West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 7th May 2019		Agenda item: 33/19	
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

This report presents a review of the Joint Committee's work in 2018/19 and sets out proposals for developing its work in 2019/20. It also updates the Committee on other current governance issues. It includes

- the draft Joint Committee Annual Report for 2018/19
- summary findings of the Joint Committee self-assessment carried out in March 2019

Recommendations and next steps

The Joint Committee is recommended to:

1. **Comment** on and **approve** the draft Joint Committee Annual Report.
2. **Comment** on the Joint Committee self- assessment and **agree** proposals for developing the work of the Committee in 2019/20.
3. **Note** the vacancy for one of the Joint Committee CCG lay members and the proposal to seek expressions of interest for the role.
4. **Note** the proposed changes to 111/999 decision making at Yorkshire and Humber level, including the proposal that Hambleton, Richmondshire and Whitby CCG becomes an associate member of the WY&H Joint Committee for 111/999 decision making only.

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:	Covered in the Annual report and self- assessment.
Public involvement:	As above.
Finance:	As above.
Risk:	Robust governance arrangements minimise the risk of Joint Committee decisions being challenged.
Conflicts of interest:	Not applicable

Annual report 2018/19

1. 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 draft annual report has been drawn largely from the 'key decisions' summary produced after each Joint Committee meeting and was shared with Accountable Officers in March for comment. Minor amendments were made to the format and content and the revised draft sent to each CCG for inclusion in their draft annual governance statement and annual report.

2. The draft annual report is now attached at Appendix A 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 B.

Joint Committee self-assessment

3. In line with the principles of good governance, the Committee evaluated its performance in March 2019. A summary of the findings is attached at Appendix C.

CCG Lay members

4. Fatima Khan-Shah, one of the two CCG Lay members representatives on the Joint Committee, has been appointed to lead the Partnership's Unpaid Carer's programme. As a result, she will be stepping down from her lay member roles with Greater Huddersfield and North Kirklees CCGs, leaving a vacancy on the Joint Committee.

5. The MoU for Collaborative Commissioning states that the Joint Committee lay representatives should be existing lay members of a CCG governing body ("provided that the two lay representatives shall not be lay members of the same CCG"). As Richard Wilkinson represents Bradford District, to ensure balance on the Committee, it is recommended that we seek to fill the PPI lay member from outside of Bradford and Airedale.

6. Following consultation with the CCG Accountable Officers, we will be seeking expressions of interest from the PPI lay members in Calderdale, Harrogate, Leeds and Wakefield.

7. Members are asked to note that that recent departures have created a number of vacancies in CCG PPI lay members. The PPI Assurance Group continues to meet to provide assurance about the Committee's commissioning decisions, but attendance at the Group will be affected until the current CCG vacancies are filled.

111/999 decision making

8. At the October 2018 Development Session, the Joint Committee discussed proposals to streamline 111/999 decision making at Yorkshire and Humber (Y&H) level. The proposal was for each STP to adopt the WY&H approach, where the Joint Committee agrees a collective position. Previously, in both South Yorkshire and Humber Coast and Vale, each CCG took an individual view.

9. Following discussion at the Y&H Joint Strategic Commissioning Board, South Yorkshire and Humber Coast and Vale have agreed to move to an STP-based approach. There will be no formal delegation and the proposed approach is informal and non-binding. For a decision to be carried at Y&H level, unanimity would be needed across the 3 STP/ICS areas. For WY&H, there will effectively be no change to the current arrangements.

10. One outstanding issue is the position of Hambleton, Richmondshire and Whitby CCG, which sits outside the 3 Y&H STP/ICSs. It has been proposed that, for 111/999 decision making only, HR&W becomes an associate member of the WY&H Joint Committee. This would not change the number of CCG votes needed to achieve 75%, which would remain at 9.

11. A report, setting out the proposed new arrangements and attaching a revised MOU for 111/999 commissioning, will be circulated to CCG governing bodies for approval.

