West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 5 June 2018	Agenda item: 53/18		
Report title:	Joint Committee governance		
Joint Committee sponsor:	Marie Burnham, Independent Lay Chair		
Clinical Lead:	N/A		
Author:	Stephen Gregg, Governance Lead		
Presenter:	Stephen Gregg		
Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance			

Executive summary

The West Yorkshire and Harrogate CCGs established the Joint Committee in 2017 to "take efficient and effective commissioning decisions on a place basis, where appropriate and in accordance with the delegation of authority from each Party, and, in doing so, to support the aims and objectives of the WY&H STP as set out in the Joint Committee work plan." This report presents:

- Variations to the Memorandum of Understanding for Collaborative Commissioning (MoU) agreed recently by the member practices of each CCG:
  - revisions to the Joint Committee work plan
  - the continuation of current Committee voting arrangements following the merger of the 3 Leeds CCGs.
- The Joint Committee's amended terms of reference.
- The Joint Committee risk management framework, highlighting the risks to the delivery of the revised work plan.
- The draft Joint Committee Annual Report.

Recommendations and next steps

The Joint Committee is recommended to:

1. **Note** that following the merger of Leeds North, South and East and West CCGs, NHS Leeds CCG is now a party to the MoU.
2. **Note** the variations to the MoU agreed by the parties, namely the revised work plan and the continuation of current voting arrangements, maintaining the 'status quo' of 3 votes for Leeds
3. **Note** the Committee's revised Terms of Reference.
4. **Review** the risk management framework and **comment** on the actions being taken to mitigate the risks identified.
5. **Approve** the draft Joint Committee Annual Report.

The revised MoU, incorporating the variations together with routine administrative amendments, will be presented to the CCG Accountable Officers for signature in June 2018 and will be published on the Joint Committee web pages.

Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)	
Effective governance arrangements are necessary to ensure the delivery of the Joint Committee work plan.	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	Not applicable.
Public involvement:	Not applicable
Finance:	Not applicable
Risk:	Robust governance arrangements are needed to minimise the risk of Joint Committee decisions being challenged.
Conflicts of interest:	Not applicable

Joint Committee Governance

1. Background

The Memorandum of Understanding for Collaborative Commissioning between the CCGs (MoU) agreed in May 2017, sets out the framework for the CCGs to work together across West Yorkshire and Harrogate. The MoU established the Joint Committee of CCGs and sets out how it will operate. Variations to the MoU have recently been agreed by the membership of each CCG and are now presented to the Committee:

- Schedule 4, para 2.3 - amendments to the Joint Committee work plan.
- Schedule 3, para 2.13 - continuation of current voting arrangements (3 votes for the newly merged NHS Leeds CCG).

2. Variations to the MoU

2.1 Work plan (Schedule 4, para 2.3)

The work plan that was used to support establishment of the Joint Committee was developed late in 2016, and reflected the relative immaturity of a number of the STP programmes. While the high level programme areas for joint decision making were clear, there was a lack of detail on the specific decisions that would be asked of the Joint Committee.

During 2017/18 the STP programme delivery plans were refreshed in response to the 'Next Steps to the Forward View' document. As part of this work, amendments to the Committee's work plan were proposed to provide greater detail and specificity about the decisions that the CCGs would delegate to the Committee.

The Joint Committee reviewed the work plan at its development session on 5th December 2017 and asked CCGs to seek the approval of their member practices to a revised work plan. A template covering report was provided to support the approval process.

The member practices of each CCG have now **approved** the revised work plan, which is attached at **Appendix 1.**

2.2 Committee membership and voting arrangements (Schedule 3, para 2.13)

From 1st April 2018, the 3 Leeds CCGs who were parties to the original MoU merged to form a single CCG. Clause 13.2 of the MoU allows that statutory successor bodies of one or more of the parties, 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 a potentially significant impact on the voting arrangements for the Committee. Following the merger, the number of parties represented on the Joint Committee fell from 11 to 9. Under the arrangements set out in the original MoU, the 878,000 registered population

of Leeds would be represented by one vote, as opposed to the 3 which it previously had through the 3 individual CCGs.

At its development session on 6th February 2018, members of the Joint Committee agreed to recommend to the CCGs a pragmatic, transitional approach to Joint Committee voting arrangements – maintaining the 'status quo' of 3 votes for Leeds until the commissioning landscape across the wider WY&H footprint is settled.

Although the recommendation was to maintain the voting 'status quo', this represents a technical change in the voting arrangements. Legal advice confirmed that this required the new arrangements to be presented to all CCG memberships for approval. A template covering report was provided to support the approval process.

