West Yorkshire and Harrogate
Health and Care Partnership

ELECTIVE CARE AND STANDARDISATION OF COMMISSIONING POLICIES
Programme Board

Tuesday 19 November 2019, 1.30pm to 4pm
Shibden Room, Dean Clough, Halifax, HX3 5AX

Key Points and Actions

Item			
1	**Welcome and Apologies**		
Members	**Title**	**Attended**	**Apologies**
Andrew Bottomley	Calderdale and Greater Huddersfield CCG	✓	
Andrew Dangerfield	Harrogate and Rural District CCG	✓	
Andrew Sixsmith	GP, Primary and Community Care representative, WYH HCP		✓
Catherine Thompson	Programme Director WY&H HCP		✓
Christine Hughes	Comms & Engagement Manager, WYH HCP	✓	
Clive Harries	GP, Planned Care Lead, Wakefield CCG	✓	
Oliver Barnes	Y&H AHSN		✓
Duncan Cooper	Business Analyst, WY&H HCP Elective Care & Maternity PMO		✓
Emily Parry-Harries	Public Health Consultant, North Kirklees CCG	✓	
Gaynor Goodman	Programme Manager WY&H HCP	✓	
Graham Prestwich	Patient & Public Representative	✓	
Helen Lewis	Leeds CCG	✓	
Helen Hunter	CEO, Health Watch, Calderdale		✓
Ian Baines	Head of Adult Social Care, Calderdale Council		✓
Ian Holmes	Director, West Yorkshire and Harrogate Health and Care Partnership		✓
Ian Wallace	Bradford CCG		✓
James Thomas	Programme Clinical Lead, Airedale, Wharfedale & Craven/Bradford CCG	✓	
Jannine Clark	Programme Support Officer, WYH HCP	✓	
Jo Fitzpatrick	Chair of WY&H Pharmacy Leadership Group (WYH PLG)		✓
Jo Rattray	Project Manager, WYH HCP	✓	
Kate Gatherer	NHS England		✓
Kate Holliday	Health Education England		✓
Keir Shillaker	Programme Director, Mental Health and Learning Disabilities Programme, WYH HCP		✓
Lauren Phillips	Head of Programmes, West Yorkshire and Harrogate Health and Care Partnership		✓
Louise Clarke	GP, Planned care lead, Airedale, Wharfedale and Craven CCG	✓	
Madi Hoskin	WYATT Programme Manager		✓
Matt Walsh	SRO/Calderdale CCG	✓	
Neil Smurthwaite	Calderdale CCG	✓	
Nicola Moss	WYATT Ophthalmology project manager	✓	
Phil Smedley	Wakefield CCG	✓	
Rachel Bolton	Wakefield CCG		✓
Rebecca Martin	Project Manager, WYH HCP	✓	
Shane Hayward-Giles	NHS England		✓
Steve Laville	Leeds CCG		✓

Tony Jamieson	Y&H AHSN		✓
Tony Wilkinson	Patient & Public Representative	✓	
Vicky Dutchburn	Greater Huddersfield CCG		✓