Recommendations

The Joint Committee is recommended to:

a) **Comment** on and **approve** the draft Joint Committee Annual Report.
b) **Comment** on the Joint Committee self-assessment and **agree** proposals for developing the work of the Committee in 2019/20.
c) **Note** the vacancy for one of the Joint Committee CCG lay members and the proposal to seek expressions of interest for the role.
d) **Note** the proposed changes to 111/999 decision making at Yorkshire and Humber level, including the proposal that Hambleton, Richmondshire and Whitby CCG becomes an associate member of the WY&H Joint Committee for 111/999 decision making only.

Chair's foreword

33_19 Appendix A

I'm really proud to introduce the second Annual Report of the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups. Now in its second year, it's been a year of sustained achievement for the Committee. We have:

- agreed improvements in the vital care that people receive in the first 72 hours after having a stroke.
- led work to better identify and treat high blood pressure and reduce the risk of people having heart attacks and strokes
- agreed policies which help reduce health inequalities and avoid the 'postcode lottery'
- agreed new ways of providing integrated urgent care services.
- supported work to reduce smoking prevalence, increase early stage diagnosis and improve support for people living with and beyond cancer.

The Joint Committee plays a vital role in the West Yorkshire and Harrogate Health and Care Partnership and links directly into the Partnership's priorities. It brings together the Clinical Commissioning Group (CCG) leaders from our local places – Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield – to take collective decisions that help improve the health and wellbeing of our people and communities.

It is important that, as the Lay Chair, I am independent of the CCGs. I'm supported by two CCG Lay Members - Fatima Khan-Shah and Richard Wilkinson. We make sure that the Joint Committee puts people rather than organisations first, and that its decisions are transparent, fair and robust.

I've been greatly encouraged by the level of public attendance at meetings and the quality of the questions that the public have asked us. The questions – although often challenging - are always helpful in informing both our discussions and the decisions that we take.

I've also been encouraged by the willingness of my CCG colleagues to explore new ways of working together to achieve our shared aims. I am looking forward to working with the Committee over the next 12 months to further develop new and more collaborative approaches to commissioning.

Marie Burnham

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

10.04.19

You can watch our meetings 'live' on the internet and find out more about the Joint Committee here: https://www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs

You can read more about the difference our Partnership is making, including case studies, here: https://www.wyhpartnership.co.uk/

1. Key responsibilities

The Joint Committee is part of the West Yorkshire and Harrogate (WY&H) Health and Care Partnership ('the Partnership'). The Committee enables the WY&H Clinical Commissioning Groups to work together effectively – making sure that when it makes sense, work is done once and is then shared across WY&H.

The Committee has delegated authority from the CCGs to take collective decisions on agreed priorities. As well as taking formal decisions, the Committee also makes recommendations to the CCGs when a joint approach will help to achieve better outcomes.

The Members of each CCG agree the Committee's Terms of Reference and its work plan, which sets out the decisions for which it is responsible.

2. Membership and attendance

The Committee is made up of 2 representatives from each of the WY&H CCGs – usually the 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 Partnership team and NHS England also attend.

The Committee met 6 times in 2018/19. The attendance record is at Appendix 1.

3. Public and patient involvement

Reports to the Committee identify the patient and public involvement (PPI) that has already taken place or is planned to inform any commissioning proposals. In this way, the Committee ensures that the voice of patients is at the centre of its decisions. To support this process, the Committee has established a PPI Assurance Group.

Committee meetings are held in public and are also streamed 'live' on the internet. The Committee invites questions about its business and answers them at each meeting. Full written answers to all questions were published after each meeting.

4. Achievements

The Committee has led important work to improve health and wellbeing across WY&H:

Stroke

Specialist hyper acute stroke care is the vital care that people receive in the first 72 hours after a stroke. Following extensive consultation with patients, the public and health care professionals, the Committee agreed that the best way to ensure that hyper acute stroke services are sustainable and fit for the future is to have 4 units across WY&H:

- Bradford Teaching Hospitals NHS Foundation Trust – Bradford Royal Infirmary
- Calderdale and Huddersfield NHS Foundation Trust – Calderdale Royal Hospital,
- Leeds Teaching Hospitals NHS Trust – Leeds General Infirmary and;
- Mid Yorkshire Hospitals NHS Trust – Pinderfields Hospital.