The member practices of each CCG have now **approved** a variation to the MoU to continue the current voting arrangements (i.e. 3 votes for the newly merged Leeds CCG). These arrangements will be reviewed by 31 March 2019, by which time the parties will have considered any extension to the initial term of the MoU.

The Committee terms of reference, incorporating this variation, are attached at **Appendix 2**.

2.3 Administrative amendments

The MoU is also being been updated to reflect changes in the membership of the Committee, and to correct drafting and typographical errors. The updated MoU will be presented to the CCG Accountable Officers in June 2018 for sign off.

3. Risk management

In September 2017, the Joint Committee agreed an approach to reviewing and managing the significant risks to the delivery of the STP objectives covered by the Joint Committee's work plan. The Committee acknowledged that the responsibility for managing most risks relating to the delivery of the STP does not rest with the Committee. To avoid duplication, it was agreed that the Joint Committee would not establish its own risk register, but would draw on the risk registers at Programme level. It agreed a proportionate approach, related directly to the Committee's decision-making processes and work plan.

The Committee subsequently agreed that the risk management framework be refreshed to align with the Committee's revised work plan. The refreshed framework, identifying the significant risks as at 29th May 2018, is attached at **Appendix 3.**

There are 4 risks scored at 15 or above after mitigation:

- Cancer waiting times - financial penalties
- Elective care/standardisation of commissioning policies
  - potential resistance to proposed changes
  - pace of implementation

Controls, assurances and planned mitigating actions are set out for all risks.

This is the first time that the populated framework has been presented to the Joint Committee. To give the Committee assurance that the framework is calibrated correctly and is reporting risks at the right level, significant risks scored at below 15 have also been included in this first iteration.

The Committee is invited to review the risks presented and comment on the actions being taken to mitigate them.

4. Annual report

The Joint Committee terms of reference require the Joint Committee to produce an annual report and to provide it to the members and/or governing bodies of each CCG. The annual report has been drawn largely from the 'key decisions' summary produced after each Joint Committee meeting and was shared with Joint Committee members in May for comment. Minor amendments were made to the format and content in response to comments and the revised draft circulated to each CCG for inclusion in their annual reports.

The Annual report is now attached at Appendix 4 for formal approval. It will be circulated to key stakeholders and posted on the Joint Committee web pages. A public friendly version has also been produced and is attached at Appendix 5.

5. Recommendations

The Joint Committee is recommended to:

a) **Note** that following the merger of Leeds North, South and East and West CCGs, NHS Leeds CCG is now a party to the MoU.
b) **Note** the variations to the MoU agreed by the parties – the revised work plan and continuation of current voting arrangements, maintaining the 'status quo' of 3 votes for Leeds.
c) **Note** the Committee's revised terms of reference.
d) **Review** the risk management framework and **comment** on the actions being taken to mitigate the risks identified**.**
e) **Approve** the draft Joint Committee Annual Report.

53/18 Appendix 1

West Yorkshire and Harrogate Joint Committee of CCGs - work plan 2018/19

Decisions delegated to the Joint Committee by the CCGs

Cancer

Agree new strategic approaches to the commissioning and provision of cancer care, building on the 'Commissioning for Outcomes' work.

Mental health

- *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.*

Stroke

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

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*

Elective care and standardising commissioning policies

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.*

TERMS OF REFERENCE OF THE JOINT COMMITTEE – Amended May 2018

1. ROLE OF THE JOINT COMMITTEE

1.1. The overarching role of the Joint Committee is to take efficient and effective commissioning decisions on a place basis, where appropriate and in accordance with the delegation of authority from each Party, and, in doing so, to support the aims and objectives of the STP as set out in Schedule 7. The Joint Committee shall at all times act in accordance with all relevant Law and Guidance applicable to the Parties and relevant to the joint exercise of each Party's Functions.

2. TERMS OF REFERENCE OF THE JOINT COMMITTEE

Frequency and notice of meetings

2.1. Meetings shall be held monthly or other such frequency as agreed by the Parties.

2.2. Meetings may be held by telephone or video conference. Joint Committee Members may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference.

2.3. The Chair shall set the agenda and arrange for the circulation of any papers to be considered at least five Working Days prior to the meeting.

2.4. Meetings of the Joint Committee shall be open to the public save where the Joint Committee resolves to exclude members of the public from any meeting or part of a meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or there are special reasons as stated in the resolution and arising from the nature of the business of the proceedings.

2.5. The Chair may exclude any member of the public from a meeting of the Joint Committee if they are interfering with or preventing the proper or reasonable conduct of that meeting.

2.6. Members of the public or representatives of the press may not record proceedings in any manner whatsoever, other than writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.

2.7. The right of attendance at meetings by members of the public as referred to in paragraph 2.4 does not give the right to such members of the public to ask questions or otherwise participate in that meeting, unless invited to do so by the Chair.