1	**Notes and actions from previous meeting** The notes and actions from the previous meeting on 17 September 2019 were accepted as a true record and signed off.
2	**Register of interests:** The register of interests was accepted as a true record with a reminder to members that a number of declarations of interest are coming up to their 12 month review. The programme secretariat will contact those members concerned. Members had no conflicts of interest to declare at the programme board meeting. **Action: members to return revised declaration of interest when asked to do so by the programme secretariat (All)**
3	**Action Register** • **Action number 1: Health Equity –Hip replacements** – this item was for discussion on the meeting agenda (see below at programme update, item 11). • **Action number 2: Hydroxychloroquine –** The Joint Committee of Clinical Commissioning Groups (JCC) agreed the Policy and Pathway paper on 5 November. Discussions were had at JCC on the issue of the implementation and whether the treatment will be done in hospital eye services or community optometrists. The programme board accepted there are challenges and will help to take this forward to come to a decision on implementation both at place and across the system. • **Action number 3: Value based Checker –** There was no further update at the meeting. • **Action number 4: Moving to one Area Prescribing Committee –** Work is ongoing and the move to one Area Prescribing Committee will take place in the next financial year. • **Action number 5: Joined up programme planning and management with WYAAT –** An update was provided on the membership of the Joint Planned Care Collaboration and Oversight Group between this programme leadership and the elective care leadership of the West Yorkshire Association of Acute Trusts (WYAAT). A combined governance framework has been designed to facilitate a joined up system response to planned care. The progress of the joint programme will be reviewed on an ongoing basis. Examples of this joined up working with WYAAT are: the programme manager working between both providers and commissioners in the system on Ophthalmology and a new programme manager will start in the New Year to manage the transformation of Dermatology services across West Yorkshire and Harrogate. The WYAAT clinical lead for this piece of work leaves in the New Year and a replacement is being appointed. • **Action number 6: Stoma and Continence appliances –** A business case was taken for discussion with the Accountable Officers at JCC development session on appliances who requested further financial considerations to be addressed in that business case. This programme will work with the Ageing Well programme in the Integrated Care System (ICS) to revise that business case. This will be reviewed again in March 2020. • **Action numbers 7 & 8: Hip Arthroscopy and Hip Replacement policies** – Item is for discussion on the meeting agenda (see below at programme update, item 7). • **Action 9**: **Terms of Reference** – The programme board terms of reference have been finalised and these are now available on the West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) website. • **Action 10**: **Programme metrics** – An update was provided on the 5 eye care projects and the activity data and the finance around them. A driver diagram has been devised for each theme which is looking at what the project is hoping to achieve and defining the metrics to monitor progress and achievements. The work is complex and involves capturing data from 6 trusts. The WYAAT business analyst has been working on the data available from Medisoft software, which is complex in itself so the programme will look at what information can be gleaned for Leeds Teaching Hospital Trust in the first instance before moving on to the

	other trusts.
4	**Risk Register (for review)** • Members were asked if they agreed with the risks and their ratings, and if there was anything missing or any questions to be raised; with the emphasis on the difference the programme is making. Members were asked whether there is a risk that we are too busy agreeing pathways and policies that there is no effective connection between our work and what is happening at place? Discussions were had that a lot of work being undertaken across West Yorkshire and Harrogate (WY&H) is on goodwill and Places will draw people back when they are running out of capacity. It's important we engage and ensure we have the correct collaboration of clinicians to be sure we all take ownership and have a consensus on delivering good health care to our population. • It was relayed that each Accountable Officer received a letter on the current position against the 17 Evidenced Based Interventions (EBIs) in that NHS England (NHSE) have not seen the collective impact they were hoping to see. The ICS is looking at its activity and what the impact has been on the workforce, such as the decisions made by hospital consultants. The ICS and each of our Places need to look at what they're saying they are doing and what they actually are doing in respect of these clinical interventions. The SRO of this programme will be responding to NHSE's letter as to the activity across the West Yorkshire and Harrogate region. • The timescale of 3 years to implement the MSK pathway and what this means was raised by members. It is hoped that the threshold work would happen straight away and then being explicit on what might take longer such as: the recruitment decisions to support implementation of the MSK pathway? Places could then address flexibility of implementation with JCC if there are recruitment challenges. Implementation will be different at each Place depending on their starting point. Places need to be able to tell the story on what they have done and what has changed and account for where they've not been able to deliver on implementation timelines. • It's important we engage with the public and have patients involved in the outcome of our policies and pathways, and also demonstrate we are supporting patients in changing their behaviour in making healthier choices around their lifestyle. Additionally, adopting best practice in that we build the right kind of relationships to create opportunity to getting real engagement with our policies so other colleagues get on board with what this programme is doing and it creates an expectation for colleagues across the ICS to deliver and implement the changes in their Places. • Discussions were had about the need to change how we conduct our board meetings and what we agree on as a board? Conversations about sharing responsibility and shared decision making were raised as good practice the board could adopt so we're clear on what we as a board hold people to account for. Members considered the risk register ought to be clear on: 1) Implementation and 2) Accountability. **Actions:** • **The programme SRO to respond to NHS E's letter regarding the EBIs in the ICS.** • **The programme to be clear and concise at the Clinical Forum and Joint Committee on accountability and decision making in Place and the explicit timescales for implementation, and also stating implicitly Providers involvement and input to developing policies and pathways.** • **The programme to strengthen the way its describes the implementation risk and details the role of clinical leadership, the role of the contract, the role of Place and the role of Joint Committee in terms of holding Places to account on implementation.** • **Including the personalisation agenda, shared decision making and supporting and coaching people in changing their behaviours in context on the risk register to emphasize our changing relationship with people and how we mitigate identified risks.** • **The responsibility of other programmes around this space and how they link with this programme to reflect the ICS's priorities outlined in its 5 year strategy.**
5	**WYH HCP update and Programme Communication & Engagement update** • The ICS updates for October and November 2019 and an update for the Improving Planned Care