The Committee also agreed a common specification for commissioning hyper acute stroke services. It agreed to set up a Clinical Network to bring stroke health care professionals together and endorsed a service specification covering all stages from prevention to recovery. The Committee also led joint work by the CCGs to improve the detection and treatment of Atrial Fibrillation (AF). AF is a fast and erratic heartbeat which is a major cause of stroke.

Healthy Hearts

On the recommendation of the Committee, the CCGs adopted the Healthy Hearts improvement project, building on successful work in Bradford. The project aims to identify more people with high blood pressure, help them to control it better and as a result reduce the risk of heart attacks and strokes. To support the project, the Committee approved simplified guidance for treating high blood pressure in adults aged below 80. The guidance is strongly supported by clinical staff and pharmacists and will be used across WY&H.

Reducing variation in planned care

The Committee agreed commissioning policies which address the 'postcode lottery' and help reduce health inequalities:

Evidence based interventions

The Committee agreed to adopt NHS England statutory guidance on Evidence Based Interventions. The guidance identified 4 interventions that should only be offered to patients in exceptional circumstances and 13 that should only be offered when certain clinical criteria are met. Key aims are to:

- prevent avoidable harm to patients and avoid unnecessary operations
- free up time and resources for evidence-based interventions
- ensure equitable access and tackle unwarranted variation

Spinal policies and pathways

The Committee approved spinal policies and pathways designed to ensure that only patients who will benefit from a consultation with a spinal surgeon will enter that pathway. Other patients will access more appropriate treatments locally. This will help to address waiting time pressures and reduce variation. Full implementation is envisaged over 12 months, with commissioners and providers working collaboratively towards this.

Liothyronine

The Committee agreed a commissioning policy for liothyronine, a drug used for the treatment of an underactive thyroid. In most cases the first line drug is levothyroxine, but a small number of people do not get adequate control of their symptoms from levothyroxine alone, and some people experience improvement from liothyronine. NHS England has published a commissioning policy as part of their Low Value Medicines programme and the Committee adopted a policy for WY&H which clarified some parts of the NHS England policy.

Surgery for severe and complex obesity (bariatric surgery)

The Committee endorsed expert medical advice confirming the benefits of bariatric surgery for people with severe and complex obesity. The CCGs agreed a recommendation from the Committee to commission more bariatric surgery over the next 2 to 5 years and address inequities in access. In support of this, the Committee agreed a new policy and service specification.

Urgent and emergency care

In March 2018, the Committee approved a new approach to commissioning Integrated Urgent Care services. This involved working with service providers to agree the best service model. Following on from this process, in December 2018 the Committee approved the award of the contract to Yorkshire Ambulance Service. The new service will help to ensure that people who call 111 needing urgent medical attention receive the most appropriate help.

Cancer

The Committee reviewed progress on 'whole system' collaboration to reduce smoking prevalence, increase early stage diagnosis and improve support for people living with and beyond cancer. The Committee supported continuing work to improve cancer waiting times. It also supported work to find more cancers when they are potentially curable and develop more personalised, integrated health and wellbeing support.

5. Working better together

The Committee pioneered new approaches to enable the CCGs to work more efficiently and effectively together:

Quality and equality impact assessment

The Committee approved a new approach to providing assurance that its decisions are supported by robust impact assessments, avoiding unnecessary duplication across the CCGs. We have already used this 'do once and share' approach to Quality and Equality Impact Assessment to assess new commissioning policies and will be exploring the potential for it to be used across the wider Health and Care Partnership.