Joint Committee Members and attendees

2.8. The Joint Committee Members shall comprise:

2.8.1. two voting representatives appointed by each Party; and

2.8.2. three non-voting lay representatives (appointed by the Parties via an open application process) to comprise:

(a) one lay representative who is independent of any of the Parties (the "Independent Lay Representative"); and

(b) two lay representatives who are existing lay members of a Party's governing body (provided that the two lay representatives shall not be lay members of the same Party).

2.9. The Joint Committee shall invite a representative of NHS England to attend meetings and may invite other persons to attend meetings as it deems appropriate.

2.10. No such persons invited to attend meetings shall be able to vote on a matter.

Quorum

2.11. Meetings of the Joint Committee shall be quorate when at least 75% of the Joint Committee Members are present.

2.12. In circumstances where a Joint Committee Member who is not a lay representative is unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the nominating Party may send to a meeting of the Joint Committee a deputy (a "**Deputy**") to take the place of the Joint Committee Member. Where a Party sends a Deputy to take the place of the Joint Committee Member, the references in this paragraph 2 to Joint Committee Members shall be read as references to the Deputy. Parties must ensure that a Deputy attending a meeting of the Joint Committee has the necessary delegated authority.

Voting

2.13. The Joint Committee Members nominated by each Party (referred to in paragraph 2.8.1 above) shall have one vote between them, so that there is one vote per Party, except that Leeds CCG, which came into existence on 1st April 2018 following the merger of Leeds North, Leeds South East and Leeds West CCGs, will retain the 3 votes of the separate CCGs prior to the merger. The lay representative Joint Committee Members shall not vote on any matter.

2.14. The Joint Committee will make decisions by consensus of those Joint Committee Members present and voting at the meeting wherever possible. If a consensus decision cannot be reached then decisions of the Joint Committee will be made by 75% majority of those Joint Committee Members voting and present at the meeting.

2.15. The validity of any act of the Joint Committee shall not be affected by any defect in its constitution, by any vacancy among the Joint Committee Members or by any defect in the appointment of any of its Joint Committee Members.

Chair

2.16. The Independent Lay Representative shall be appointed Chair of the Joint Committee. The Joint Committee will appoint another of the Joint Committee Lay Members to act as Deputy Chair.

Administration

2.17. The Programme Management Office shall provide administrative support and advice to the Joint Committee including but not limited to:

2.17.1. taking the minutes and keeping a record of matters arising and issues to be carried forward;

2.17.2. maintaining a register of interests for Joint Committee Members; and

2.17.3. advising the Joint Committee and attendees if relevant as appropriate on best practice, national guidance and other relevant documents.

Duties

2.18. The Joint Committee will:

2.18.1. make Joint Committee Decisions (as set out in Schedule 4 and/or the Workplan); and

2.18.2. undertake actions as set out in this Agreement.

Relationship with the Parties

2.19. Minutes of meetings of the Joint Committee shall be provided to the members and/or governing bodies of the Parties.

2.20. The Joint Committee shall produce, with the support of the Programme Management Office, an annual report of the work of the Joint Committee which shall be provided to the members and /or governing bodies of each Party.

Special Meetings

2.21. Special meetings of the Joint Committee on any matter may be called by any of the Parties acting through its Joint Committee Member by giving at least forty-eight (48) hours' notice by e-mail to the other Joint Committee Members in the following circumstances:

2.21.1. where that Party has concerns relating to the safety and welfare of Service Users under any Commissioning Contract(s);

2.21.2. in response to a quality, performance or financial query by any Regulatory or Supervisory Body;

2.21.3. to convene a meeting under Clause **Error! Reference source not found.** (Dispute Resolution) of the Agreement; and/or

2.21.4. for the consideration of any matter which that Party considers of sufficient urgency and importance that its consideration cannot wait until the date of the next meeting.

Conflicts of Interest

2.22. Each Joint Committee Member must abide by all policies of the Party it represents in relation to conflicts of interest.

2.23. Where any Joint Committee Member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that Joint Committee Member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed. Where the Chair decides to exclude a Joint Committee Member, the relevant Party may send a Deputy to take the place of the conflicted Joint Committee Member in relation to that matter in accordance with paragraph 2.12.

Review

2.24. These terms of reference shall be reviewed by the Joint Committee at least annually and any consequential amendments approved by each Party's members.

22.05.18

Appendix 3

West Yorkshire and Harrogate Joint Committee of CCGs

Assurance Framework

Introduction

The Assurance Framework sets out how the Joint Committee will manage the principal risks to delivering agreed STP outcomes covered by the Committee's work plan. The Framework enables the Committee to assure itself (gain confidence, based on evidence). The framework aligns risks, key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to reduce the risk of non-delivery, the Committee will agree the action that needs to be taken. Planned actions will enable the Committee to monitor progress in addressing gaps or weaknesses.

