NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG)
Chair's responses to public questions from April 2016 to March 2017 Governing Body meeting

15th April 2016

	Question	Response	Any additional update or response
1	What will be the impact of the Commissioning of Lanc Ltd Mental Health Services as part of GM Devolution ?	*The current contract is in place and will be ongoing with no plans to change the contract as part of GM Devolution.*	

20th May 2016

	Question	Response	Any additional update or response
1	The following questions was raised by a member of the public, Mr R Newton who is a carer. *Pennine Care NHS Foundation Trust (PCFT) are currently implementing annual financial efficiency savings of £8 million per annum over 5 years, £40 million in total.* *The Medical Director of PCFT has recently disclosed that an external management consultant was appointed in order to ascertain if the Trust had followed its 2011 published policy on the implementation of NICE Guidelines.*	*Mr Ian Mello, Director of Commissioning and Provider Management raised the specific issues at the PCFT Contract Management Board meeting on Thursday 9 June 2016.* *Healthwatch Rochdale also wrote to PCFT and received the following response in relation to this question.* *"You recently reviewed a complaint around Pennine Care FT implementation of NICE guidance referring to Bipolar Disorder: assessment and management, CG185.* *Your letter dated 3 June 2016 refers to a letter shared with Healthwatch Rochdale written by Dr Henry Ticehurst (Medical Director) to a service user, in particular specific questions about whether the Trust's NICE Implementation Policy was followed with regards to NICE CG185.* *You have requested further clarification around why the Trust did not follow the Pennine Care NHS Foundation Trust – NICE Guidance Implementation Policy v4, specifically relating to Bipolar Disorder: assessment and management, NICE*	The outcome of the CQC inspection held in June 2016 was published on 9 December 2016. Overall the trust was rated as 'requires improvement' as a result of 6 of the 16 services being rated as such. Of the remaining 10 areas, nine were rated as 'good' and one, the Children and Adolescent mental health wards, was rated as 'outstanding'. PCFT was rated as 'requires improvement' against the CQC criteria for 'well led'. An Improvement and Transformation Board has been established to oversee the implementation of PCFT's action plan to address the requirements and recommendations of the CQC. The CCG is working with NHS Improvement, CQC and PCFT to support quality improvement and service transformation.

	After conducting a "Deep-dive" investigation the management consultant was able to reassure the Medical Director that the Trust did have a policy in place with regard to the implementation of NICE Clinical Guidelines relating to Adults with Bi-Polar. *The Trust has now created a new management role of Clinical Effectiveness and Quality Improvement Lead in order to ensure that the NICE Implementation Policy is embedded into practice.* *Are the CCG confident that PCFT will pass next month's Care Quality Commission inspection criteria for being well led?* *Are the CCG satisfied that PCFT are spending public money wisely?*	*guidance, CG185, and have requested assurance what is now in place to ensure this policy is effective and actioned by staff members.* *I will respond to each element of your request individually.* *NICE guidance, CG185: Bipolar Disorder: assessment and management* *NICE Guidance CG185 was initially published in September 2014 and was revised and re-published in February 2016 and given the same reference number by NICE.* *Normal practice within the department at the time CG185 was initially published in September 2014 was to share new guidance with identified leads based in clinical services during the first week of the month following publication. Unfortunately, the system at that time was unable to capture dates correspondence was shared and although I can assure you with some degree of confidence that the guidance was shared I am unable to state the date that happened.* *CG185 was revised and re-published in February 2016 and due to changes to the system which had just happened at that time, the guidance was shared with identified leads, including Rochdale Mental Health Clinical Business Unit, on 2 March 2016. The team manager has given assurance that CG185 has been reviewed by the service.* *NICE Guidance Implementation Policy v4* *Following a review of the NICE implementation process and systems which was conducted from December 2016 to March 2016, the NICE Guidance Implementation Policy v4 was revised quite radically. The NICE Implementation Policy v5 was*	