Assuring public and patient involvement (PPI)

In November 2018, the Joint Committee formally established a PPI Assurance Group, made up of the PPI Lay members from each CCG. The Group built on the work of the informal Lay Members Group. The role of the PPI Group is to assure the Joint Committee that the public and patient voice informs decisions on the planning, design and evaluation of commissioned services.

Commissioning development

At a series of workshops, the Committee explored potential new ways of commissioning services across WY&H. The Committee will be building on this work during 2019/20 as it seeks to further develop collaborative working with commissioners and service providers.

6. Governance

During the year, CCG Members agreed a refreshed work plan for the Committee. In March 2019, CCG Accountable Officers signed off a 12-month extension of the Memorandum of Understanding which established the Committee.

The Committee maintains a register of members' interests and declarations of interest are a standing item on all agendas. At each meeting, the Committee reviews the significant risks to the delivery of its work programme and assesses how these risks are being mitigated.

In line with the principles of good governance, the Committee evaluated its performance in March 2019. Whilst much of the feedback was very positive, members identified areas for further improvement, including how the Committee focuses on:

- ensuring that accountability is clear for implementing agreed actions in our places and the wider health and care system
- reducing health inequalities and improving health and well being
- value for money, productivity and effectiveness
- promoting innovation

The Committee will use the learning from the evaluation to help develop its work in 2019/20.

Attendance record **Appendix 1**

Organisation and role	Member	Attendance (eligible)
Independent Lay Chair	Marie Burnham	**6** (6)
CCG Lay member	Fatima Khan-Shah	**4** (6)
	Richard Wilkinson	**6** (6)
NHS Airedale, Wharfedale and Craven CCG		
Clinical Chair	Dr James Thomas	**6** (6)
NHS Bradford City CCG		
Clinical Chair	Dr Akram Khan	**4** (6)
(Deputy: Clinical Board member)	*Dr Sohail Abbas*	**1** (1)
NHS Bradford Districts CCG		
Clinical Chair	Dr Andy Withers	**5** (6)
(Deputy: GP Board member)	*Dr Louise Clarke*	**1** (1)
NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs		
Chief Officer	Helen Hirst	**6** (6)
NHS Calderdale CCG		
Clinical Chair	Dr Steven Cleasby	**4** (6)
Chief Officer	Dr Matt Walsh	**5** (6)
(Deputy: Chief Finance Officer)	*Neil Smurthwaite*	**1** (1)
NHS Greater Huddersfield CCG		
Clinical Leader	Dr Steve Ollerton	**6** (6)
NHS North Kirklees CCG		
Clinical Chair	Dr David Kelly	**5** (6)
NHS Greater Huddersfield and North Kirklees CCGs		
Chief Officer	Carol McKenna	**5** (6)
(Deputy: Chief Finance Officer)	*Ian Currell*	**1** (1)
NHS Harrogate & Rural District CCG		
Clinical Chair	Dr Alistair Ingram	**5** (6)
(Deputy: Lead for Planned Care0	*Dr Bruce Willoughby*	**1** (1)
Chief Officer	Amanda Bloor	**6** (6)
NHS Leeds CCG		
Clinical Chair	Dr Gordon Sinclair	**5** (6)
Chief Executive	Philomena Corrigan	**5** (6)
(Deputy: Director of Quality and Safety)	*Jo Harding*	**1** (1)
NHS Wakefield CCG		
Clinical Chair	Dr Phillip Earnshaw	**5** (6)
(Deputy: Assistant Clinical Chair)	*Dr Adam Sheppard*	**1** (1)
Chief Officer	Jo Webster	**3** (6)
(Deputy: Chief Finance Officer)	*Jonathan Webb*	**3** (3)

33_19 Appendix B

NHS

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Annual report
2018/2019

West Yorkshire and Harrogate
Health and Care Partnership

» Chair's foreword

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We have:

- Agreed improvements in the vital care that people receive in the first 72 hours after having a stroke.
- Led work to better identify and treat high blood pressure and reduce the risk of people having heart attacks and strokes.
- Agreed policies which help reduce health inequalities and avoid the 'postcode lottery'.
- Agreed new ways of providing integrated urgent care services.
- Supported work to reduce smoking, increase early stage cancer diagnosis and improve support for people living with and beyond cancer.