The Committee will:

- Monitor the principal risks that threaten the achievement of the STP outcomes covered by the Joint Committee's workplan.
- Evaluate the controls intended to manage these principal risks.
- Evaluate the assurance across all areas of principal risk.
- Identify positive assurances and areas where there are gaps in controls and / or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks.

Risks are given a score of 1-5 for likelihood and 1-5 for impact. These scores are then multiplied to give the total risk score. The framework identifies risks with a score of 15 or more, after mitigating controls and assurances have been taken into account.

Note:
This is the first time that the populated framework has been presented to the Joint Committee. To give the Committee assurance that the framework is calibrated correctly and is reporting risks at the correct level, significant risks scored at below 15 have also been included in this first iteration.

Summary of risks 29.05.18

STP outcome covered by work plan	Risk to delivering the outcome	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
1. Joint Committee decision-making • Joint Committee decisions are robust, with appropriate public and patient involvement, clinical engagement and quality assurance.	1.1 Decisions taken by the Committee are not properly and lawfully delegated by the CCGs or are not made with appropriate clinical, public and patient engagement, resulting in legal challenge and/or reputational damage.	20 (4 x 5)	• Matters delegated to the Joint Committee set out in the work plan, agreed by CCG member practices in May 2017 • Work plan refreshed in 2017/18 and submitted to CCG member practices for approval. • Lay Chair and Members • Meetings held in public • Covering reports to Committee require PPI and clinical engagement to be highlighted. • Clinical Forum provides clinical input. • Lay Member Assurance Group • Quality and Equality Impact Assessment processes in each CCG.	12 (3 x 4)	• Confirm to Joint Committee that CCG member practices have formally agreed refreshed work plan and Committee voting arrangements. • CCG members review the work plan periodically and agree any new matters to be delegated to the Joint Committee. • Review MoU prior to its expiry date of 31 March 2019. • Establish Lay Member Assurance Group as a formal part of the Joint Committee governance arrangements . • Develop common approach to quality and equality impact assessment across WY&H CCGs. .
2. Cancer • New strategic approaches to commissioning and providing cancer care.	2.1 National conditions imposed on receipt of 2018/19 Cancer Transformation Funds based on linkage with performance against 62 day CWT standard have resulted in 25% financial penalty imposed on at least Q1 and Q2 allocations. Checkpoint based on May/June/July performance presents opportunity to recoup some of the loss or risk of further loss.	25 (5 x 5)	• Work programmes for Early diagnosis and Living with and Beyond Cancer reprioritised and agreed by Alliance Board and NHS England.	20 (4 x 5)	• Comprehensive CWT Recovery Plan in place and monitored by Alliance Board. • Plans reprioritised to incorporate all CWT related deliverables in 18/19 Planning Guidance. • Regular local (DCO) and regional tripartite contact to maximise opportunities for learning and sharing good practice
3. Mental Health • Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds • Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services.	• No relevant risks on the Programme risk register.	.			

• Agree plan for the provision of children and young people inpatient units, integrated with local pathways.					
4. Stroke • Agree configuration of Hyper Acute and Acute stroke services	4.1 Providers may not be able to implement the latest stroke guidelines due to lack of available and appropriately skilled workforce able to deliver new models of care resulting in variance in stroke outcomes across the West Yorkshire & Harrogate footprint.		• New Guidelines circulated to all members of the group & implications of implementing new guidelines will inform new models of care & care pathways. • Trust representatives are reporting by exception workforce/operational pressures/concerns. • Risk scores of 12 were referenced in the stroke report to Joint Committee of CCG's (4/7/17 & 7/11/17) • T&F Group have contributed to development of STP LWAB Strategy	12 (3 x 4)	• LWAB workforce lead now attending T&F group & leading the workforce work stream. • LWAB workforce lead has received a copy of the standardised pathway & working with Clinical Working Group to ensure workforce & care pathway developments are aligned. In advance of this they are liaising with clinical colleagues to gain a clinical perspective on provider workforce priorities for action. • SY&B Stroke Lead attended T&F group (16/1/18) & it was agreed the WY&H workforce lead will liaise with SY& B & Humber Coast & Vale stroke leads to identify opportunities to learn & share from national & Y&H workforce developments. • Meetings with hospital providers continue to determine the implications of implementing improvement initiatives. • Workforce, finance and business intelligence outputs presented to T&F 25/4/18 and informing our work
	4.2 Hyper Acute Stroke services across the West Yorkshire and Harrogate footprint may experience operational resilience issues due to inability to recruit and retain appropriately skilled workforce during the transformation transition period resulting in emergency commissioning arrangements being implemented in advance of new models of care being approved and implemented.		• Risk score of 12 were referenced in the stroke report to Joint Committee of CCG's (7/11/17) • Operational resilience issues are being addressed via existing contractual routes via the Lead CCG. • T&F Group receive notification of operational pressures & will review outcome of discussion between relevant provider & Lead CCG with a view to ensuring outcome/lessons learned inform future transformation options. • Local/national developments are a standing agenda item to encourage two way dialogue between organisation representatives & the WY&H Programme developments. • Cross boundary impacts are informing our work SY& Bassetlaw, Humber Coast and Vale and WY&H Stroke Leads are in regular dialogue to ensure opportunities to learn and share.	12 (3 x 4)	• Further meetings have been scheduled with WYAAT colleagues and other key stakeholders to inform the next steps.