		ratified by the Trust's Quality Group in April 2016 and cascaded across the whole organisation. Awareness of the policy was raised with all identified leads (NICE leads) whom hold responsibility for delivery of the policy within their respective clinical services and the policy was also made available through the Trust's intranet. *The Medical Director's responsibilities are detailed in the policy, Section 4.3 along with the delegated responsibilities of the Head of Integrated Governance, the Clinical Effectiveness and Quality Improvement Lead and the Clinical Effectiveness Assistant in Sections 4.4 and 4.5 respectively.* *Overall, these roles have responsibility for embedding the policy and evaluating adherence to the policy across the organisation. The policy is scheduled to be reviewed formally on a 3-year cycle; however, a short-review date was set to the policy because incremental improvements to the process and system being piloted during this year anticipate revisions to the policy will be required much sooner.* *We are happy to share with you the outcomes of the planned evaluation mentioned above upon completion later in the year, and welcome opportunity to work with you to embed our process which we aim to become the forerunner in NICE implementation.* *Yours sincerely* *Dr Henry Ticehurst, Medical Director"*	

17th June 2016 – No public Questions

15th July 2016 – No public Questions

21st August 2016 – No meeting

16th September 2016

	Question	Response	Any additional update or response
1	Please can you provide an update regarding the Integrated Community Cardiology Service Tender and the proposed Model for the service	*Redesign of Integrated Cardiology Community pathway is currently taking place and will be presented to Governing Body in the near future*	To date the following work has been undertaken in relation to the development of an Integrated Cardiology Community pathway: • Stakeholder workshop held on 29th March • New project lead assigned to deliver agreed next steps including further engagement with stakeholders.
2	Additional Update forwarded from a complainant who requested the Governing Body were provided with an update following a previous complaint to Pennine Care NHS Foundation Trust (PCFT). Signed consent has been provided by the complainant to share the information. The initial complaint to PCFT was submitted in January 2015 and raised with Secondary Care. A significant amount of correspondence has been provided. Gratitude was expressed to Healthwatch Rochdale for their	*Concerns have been taken forward by HMR CCG Director of Operations & Engagement in the role as appointed Governor to PCFT. Liaison has also taken place with Healthwatch Rochdale, who are escalating concerns with PCFT.* *HMR CCG Chief Officer will also write to Michael McCourt to express concern in relation to length of time taken to progress this* *A formal response detailing action taken will be sent to the complainant and an update provided to Governing Body in due course.*	

	support and advocate support. Governing Body were made aware of the following concerns: • Length of time Stage 1 complaint has taken - 18 months • Secondary care support has been removed. • Request to attend a meeting providing only 2 days' notice. • Discharged from Access & Crisis Team and referred back to GP with no correspondence to GP. • Lack of Communication. • Request for readmission has been a lengthy process • Mr Michael McCourt – PCFT Chief Executive, wrote providing assurance; however 1 year later they were discharged again with no response and a reply from Dr Henry Ticehurst is still awaited.		

21st October 2016

	Question	Response	Any additional update or response
1	Question in relation to Springhill Intermediate Care.	*HMR CCG confirmed there were no financial savings to the CCG. Patient care has been improved and evidence is available to support this including*	No savings accrued to the CCG as this was a LA service. However significant improvements in intermediate care services have been made with the

	Does the clinical commissioning group believe that the closure of this service and the knock on effect onto the Adult Care social services, GP's and Care Homes and Hospital Community Care teams was worth the savings made.	*improvement to patient pathways and patient experience. The Local Authority are looking at redeveloping the building.*	development of the new collaborative of providers funded through the Better Care Funds. The new Wolstenholme ward is part of this service and has received excellent feedback from CQC inspection along with the whole service now being multi-award winning service.
2	I recently read about a new service in the Rochdale Observer called ' Pain Management Solutions' I am very interested as to when this is likely to be available to patients in the Heywood, Middleton and Rochdale CCG area?'	*The service went live for new patients on 1 October 2016, patients who are already in receipt of a service will be transferred over from 1 April 2017.*	The service commenced on 1st April 2017, is receiving excellent feedback and has commenced repatriation of patients from PAHT with the support of the consultants and management team at the hospital trust.