The Joint Committee plays a vital role in the West Yorkshire and Harrogate Health and Care Partnership and links directly into the Partnership's priorities. It brings together the Clinical Commissioning Group (CCG) leaders from our local places – Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield – to take collective decisions that help improve the health and wellbeing of our people and communities.

It is important that, as the Lay Chair, I am independent of the CCGs. I'm supported by two CCG Lay Members - Fatima Khan-Shah and Richard Wilkinson. **We make sure that the Joint Committee puts people rather than organisations first, and that its decisions are transparent, fair and robust.**

I've been greatly encouraged by the level of public attendance at meetings and the quality of the questions that the public have asked us. The questions – although often challenging - are always helpful in informing both our discussions and the decisions that we take.

I've also been encouraged by the willingness of my CCG colleagues to explore new ways of working together to achieve our shared aims. I am looking forward to working with the Committee over the next 12 months to further develop new and more collaborative approaches to commissioning.

Marie Burnham

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

10 April 2019

Information about the Committee
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1. Key responsibilities

The Joint Committee is part of the West Yorkshire and Harrogate Health and Care Partnership. **The Committee enables the CCGs to work together effectively** – ensuring that when it makes sense, work is 'done once and shared' across West Yorkshire and Harrogate.

The Committee has delegated authority from the CCGs to take decisions on agreed priorities. **The Committee also makes recommendations to the CCGs when a joint approach will help to achieve better health outcomes for people.** The members of each CCG agree the Committee's Terms of Reference and its work plan.

2. Membership and attendance

The Committee is made up of two representatives from each CCG – usually the 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 CCG lay members. Representatives from the Health and Care Partnership team and NHS England also attend. The Committee met six times in 2018/19.

3. Public and patient involvement

Reports to the Committee identify the patient and public involvement (PPI) that has already taken place or is planned. In this way, the Committee ensures that the voice of people is at the centre of its decisions. Committee meetings are held in public and are also streamed 'live' on the internet. The Committee invites questions about its business and answers them at each meeting. Full written answers to all questions are published on our website at **www.wyhpartnership.co.uk** after each meeting.

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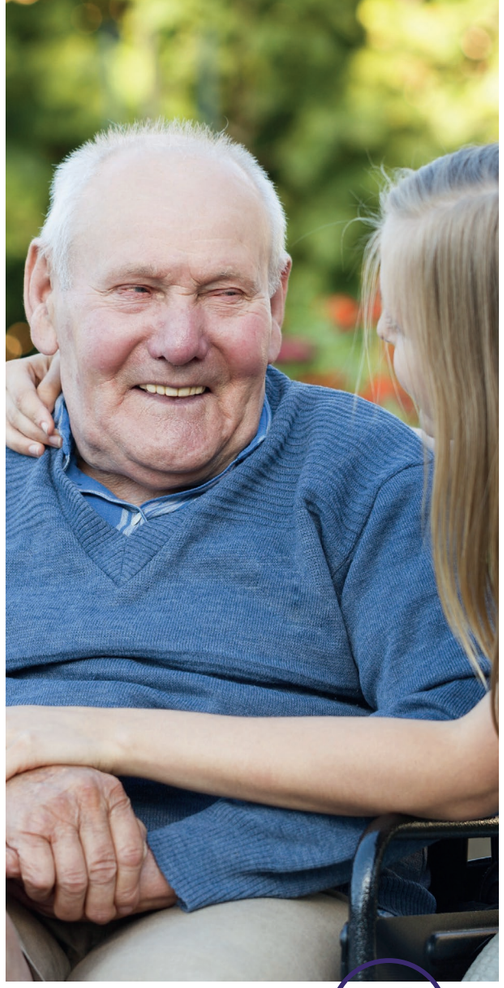
The Committee agreed a common approach for commissioning hyper acute stroke services and all stages from prevention to recovery.
It agreed to set up a Clinical Network to bring stroke health care professionals together. **It also led work to improve the detection and treatment of Atrial Fibrillation (AF),** a fast and erratic heartbeat which is a major cause of stroke.