5 Urgent and emergency care 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.	111 Procurement 5.1 Risk of a challenge being submitted due to the nature of the procurement which could result in a delay in timescales associated with delivery of the programme	25 (5 x 5)	• Regular discussions to be held at steering group meetings and Programme Board meetings to monitor this on an ongoing basis	9 (3 x 3)	• Non-conflicted clinicians to be sought to be involved in the work stream groups and the formal procurement process including the procurement evaluation panels and dialogue sessions
	5.2 There is the risk that the national target of 50% (as stipulated by NHS E) will not be reached	20 (4 x 5)	• Bidders will need to be asked how they intend to meet this target during the ITPD stage	9 (3 x 3)	• The specification workstream will need to address this through the ITPD question setting and dialogue meetings with bidders
	5.3 There is a risk of system integration & interoperability (from a clinical and patient perspective) as the regional provider will be required to interface with circa 60 local CAS providers	25 (5 x 5)	• The specification will need to be clear on system interoperability. This will need to explored in greater detail during both the ITPD and ITCD stages of the procurement	9 (3 x 3)	• The IM&T workstream will need to address this through the ITPD/ITCD question setting and dialogue meetings with bidders. The specification will need to be adapted
6 Elective Care/standardisation of commissioning policies Develop and agree commissioning policies, including: • Pre-surgery optimisation (supporting healthier choices); • Clinical thresholds and procedures of low clinical value; • Eliminating unnecessary follow-ups; • Efficient prescribing.	6.1 There might be resistance to some of the proposed changes from some stakeholders (e.g. politicians, the public)	25 (5 x 5)	• Develop a strong stakeholder management approach as part of the communications & engagement strategy • Consider the need for consultation and type of consultation where there are significant service changes required.	15 (3 x 5)	• Proactive communications and engagement. • Participation of Lay members in Programme Board to ensure lay perspective is considered throughout.
	6.2 Some CCGs will want to proceed at a slower pace than the majority.	15 (5 x 3)	• Acknowledge and accept that this will happen. • Agree an over-arching timetable with a common end-point	15 (5 x 3)	• Encourage CCGs to move together in lockstep to maximise benefit across the region and deliver economies of scale around e.g. communications & engagement, implementation etc • Establish baseline thresholds and allow for some CCGs to “go-tighter” if required

West Yorkshire and Harrogate Joint Committee of CCGs - Annual report 2017/18

Key responsibilities

The Joint Committee is part of the West Yorkshire and Harrogate Health and Care Partnership (HCP). The 11 CCGs established the Committee in May 2017, with delegated authority to take commissioning decisions at WY&H level on specific programmes including: cancer, elective care/standardisation of commissioning policies, mental health, stroke and urgent care. The Committee aims to ensure that its decisions include public and patient engagement, clinical input and have authority from the CCGs.

The Committee has a work plan, Memorandum of Understanding and Terms of Reference, which were agreed by the Members of each CCG. The Committee's work plan reflects the partnership priorities for which the CCGs believe collective decision making is essential. During the year, the Committee reviewed its work plan and asked the Members of each CCG to approve changes to it for 2018/19.

Although it can only make decisions on the programmes of work that have been delegated to it, the Committee also makes recommendations to the CCGs on other matters where it feels that a WY&H-wide approach would be beneficial.

Membership and attendance

The Committee is made up of 2 representatives from each of the WY&H CCGs – usually the CCG Clinical Chair and the Accountable Officer. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the HCP team and NHS England also attend. The Committee met for the first time in public in July 2017 and continued to meet every other month throughout 2017/18. Attendance records are set out at Appendix 1.

Public and patient engagement

Meetings are held in public and are also streamed 'live' on the Committee's web pages. The Committee invites questions about its business and, where possible, these are answered during the meeting. Full written answers to all questions are published after each meeting.

