr Nigel Taylor to take on the role of the Chair. As part of this process, Dr Cleasby has gone through the NHS Leadership Academy Assessment Centre for CCG clinical leadership roles.

2.7 No further nominations have been received for this position.

2.8 **Assistant Clinical Chair**

Dr Steven Cleasby is currently the Assistant Clinical Chair. The role of the Assistant Clinical Chair is to:

"Take a significant role in supporting clinical leadership and involvement in the CCG".

2.9 Subject to the successful appointment of Dr Steven Cleasby into the role of Chair, the Governing Body will be asked to appoint a GP Governing Body member as the Assistant Clinical Chair.

2.10 Following a call for expressions of interest and nominations, Dr Majid Azeb has been nominated by Dr Caroline Taylor and seconded by Dr Nigel Taylor to take on the role of Assistant Clinical Chair. No further nominations have been received for this position.

3.0 Recommendations

3.1 It is recommended that the Governing Body:

1. **APPOINTS** Dr Steven Cleasby as Chair of the Governing Body for a period of three years.

Subject to the outcome of the above, it is recommended that the Governing Body:

2. **APPOINTS** Dr Majid Azeb as Assistant Clinical Chair of the Governing Body

4.0 Next Steps

4.1 The decisions of the Governing Body will be communicated to the CCG membership, staff, partners and stakeholders.

4.2 The new Governing Body Chair will take on their role from 1st May 2018.

5.0 Implications – Conflicts of Interest

5.1 Dr Steven Cleasby and Dr Majid Azeb will have a direct professional and financial conflict of interest in this item, which will be managed in line with the CCG's Conflict of Interest Policy[2].

[2] NHS Calderdale CCG, Management of Conflicts of Interest Policy (revised Oct 2017)