18th November 2016

	Question	Response	Any additional update or response
1	I have read recently that the CCG has quite a large amount of money left over from their commissioning budget. Is this correct? If so why is there a surplus? Given the NHS is now integrated with the Local Authorities (LAs) Adult care, why are the NHS not commissioning the LAs to provide preventative care – particularly for the elderly and the disabled?	*In response it was highlighted that statutory duties require the CCG to hold a 1% surplus control total. This is roughly £3 million for HMR which cannot be spent locally. There are a number of pooled budgets between the CCG and the LA and the detail of these is provided within the Finance Report. It was noted that the CCG work closely with Public Health in the LA who are responsible for the majority of preventative care.*	The Integrated Commissioning Board (HMR CCG and RBC) has received a work plan for 2017/18 which will support the development of a formal pooled budget arrangement between the two organisations for health and social care. During 2017/18 the ICB will receive shadow budget reports to help determine which budgets will be formally pooled or aligned

2	Are there any areas that should be covered in our bid for the Carers universal offer?	*The Governing Body advised that they are unable to comment as this involves an ongoing procurement process*	

16th December 2016

	Question	Response	Any additional update or response
1	Will the CCG look at revising the Choose and Book form which neither allows you to choose nor book? There are two additional pages which are now irrelevant, eliminating them will help in saving money and stop confusing patients.	*HMR CCG Lay member for Patient and Public Engagement acknowledged the frustrations with the wording of the letter which can be misleading. However, it was explained that this is a national Choose and Book letter, which we cannot change locally. Information has previously been fedback and will again be escalated to the National Body to follow up.*	The Choose and Book system has ben replaced by the national e-Referrals system, unfortunately the letter remains unchangeable locally. The CCG continues to feed these issues to the National Body and is looking what can be done locally to mitigate this issue.

20th January 2017 – No public questions

17th February 2017

	Question	Response	Any additional update or response
1	As reported nationally by the media the NHS has been forced to refuse admission to patients at various hospitals in recent months. 1. Given the above what is the present situation locally, and in our Health Trust region regarding the admission of patients to hospital.	Dr Hampson provided an update on Urgent Care and clarified that nobody is refused admission that requires admission. Community services are being put into place to enable people to stay at home where appropriate. Work is ongoing with NHS 111 to look at alternatives and paramedic car is to assess patients. The area of issue is related to trolley waits due to patients not being able to access a bed. Out of hospital pathways are being reviewed to ensure a speedy discharge to enable beds to be available within the	Work is ongoing with NHS 111 to look at alternatives to ambulance transfer and a pilot is taking place in HMR of a paramedic car is with one of the nurse practitioners from the intermediate tier service to assess patients. 85% have not needed to go to hospital and been managed at home

	2. Are there any plans to increase the provision of beds and staff to cope with increasing demand?	hospitals when needed. At a commissioning meeting earlier this week HMR were noted as having a lower % of delayed transfer of care in comparison to other CCG's. Good integrated services are in place within HMR CCG and Rochdale Borough Council. Contrary to reports that Rochdale Infirmary is closed, Dr Hampson confirmed that Rochdale Infirmary continues to provide services. Focus currently is on making better use of beds within hospitals. HMR CCG and other CCGs are working closely with the Urgent Care Delivery board and meet monthly to review. All patients who need admission had been accommodated. In Children's services these had been occasional transfer to other hospitals where beds were full. This had been closely monitored by the CCG Dr Duffy updated on the work with PAHT, to address staffing issues and funding which is being provided to address the issues.	Good integrated services are in place within HMR CCG and Rochdale Borough Council. Contrary to reports that Rochdale Infirmary is closed, Dr Hampson confirmed that Rochdale Infirmary continues to provide a vast number of excellent services.

17th March 2017

	Question	Response	Any additional update or response
1	What medical services are currently in place in the Rochdale Infirmary building on Whitehall Street?	These include:	Rochdale Infirmary also hosts the newly expanded Oasis Unit for patients with dementia and an acute medical need. The outcome based commissioned Intermediate Tier of Service also has a number of step up/step down beds at this site.