	Programme were relayed to members. This highlighted that the programme's Terms of Reference is available on the ICS website. There's also a section on website accessibility on there, podcasting and the ICS 5 year strategy. Any questions on these, please contact the team mailbox: Wyhhcp.plannedcare@nhs.net • Members were also given an update of what the programme has achieved so far this year. Members fed back that it was a fantastic summary of achievements that everyone has been a part of and we should be proud of our work. • The programme leadership presented at the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) that day; highlighting that it's important that we are making it clear what difference the programme is making to the people we serve and how we are making that difference, and being able to describe this clearly. JHOSC are happy to have further conversations with the programme leadership and can help us to implement what we are doing on the programme and its impact on addressing health inequalities. It's important in terms of our development that the work we're doing with commissioning colleagues is done on a 'commissioning future' basis – building capability for a Do Once and Share Approach (DOAS) so that Accountable Officers are seeing the things we are doing and the impact we are having in terms of doing things collectively, and our capability to do DOAS and focus on creating relationships. **Action: Further conversations with JHOSC on the work of this programme and bringing back the learning outcomes to this board.**
6	**Programme Key Lines of Enquiry (KLOES) to support the Programme Board** • KLOES enable us to be more challenging of ourselves and how we demonstrate a wider context and understanding of the work we are doing when we are taking our policies and pathways through Joint Committee and scrutiny Committee arrangements. • Discussions took place on items 1-9 and whether they should be ordered to be in-line with our framework and values, although the list wasn't drawn with any intention around the priority of the list. • Members felt KLOES are useful and perhaps it would be beneficial to include Population Health and bring in ambitions, e.g. MSK pathways and getting people back into work? • Discussions were had on variation. It was relayed to members that in addressing priority work for the programme that test questions round such as variation were already applied when commencing this piece of work and would again be applied at sign off to measure the change. • Members queried whether patient and public involvement ought to be included in the KLOES with an assurance provided from the programme management office that patient experience and patient safety is included in the Quality and Equality Impact Assessment (QEIA), which forms part of the assurance and governance process that policies and pathways are required to go through before they're ready to be put before the programme board and clinical form, and joint committee. • Members' attention was drawn to the work undertaken by the programme on involving patients and the public such as the Institute of Voluntary Action Research project involving Wakefield's sight loss prevention programme and Calderdale's MSK project, plus the patient insight project looking at how we capture patient insight and experience along a care pathway. These examples can be built upon and linked in with policies and pathways. • It was consider that the KLOES will raise the competence of the board and our level of confidence that we are addressing the items detailed within them. **Actions:** • **Agreed the KLOES as a framework to facilitate better conversations around the papers that are being presented at programme board and to look at listing them in order of priority in line with our values with the inclusion of looking through a population health lens about the questions we would want to be asking of ourselves.** • **Our patient and public representatives to help the board to find the right words for involvement of patients and public for inclusion in the KLOES.**