Healthy Hearts

The CCGs adopted the Healthy Hearts improvement project, building on successful work in Bradford. **The project aims to identify more people with high blood pressure, help them to control it better and as a result reduce the risk of heart attacks and strokes.**
To support the project, the Committee approved simplified guidance for treating high blood pressure in adults aged below 80.

You can find out more on our website here **www.westyorkshireandharrogatehealthyhearts.co.uk**

Reducing variation in planned care

The Committee agreed policies which address the 'postcode lottery' and help reduce health inequalities:

Evidence based interventions

The Committee adopted NHS England guidance on Evidence Based Interventions. The guidance identified four interventions that should only be offered to patients in exceptional circumstances and thirteen that should only be offered when certain clinical criteria are met. The aim is to:

- Prevent avoidable harm to patients and avoid unnecessary operations
- Free up time and resources for evidence-based interventions
- Ensure equitable access and tackle unwarranted variation.

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Urgent and emergency care

The Committee approved the award of a new contract for Integrated Urgent Care services to Yorkshire Ambulance Service. The new service will help to ensure that people who call 111 needing urgent medical attention receive the most appropriate help. The new contract began on 1 April 2019.

Cancer

The Committee reviewed progress to reduce smoking, increase early stage diagnosis and improve support for people living with and beyond cancer. The Committee supported work to improve cancer waiting times, find more cancers when they are potentially curable and develop more personalised, integrated health and wellbeing support.

5. Working better together

The Committee pioneered new ways for the CCGs to work together:

Quality and equality impact assessment

The Committee agreed a new approach to assessing the impact of its decisions, avoiding unnecessary duplication across the CCGs. We used this **'do once and share' approach** to assess new policies and will be exploring how it can be used across the wider Health and Care Partnership

Assuring public and patient involvement (PPI)

The Committee established a PPI Assurance Group, made up of the PPI Lay members from each CCG. The Group reviews how PPI has been taken into account in the plans and policies that are presented to the Joint Committee.

This helps to ensure that decisions on the planning, design and evaluation of services have the right level of involvement from patients and the public.

Commissioning development

At a series of workshops, the Committee explored new ways of working, including further **improving joint working with commissioners and service providers.**

6. Governance

CCG members agreed a refreshed work plan for the Committee and In March 2019, CCG Accountable Officers signed a 12-month extension of the Memorandum of Understanding which established the Committee.

The Committee keeps a register of members' interests and declarations of interest are a standing item on all agendas. The Committee regularly reviews the risks to the delivery of its work programme and how they are being tackled.

The Committee evaluated its performance in March 2019. Whilst much of the feedback was very positive, members identified areas for further improvement, including how the Committee focuses on:

- Ensuring clear accountability for implementing agreed actions
- Reducing health inequalities and improving health and well being
- Value for money, productivity and effectiveness
- Promoting innovation.

The Committee will use the learning from this to help develop its work in 2019/20.

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.

Spring 2019

West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership

33_19 Appendix C

Joint Committee self-assessment– Summary report

Introduction

1. In line with the principles of good governance, the Committee evaluated its performance in March 2019. A questionnaire invited members to score different aspects of the Committee's performance on a scale of 1 (low) to 5 (high). 12 responses were received, a response rate of 66%.