There is a 'patient story' at most meetings, which enables the Committee to get the perspective of patients and service users. For example, the Committee considered videos presenting the experience of patients with cancer, highlighting variation in general practice and the need for effective early diagnosis. Reports to the Committee identify the patient and public engagement that has already taken place or is planned. For example, the Committee received a report on the major public engagement exercise on stroke services. In this way, the Committee ensures that the voice of patients is at the centre of its decisions.

Highlights of the Committee's work

Cancer

The cancer work streams are tobacco control, early diagnosis, high quality services, patient experience and living with and beyond cancer. The Committee reviewed partnership working by the WY&H Cancer Alliance, which had bid successfully for additional funding, linked to delivery of the 62 day standard for cancer waits. The Committee noted awareness-raising campaigns to improve early diagnosis and screening take-up. Work was being co-ordinated with other STP programmes, including support for healthier lifestyle choices.

The Committee supported the proposal that the Cancer Alliance develop a common set of agreed outcomes and stronger system leadership to support all partners to make good, evidence-based decisions.

Elective care/standardisation of commissioning policies

The programme aims to improve health by better prevention and supporting healthier choices. This will reduce variation, inconsistency and the perception of a 'postcode lottery' and has the potential to create financial efficiency gains.

The Committee agreed an approach in which before surgery, patients are offered a choice of services to address lifestyle factors. It agreed to standardise commissioning policy across WY&H for procedures of limited clinical value and elective orthopaedic surgery. It also supported the development of new approaches to outpatient services in elective orthopaedic surgery and eye care.

Mental health

The programme aims to reduce variation, develop consistent pathways, support all to achieve the best standards and achieve economies of scale. Areas of focus include emergency care, specialist Child and Adolescent Mental Health Services (CAMHs), and autism, with supporting people in crisis closer to home a key aim.

The Committee noted work by mental health providers to share beds, improve access to local services and reduce out of area placements. It supported work by CCGs to review commissioning plans, reduce variation and establish common levels of community services across WY&H. The Committee supported the development of new care models for CAMHs & Adult Eating Disorders and agreed to develop a joint approach to commissioning acute mental health services.

Stroke

The programme aims to improve stroke outcomes, use resources efficiently and effectively and ensure that stroke services are sustainable and fit for the future. The Committee noted that clinical outcomes varied across WY&H and that outcomes were better when treatment was provided in specialist centres. The Committee noted progress in developing standardised care pathway and clinical standards for hyper acute and acute stroke services. The Committee noted extensive engagement with key stakeholders, including clinicians, patients and the public and providers.

The Committee considered a proposal for the 11 CCGs to work together to further improve the detection and treatment of Atrial Fibrillation (AF), a fast and erratic heartbeat which is a major cause of stroke. It recommended that each CCG agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation and adopt a targeted and phased approach to working with their local practices.

Urgent and emergency care

The programme aims to ensure that people get the right care, in the right place at the right time. The Committee noted that NHS England required all CCGs to have an Integrated Urgent Care (IUC) programme in place by 1 April 2019 and considered recommendations to achieve this. The work was being overseen by the Y&H Joint Strategic Commissioning Board.

The Committee recommended that a formal procurement process be undertaken, using a 'structured dialogue' approach which would enable the service model to be refined with providers. This was particularly important given the complexity of delivering services in 3 STP areas across Yorkshire and the Humber.

Attendance record **Appendix 1**

Organisation and role	Member	Attendance (eligible)
Independent Lay Chair	Marie Burnham	5 (5)
CCG Lay member	Fatima Khan-Shah Richard Wilkinson	5 (5) 4 (5)
NHS Airedale, Wharfedale and Craven CCG - Clinical Chair	Dr James Thomas	5 (5)
NHS Bradford City CCG - Clinical Chair	Dr Akram Khan	3 (5)
NHS Bradford Districts CCG - Clinical Chair	Dr Andy Withers	5 (5)
NHS AW&C, Bradford City & Bradford Districts CCGs Chief Officer	 Helen Hirst	 5 (5)
NHS Calderdale CCG Clinical Chair Chief Officer Chief Finance Officer	 Dr Alan Brook Dr Matt Walsh Neil Smurthwaite (deputy for Matt Walsh)	 5 (5) 4 (5) 1 (1)
NHS Greater Huddersfield CCG Clinical Leader Chief Officer Chief Finance Officer	 Dr Steve Ollerton Carol McKenna Ian Currell (deputy for Carol McKenna)	 5 (5) 4 (5) 1 (1)
NHS Harrogate & Rural District CCG Clinical Chair Chief Officer	 Dr Alistair Ingram Amanda Bloor	 5 (5) 5 (5)
NHS Leeds North CCG - Clinical Chair **NHS Leeds South & East CCG** - GP Clinical Lead **NHS Leeds West CCG** - Clinical Chair **NHS Leeds CCGs Partnership** Chief Executive Chief Finance Officer	Dr Jason Broch Dr Alistair Walling Dr Gordon Sinclair Philomena Corrigan Visseh Pejhan-Sykes (deputy for Philomena Corrigan)	3 (5) 3 (5) 4 (5) 4 (5) 1 (1)
NHS North Kirklees CCG Clinical Chair Chief Officer (to 5 September 2017 meeting) Chief Officer (from 7 November 2017 meeting)	 Dr David Kelly Richard Parry Carol McKenna	 4 (5) 2 (2) 3 (3)
NHS Wakefield CCG Clinical Chair Chief Officer Deputy Chief Officer	 Dr Phillip Earnshaw Jo Webster Pat Keane (deputy for Jo Webster)	 5 (5) 2 (5) 2 (2)