7	**Hip Arthroscopy and Hip Replacement Policies (paper for approval)** • The hip arthroscopy and hip impingement (replacement) policies were presented to the board to seek approval for them being ready to progress to clinical forum and joint committee. • Discussions were had on what processes were involved in arriving at these policies and also which clinicians were involved in this work, and what the implications are for Place on the implementation of these policies. • Members considered it would be beneficial to identify any consequences of the change to this policy and to include wording to say that this may create pressure in another part of the system, e.g. people being denied MSK procedures being referred for pain management, weight management and MSK support etc. It was also considered by members that any resistance to the policy or identified risks and issues in implementing the policy and/or pathway ought to be highlighted early on in the process. • Making a link to our Places with these policies and pathways members considered would support the programme in knowing what is going on at our Places, with this responsibility falling to the board members to keep us updated as to who's involved in their individual Places so we can make these connections and further build relationships across WY&H, and to enable the programme and its board to adopt an accountability and responsibility approach. • Queries were raised about whether the Oxford Hip Score included in the policies is mandated. The Oxford Hip Score is to help the referring clinician to gauge what might be appropriate management, i.e. referral or managed intervention, which the consultants who were engaged with in developing and writing the policies considered ought to be included in said policies. There were subsequent discussions around shared decision making (SDM) and including the Oxford Hip Score in this part of the policy document to support the conversation between the clinician and patient on the clinical intervention and conservative management of their condition. As SDM is covered by the personalised care programme across WY&H, the board would be interested in receiving highlight reports from that programme to verify its delivery to this programme. • Clarification was requested by the members as to whether the policy is for treatment to be done by a specialist surgeon at a specialist centre with the reference to this in the policy. **Actions:** • **The board agreed to empower the programme leadership to take the policy paper to Clinical Forum in December and Joint Committee of the CCGs in January 2020 for approval, after making any required amendments.** • **Clarity on the process undertaken to get the policy to this point, the risks and issues to implementation and what Places have now and the barriers to implementation, i.e. the mapping and gapping exercise to be detailed in policies and pathways moving forward. The impact introducing the policy may have on other services would be beneficial, i.e. patients not having hip replacement may experience more pain and stiffness with the need for pain management and physiotherapy services.** • **The history and intelligence of the work done and who's been engaged with to get to this policy to be transparent. This ought to include activity data and any known resistance, issues and risks to the policy.**
8	**Cataracts Policy (paper for approval)** • The board were updated on the new standardised cataracts pathway and policy for WY&H. The process to get to this point has been supported at Place and at the cataracts and eye care working group. Work is taking place to develop a pathway across West Yorkshire which is already well embedded in Wakefield and North Kirklees. Most Places didn't have an existing policy and pathway. The threshold was agreed by clinicians to be based on the NICE Guidance and on not visual acuity, which will be emphasized in the papers to CF and JC. • Members' attention was drawn to the addition on page 13 which details a proposal which says that we will commission cataracts services from providers who are compliant with the current service specifications for cataract surgery. The idea is to create a level playing field so providers have the same expectations regarding commissioning and that their staff would have had the appropriate training to