	Rochdale Infirmary		
Speciality	**Day Case**	**Elective**	**Non Elective**
General Surgery	✓	✓	X
Urology	✓	✓	X
Colorectal Surgery	✓	✓	X
Upper GI Surgery	✓	X	X

		Vascular Surgery	✓	X	X	
		Trauma & Orthopaedics	✓	✓	X	
		Ophthalmology	✓	✓	✓	
		Oral Surgery	✓	✓	X	
		Paediatric Dentistry	✓	X	X	
		Plastic Surgery	✓	X	X	
		Accident & Emergency	✓	X	X	
		Pain Management	✓	✓	X	
		General Medicine	✓	✓	✓	
		Gastroenterology	✓	✓	X	
		Clinical Haematology	✓	✓	✓	
		Diabetic Medicine	✓	X	X	
		Rehabilitation	✓	✓	✓	
		Cardiology	✓	X	X	
		Respiratory Medicine	✓	✓	✓	
		Nephrology	✓	X	X	
		Medical Oncology	✓	X	X	
		Rheumatology	✓	✓	X	
		Geriatric Medicine	✓	X	✓	
		Obstetrics	✓	X	X	
		Gynaecology	✓	✓	X	
2.	What is the extent of the facilities and the availability of rooms and space on the site?	As with most healthcare facilities clinical space is at a premium . There have been a number of recent developments that have seen a significant proportion of the vacant space on the site, resulting from Healthy Futures, now filled . These developments include the Wolstenholme IMC unit , the expanded Oasis Unit and the 23 hour surgery beds				
3.	Who is responsible for the planning of use, and the allocation of these	Pennine Acute Hospitals Trust are responsible for the RI estate but work closely with HMR CCG on the planning and commissioning of services delivered on the site				

	spaces?		
4.	How much of the total budget for North Manchester maternity care is allocated for Rochdale women?	Maternity care is funded using the national payment by results (PBR) tariff system. PBR is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treatment, that takes into account the complexity of the patients healthcare needs. The aim of PBR is to provide a transparent, rules-based system for paying trusts. It rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions. This system is used across the NHS in England in all hospitals and ensues a fair and consistent basis for hospital funding. The maternity pathway payment system splits maternity care into three stages: antenatal, delivery and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care, the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need. Women may still receive some of their care from a different provider for clinical reasons or to support their choice. This care is paid for by the lead provider that will have received the entire pathway payment from the commissioner. It is patients choice where they receive their maternity care within available services and therefore patient numbers at a particular hospital site can and will change on a year on year basis.	
5.	What is the rough estimate for this amount?		

Trust	**Actual Spend 2015/16 £**	**Budget / Plan 2016/17 £**
Pennine Acute Hospitals NHS Trust	11,012,036	11,542,185

		Central Manchester University Hospitals NHS Foundation Trust	153,707	171,737	
		Other	46,069	41,760	
		GRAND TOTAL	**11,211,813**	**11,755,682**	

Questions from PCFT Public Governors March 2017

	Question	Response	Any additional update or response
1	How do we ensure the needs of the public and our patients are at the heart of STP'S and that co-design of services is meaningful?	STPs at a local level within Greater Manchester are known as locality plans, the CCG commenced engagement some time ago and had approximately 60 engagement events to understand the views of our patients and public, all the information and views shared have been taken in to consideration, in addition to the information shared from partners within the borough	During January to March we held a series of workshops and engagement events for many stakeholders, including front line staff, clinicians and members of the public. We outlined our plans, which were based on information gathered from previous events. Our plan's were well received by the public. We are committed to continue to engage with the public both in terms of our overall plans and also to support the delivery of key interventions or projects.
2.	How does our STP preserve the clinical voice in healthcare planning in the current challenging financial conditions?	Clinicians have been involved in every stage and across the borough GPs and clinical staff from other organisations have been involved in the locality plan development and played a key role in contributing and ensuring the patient is at the heart of the plans going forward	We have continued to build on this clinical involvement to ensure that all key areas of work have clinical leads to ensure that the patient outcomes are always at the forefront of our decision making.
3.	How can STP governance help health and social	As a consequence of STPs, the locality plan and the future way of working services will be integrated to support this, within the borough a	