Summary findings

1. The mean scores for each question are set out in Appendix C.1. Much of the feedback was very positive, particularly around Committee processes and levels of trust, collaboration and cooperation. Areas with mean scores of 4 or above include:

    - secretarial arrangements for the Committee (4.8)
    - frequency of meetings (4.6)
    - appropriateness of membership and attendance (4.4)
    - quality of reports (4.3)
    - effectiveness of Committee Chair (4.3)
    - involvement of patients and the public in the commissioning cycle (4.1)
    - effectiveness in meeting the terms of reference (4.1)
    - trust, openness, support and collaboration (4.0)
    - transparent decision-making (4.0)

2. Members identified areas for further improvement, particularly around how the Committee meets some of its key objectives. The areas which scored the lowest were:

    - promoting innovation (3.1)
    - reducing health inequalities and improving health and well being (3.1)
    - ensuring a clear and effective relationship between the Joint Committee and the wider Partnership (3.4)
    - value for money, productivity and effectiveness (3.4)
    - sharing information, experience, materials and skills (3.4)

3. As well as numerical scores, members were also invited to submit comments and suggestions for improvement. These help us to understand the reasons for the scores and to develop the Committee's improvement plan. The table at Appendix C.2 summarises the comments on those areas which scored the lowest. A consistent theme which runs through the lower scoring areas is a concern about how the Joint Committee assures itself that agreed actions are being implemented in each place and across the wider Partnership.

4. The table at Appendix C.2 also includes proposed actions to address the areas identified for improvement. Members are invited to comment on the findings of the self-assessment and to comment on and approve the proposed improvement actions.

Appendix C.1

Joint Committee self-assessment 2018/19 – summary

Issue	Mean score
Objectives and purpose	
1. How clear is the Joint Committee on its core purpose and key objectives?	3.9
2. How effective is the Joint Committee in meeting its terms of reference?	4.1
3. How would you assess the clarity and effectiveness of the relationship between the Joint Committee and the wider Health and Care Partnership?	3.4
4. How clear is accountability for delivering the Committee's work plan?	3.8
5. How effectively does the Committee focus on?	
a. Ensuring the involvement of patients and the public in all stages of the commissioning cycle	4.1
b. Reducing health inequalities and improving health and well being	3.1
c. Value for money, productivity and effectiveness	3.4
d. Sharing information, experience, materials and skills	3.4
e. Learning from best practice	3.5
f. Promoting innovation	3.1
g. Managing risks to delivery of the Committee's work plan	3.5
Culture and behaviour	
6. How would you assess the level of trust, openness and support between Joint Committee members?	4.0
7. How would you assess the level of collaboration between Joint Committee members and their willingness to co-operate?	4.0
8. How would you assess the quality of participation from both members and attendees?	3.9
Conduct of meetings	
9. How would you assess the appropriateness of the membership and attendance of the Joint Committee?	4.4
10. How effective is the Chair of the Joint Committee? (e.g. keeping to time, summarising, checking for consensus, ensuring decisions are clear)	4.3
11. To what extent is there a clear and transparent decision making process at the Joint Committee, including appropriate discussion and debate?	4.0
Administration and support	
12. How effective are the secretarial arrangements for the Joint Committee including agenda setting, minutes and following up actions?	4.8
13. How would you rate the quality of reports presented to the Joint Committee?	4.3
14. How would you assess the frequency of meetings in enabling the Joint Committee to effectively carry out all of its duties?	4.6