Appendix 5

NHS

West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

Annual Report
2017 - 2018

West Yorkshire and Harrogate
Health and Care Partnership

Chair's foreword

I'm proud to introduce the first Annual Report of the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups (CCGs).

It's an exciting time to be working with CCG leaders from our local places – Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The Joint Committee plays an important role within the West Yorkshire and Harrogate Health and Care Partnership. Its work plan is directly connected to the objectives of the wider partnership, and it enables the CCGs to come together and take collective decisions where they have agreed to do so. You can read more about the partnership here: www.wyhpartnership.co.uk

As the Lay Chair, I am independent of the CCGs. It is my job to make sure that the decisions the Joint Committee take are fair and transparent. I'm supported in this by two CCG Lay Members - Fatima Khan-Shah and Richard Wilkinson - who ensure that we make decisions in the right way, putting people's needs rather than organisations first.

The Joint Committee held its first meeting in July 2017, and I've been delighted by the progress that we have made during the year. The Joint Committee has led innovative work to:

- Help the Cancer Alliance to improve cancer prevention and early diagnosis
- Support healthier lifestyles and reduce the perception of a 'postcode lottery' in health services
- Improve access to local mental health services
- Improve stroke services in the first few hours and days after a stroke occurs
- Make sure that people get the right urgent and emergency care, in the right place, at the right time.

We encourage and welcome the public to attend our meetings. If it is easier for you, you can watch our meetings 'live' on the internet at http://www.wyh-jointcommiteeccgs.co.uk, where you can find more information about the Joint Committee.

It is my pleasure to serve as Lay Chair of the Joint Committee. We have achieved many things in our first 9 months. There is more for us to do to improve health and care for everyone living in West Yorkshire and Harrogate and I am looking forward to the challenge.

Marie Burnham
Independent Lay Chair, West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

Key responsibilities

The Joint Committee is part of the West Yorkshire and Harrogate Health and Care Partnership (HCP). The 11 CCGs established the Committee in May 2017, with delegated authority to take commissioning decisions at West Yorkshire and Harrogate level on specific programmes including: cancer, elective care/ standardisation of commissioning policies, mental health, stroke and urgent care. The Committee aims to ensure that its decisions include public and patient engagement, clinical input and have authority from the CCGs.

The Committee has a work plan, Memorandum of Understanding and Terms of Reference, which were agreed by the Members of each CCG. The Committee's work plan reflects the partnership priorities for which the CCGs believe collective decision making is essential. During the year, the Committee reviewed its work plan and asked the Members of each CCG to approve changes to it for 2018/19.

Although it can only make decisions on the programmes of work that have been delegated to it, the Committee also makes recommendations to the CCGs on other matters where it feels that a West Yorkshire and Harrogate-wide approach would be beneficial.

Membership and attendance

The Committee is made up of 2 representatives from each of the West Yorkshire and Harrogate CCGs – usually the CCG Clinical Chair and the Accountable Officer. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the HCP team and NHS England also attend. The Committee met for the first time in public in July 2017 and continued to meet every other month throughout 2017/18.

Public and patient engagement

Meetings are held in public and are also streamed 'live' on the Committee's web pages. The Committee invites questions about its business and, where possible, these are answered during the meeting. Full written answers to all questions are published after each meeting.

There is a 'patient story' at most meetings, which enables the Committee to get the perspective of patients and service users. For example, the Committee considered videos presenting the experience of patients with cancer, highlighting variation in general practice and the need for effective early diagnosis. Reports to the Committee identify the patient and public engagement that has already taken place or is planned. For example, the Committee received a report on the major public engagement exercise on stroke services. In this way, the Committee ensures that the voice of patients is at the centre of its decisions.