	care organisations work more effectively together?	Joint director of Integrated Commissioning, Sally McIvor has been appointed, this is a key role in the future development whereby services will be integrated to ensure there's a cohesive way of working together which will reduce duplication	
4.	Are we building a collaborative relationship within Rochdale with our local government regarding healthcare and wellbeing?	Yes – definitely – in addition to the above joint ways of working the budgets for health and social care will be pooled, this is a phased approach over an agreed period of time with the appropriate governance to manage this	
5.	Does the CCG have robust standards of care and key priorities that underpin decisions made when looking for value for money from providers?	Yes – the NHS mandatory contract incorporates these, in addition to local indicators agreed with providers, within the NHS there is also standard tariff process/costs which are agreed and set nationally	
6.	Can the CCG set own standards for training for healthcare workers?	This is part of the specific professional accountability and is monitored with providers, as part of the contract and CQC processes	
7.	Where we have differing provider management structures how do the CCG plan to ensure independent scrutiny, accountability and transparency so that decision - making remains firmly in the interests of the public and patients?	Independent scrutiny, accountability, decision making and transparency will continue as at present, the CCG has robust conflicts of interest policy to ensure conflicts are managed robustly and the appropriate assurance is provided via the reporting, management and governance structures	

8.	Where providers are assessed to operate below acceptable standards does the CCG have to ability to provide funds to help improve services if the provider is unable to fund own improvements?	If this is deemed appropriate within the agreed commissioning and contractual arrangements, it would need to progress through a formal robust governance structure to ensure the correct level of diligence when spending public funds. The CCG is also able to issue remedial notices whereby providers are given the opportunity to put action plans in to place to improve service delivery/patient experience/outcomes	
9.	How does the CCG monitor provider performance?	Through robust governance, reporting and monitoring, which includes attendance at regular meetings, presenting information and reports, in addition the CCG does announced and unannounced walk rounds, engaging with patients, family/carers and staff to receive feedback, both positive and negative. The CCG also work closely with Healthwatch Rochdale and other voluntary organisations to receive feedback.	
10.	Whilst imposing a balanced budget at a time of great local change in our health services, is the CCG confident that comprehensive, safe standards of care can be maintained?	Yes – this is key and is monitored closely, at a local level, GM and national level	
11.	Does the new appointment of a Joint Director of Integrated Commissioning to integrate services have a budget to facilitate the objectives of the position	Yes – the joint post will have responsibility for the commissioning budgets across the borough – for both health and social care	

12.	The new Joint Director of Integrated Commissioning says she aims to develop services that ensure people have control of their own lives and of the future of local care services. How will this be achieved	In the Locality plan and Transformation fund bid for Rochdale each of the themes for changes to service will be expected to demonstrate how local people have been involved in the development and design of the planned services . Service s will be evaluated by patient and public experience alongside all other key performance measures including how much influence the patient or person receiving support felt they had in decisions about their health and care and the impact on their life.	
13.	Does the CCG have standards for training of care assistants and professional carers that ensure person centered care?	The CCG monitors providers, as the CCG does not employ care assistants it monitors and supports providers, including the funding of apprentice's supported via Pennine Acute and Hopwood Hall College The safeguarding team from within the CCG provide training to providers	
14.	What measures are in place to safeguard vulnerable adults under the care of the 3rd sector?	Funding for third sector organisations is monitored in the same way as other funding from within the CCG, the safe guarding team work closely with others within the borough to ensure the needs of vulnerable adults are supported in the best way possible	
15.	Patients in the Whitworth area would like to access services within Rochdale but have been told this isn't possible – is it not patient choice? Whose decision is this?	The NHS Constitution states that patient choice is applicable to: • First outpatient appointments for physical health conditions where either a hospital or named consultant can be chosen • First outpatient appointments for mental health where either a provider or clinical team can be chosen Patients in Whitworth continue to be able to have a choice of services in line with the NHS Constitution	