Key:	4 or above	3.5 – 3.9	Less than 3.5

Joint Committee self-assessment 2018/19 – Areas for improvement Appendix C.2

Area for improvement *Comment by Joint Committee member*	**Proposed action**
1. Reducing health inequalities and improving health and well being • *"Good awareness of the issues but tackling them is another matter."* • *"We have not really looked at the wider determinants in any detail but have addressed some issues eg in the cancer work programme"* • *"Like all committees you hope you are but always difficult to judge"* • *"Clearly articulated and the challenges of this too"* • *"With the development of the five year strategic plan to include more of a focus on health inequalities, there is an opportunity to feed this in to the future work plan".* • *"Could have far more meaningful input"* • *"Not sure we do this"* • *"It is the aim of the committee but are we truly making decisions that are reducing health inequalities? Liothyronine policy- hard but it is the aim. Absolutely trying to improve health and wellbeing."*	1. Use the development of the Partnership five year strategic plan as a framework to strengthen the Joint Committee's focus on health inequalities. 2. Review the effectiveness of the Quality and Equality Impact Assessment process as part of the six month evaluation. 3. Use the Quality and Equality Impact Assessment tool to build into the Joint Committee work plan a periodic review of the impact of decisions on health inequalities.
2. Promoting innovation • *This is becoming stronger and I would cite cancer as a good example.* • *Not really had a strategic approach to this, but I think this is more likely to come from the ICS* • *Sometimes I think the papers suggest we are but are we really?* • *We could potentially use development sessions to focus on 'the things that places are proud of' to assess transferability.* • *Not 100% sure that a formal committee is going to be the correct environment to promote innovation.* • *The programmes do this. Not sure the committee invites anything specifically in this area – tends to rely on programmes doing this.* • *Many examples esp with AHSN*	4. Use Joint Committee development sessions to focus on innovation, best practice and 'the things that places are proud of'. Assess their transferability.

3. Clarity and effectiveness of the relationship between the Joint Committee and the wider Health and Care Partnership • *There are issues around the financial arrangements eg decisions on extra resourcing and how CCGs may choose to use their own funding. There is the ongoing move towards collaborative decision making across commissioners and providers which can feel less clear but ultimately probably more effective.* • *Lack of clarity of how decisions made at JC translate into delivery either at place or through the wider system* • *The relationship between the workplan of JCC and WYAAT is not as aligned as it could be* • *As we progress on our commissioning development journey it will be important to understand and review, how the Joint Committee function fits in the context of commissioning and the wider collaboration landscape* • *This needs work – need to be clear what is the role of the committee vis a vis the role of the wider partnership* • *Needs closer links to WYATT especially. Programmes are doing this but needs greater visibility at committee of WYATT workings. Also places need to be able to communicate what they are doing as that is where the enacting is happening and I am sure lots to share and tell but very little opportunity to understand what others are doing to enact things at place that we are deciding jointly* • *Joint Committee terms of reference are too wooly*	5. Require all proposals brought to the Joint Committee to include an implementation plan. 6. Build into the Joint Committee work plan a periodic review of the implementation in place of Committee decisions and recommendations. 7. Set out in the Partnership governance structure explicit linkages to other forums e.g. Clinical Forum, West Yorkshire Association of Acute Trusts. Include key dependencies in the Joint Committee work plan. 8. Review the future role and terms of reference of the Joint Committee in the light of the findings of ongoing work to develop the commissioning strategy.
4. Value for money, productivity and effectiveness • *I'm not sure we have effectively focused on this.* • *The biggest challenge for us, the approach feels correct but difficult to demonstrate benefit as yet.* • *Some key decisions made and demonstrate efficiency ie Ambulance contract management. Not sure it has produced much yet that is apparent at the coal face.* • *Could always be more productive- can be a slow process but that's working at a system level*	9. Build into the Joint Committee work plan periodic review of the value for money, productivity and effectiveness impacts of Committee decisions and recommendations.
5. Sharing information, experience, materials and skills	

• *Do once and share is a bit of a mantra but I feel individual CCGs are still a little wary of this.* • *Steadily improving.* • *We do this well but then our Comms are good* • *Improving in this area* • *Not 100% sure that this is the role of the committee* • *Generally very good. Just feel that we never hear how places are enacting programmes – so much to learn from and there is an opportunity to do it at Jt committee*.	10. See proposed action 4 above.
6. General comments • *Public questions should be more tightly managed, with questions answered verbally in the meeting. Written responses should be an exception.* • *Brighouse is not the most accessible venue. Holding all meetings there restricts our ability to interact with patients and the public from elsewhere in West Yorkshire and Harrogate. We should consider alternating the venue.* • *We should review the focus of development sessions and make them less like committee meetings. Perhaps they should focus more on sharing learning and debating "deal breakers".*	11. Review approach to patient and public involvement in meetings, including managing questions and location of meetings. 12. Continue to focus development sessions on commissioning development. See also proposed action 4.