Highlights of the Committee's work

Cancer

The cancer work streams are tobacco control, early diagnosis, high quality services, patient experience and living with and beyond cancer.

The Committee reviewed partnership working by the West Yorkshire and Harrogate Cancer Alliance, which had bid successfully for additional funding linked to the delivery of the 62 day standard for cancer waits. The Committee noted awareness-raising campaigns to improve early diagnosis and screening take-up. Work was being co-ordinated with other STP programmes, including support for healthier lifestyle choices.

The Committee supported the proposal that the Cancer Alliance develop a common set of agreed outcomes and stronger system leadership to support all partners to make good, evidence-based decisions.

Elective care/standardisation of commissioning policies

The programme aims to improve health by better prevention and supporting healthier choices.

This will reduce variation, inconsistency and the perception of a 'postcode lottery' and has the potential to create financial efficiency gains.

The Committee agreed an approach in which before surgery, patients are offered a choice of services to address lifestyle factors. It agreed to standardise commissioning policy across West Yorkshire and Harrogate for procedures of limited clinical value and elective orthopaedic surgery. It also supported the development of new approaches to outpatient services in elective orthopaedic surgery and eye care.

Urgent and emergency care

The programme aims to ensure that people get the right care, in the right place at the right time.

The Committee noted that NHS England required all CCGs to have an Integrated Urgent Care (IUC) programme in place by 1 April 2019 and considered recommendations to achieve this. The work was being overseen by the Yorkshire and Humber Joint Strategic Commissioning Board.

The Committee recommended that a formal procurement process be undertaken, using a 'structured dialogue' approach which would enable the service model to be refined with providers. This was particularly important given the complexity of delivering services in 3 STP areas across Yorkshire and the Humber.

Mental health

The programme aims to reduce variation, develop consistent pathways, support all to achieve the best standards and achieve economies of scale.

Areas of focus include emergency care, specialist Child and Adolescent Mental Health Services (CAMHs) and autism, supporting people in crisis, closer to home.

The Committee noted work by mental health providers to share beds, improve access to local services and reduce out of area placements. It supported work by CCGs to review commissioning plans, reduce variation and establish common levels of community services across West Yorkshire and Harrogate. The Committee supported the development of new care models for CAMHs & Adult Eating Disorders and agreed to develop a joint approach to commissioning acute mental health services.

Stroke

The programme aims to improve stroke outcomes, use resources efficiently and effectively and ensure that stroke services are sustainable and fit for the future.

The Committee noted that clinical outcomes varied across West Yorkshire and Harrogate and that outcomes were better when treatment was provided in specialist centres. The Committee noted progress in developing standardised care pathways and clinical standards for hyper acute and acute stroke services. The Committee noted extensive engagement with key stakeholders, including clinicians, patients and the public and providers.

The Committee considered a proposal for the 11 CCGs to work together to further improve the detection and treatment of Atrial Fibrillation (AF), a fast and erratic heartbeat which is a major cause of stroke. It recommended that **each CCG agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation** and adopt a targeted and phased approach to working with their local practices.

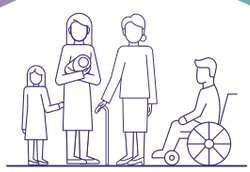
Our vision

01 In your neighbourhood and community

- Health and social care will work together to support your social, physical and mental health
- Your carers will be supported too
- And where safe to do so you will be supported to self-care

02 In your local area

- Care will be delivered locally, managed locally and planned locally
- You will be seen as equal partners and encouraged to support one another
- Community groups and local teams including your GP will work with you
- You know better what you and your community needs



You are at the centre of everything we do

You will have the best start in life so you can live and age well.

We will work with you to deal with the issues that affect your health and wellbeing in your communities, whether it's loneliness or learning disability; housing or mental health; childhood obesity or air quality – **together we can make things better with you.**

03 Across West Yorkshire and Harrogate (WY&H)

- We will plan care across WY&H. E.g. sharing good practice, staff skills and buildings
- Our hospitals will work together so you have the best treatment possible
- We will make the best use of all the expertise and staff skills available to us
- We will work across the area on issues like mental health, cancer, stroke and urgent care

Our partnership is not a new organisation. It is a new way of working for the 2.6million people who live in Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

NHS services, councils, voluntary and community organisations will work together to improve your health and wellbeing.

The West Yorkshire and Harrogate Health and Care Partnership is made up of organisations working closely together to plan health and care services across the area.

This information is available in alternative formats, for example large print, Braille, EasyRead and community languages. For more information contact:

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@WYHpartnership

A partnership made up of the NHS, local councils, care providers, Healthwatch and community organisations.

2017 - 2018

West Yorkshire and Harrogate
Health and Care Partnership