	undertake these procedures. A risk assessment of this service specification will be added to the policy. • Paragraph 34 of the policy paper highlights the implementation plan and the pathway change around a resourced shared decision making discussion between the patient and the optometrists, i.e. the anticipated risks, benefits and intended health outcomes from having the medical intervention (i.e. surgery). Routine follow up being undertaken by a primary care optometrist and the financial investment to facilitate this will be addressed by a separate finance task and finish group. Paragraph 29 gives details of the initial modelling costs. • The role of community optometrists was also discussed in using them to deliver services to enable equity of access for people to those services and the sharing of health outcomes in each Place. Members considered this is a Placed based challenge and for the system; addressing commissioning at scale to create better health outcomes and better value for people and the system, and what identifying opportunities can be explored with community optometrists? • The practicalities of implementing pathways and undertaking a formal consultation to this was highlighted to the board as something the board could take to JHOSC to enable it to identify recommendations for the programme as to how it engages with people on changes to care pathways. **Actions:** • **The content of the policy and robustness of the process was agreed by the board with the agreement that a risk assessment around the service specification to be undertaken and included in the policy.** • **The pathway needs further discussion and involvement with providers. The pathway will be brought to the board at a later date. The policy and pathway risks and issues for implementation will to be articulated for discussion at the JCC.** **Contracting Options for Optometry services provided by community/primary care optometrists (for discussion)** • Discussions are taking place on contracting for optometry services across WY&H which will be picked up as part of that wider conversation about implementation, and also the financial activity and contract involvement to address concerns about the commissioning policy and pathway being developed in a silo way of working. The wider pathway will be tabled for discussion with the DOAS working group.
9	**Loop Gastric Bypass Policy (for discussion)** • Members discussed the process for updating policies which have already been agreed, with particular reference to the bariatrics policy. **Action: It was agreed that such policies will need to go back through the same approval process if a variation is made, i.e. programme board, clinical forum and joint committee with the mapping and gapping work and QEIA completed with risks and issues and financial implications addressed.**
10	**Single point of access: referral from MSK services in to elective orthopaedics (for discussion)** • Highlighting the WY&H MSK pathway approved in May 2019; making it explicit as to how these referrals in to secondary care elective orthopaedic services will be made. Being clear on whether GPs can refer directly to orthopaedic surgery or whether referrals ought to go through MSK services for a specialist to do the referral in to elective orthopaedics with GP direct referrals being an exception. Question to be taken to JCC. **Action: Amending the MSK policies to include referral in to elective orthopaedics to be discussed by the programme's risks and operational group later in November and taken to JCC for decision.**
11	**Hip Equity Audit – feedback from Places (for discussion)** This item was deferred until the next meeting.
12	**Programme Update** Attendees had no further updates on the questions and information they'd received. Members requested to note the content of this paper. The board were updated that one of the programme team project managers

	leaves at the end of the year. The Board thanked the project manager for their hard work and wished them all the best for the future.
13	**Workstream Update:** Papers O, P and Q were circulated to the group. There were no further updates at this meeting. Members requested to note the content of these papers.
14	**AHSN update** Members requested to note the content of the paper. New membership at the AHSN so a different person from the previous one at the AHSN will be attending future meetings.
15	**Next Steps and AOB** • One of our Places across WY&H stated they've updated some of their policies and would like to circulate them around members to see what the appetite is for taking a DOAS approach to adopting these updates. **Action: The respective CCG to send details to the programme leadership for a decision to be made on these policy updates.** **Next Steps:** **a. Key messages to be sent out to board members next week** **b. Discussions to be had amongst the board as to this being a two way process; what we need to develop and what needs to be presented in the papers to help the board make recommendations and approvals** **c. Development session: the expectations of the board, what's important to us and what talks to the maturity of the board? Set as Tuesday 25 February 2020.** **d. Risk register: highlight on there the primary of Place and commitment of Place – the capacity to remain involved and the role of this board in what's going on in Place?** **e. Clarity on policy and pathway and service specifications and the importance of our Key Lines of Enquiry (KLOES) and bringing out the finance lines of enquiry. Including financial considerations early on in our thinking. How do we engage and create the right relationship and highlight the financial risk, i.e. developing a business case and what does it look like and how does it translate in to action?** **Next meeting:** Tuesday 21 January 2020, 1.30pm – 4pm, Calderdale CCG, Dean Clough Mills, Halifax, HX3 5AX **Development session:** Tuesday 25 February 2020, 10am – 12 Noon, Calderdale CCG etc.