West Yorkshire and Harrogate Sustainability and Transformation Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

DRAFT Minutes of the meeting held in public on Tuesday 4 July 2017

Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF

Members	**Initials**	**Role and organisation**
Marie Burnham	**MB**	Independent Lay Chair
Richard Wilkinson	**RW**	Lay member
Fatima Khan-Shah	**FKS**	Lay member
Dr James Thomas	**JT**	Clinical Chair, NHS Airedale, Wharfedale and Craven CCG
Dr Andy Withers	**AW**	Clinical Chair, NHS Bradford Districts CCG
Helen Hirst	**HH**	Chief Officer, NHS Bradford City & Districts
Dr Alan Brook	**ABr**	Clinical Chair, NHS Calderdale CCG
Matt Walsh	**MW**	Chief Officer, NHS Calderdale CCG
Dr Steve Ollerton	**SO**	Clinical Leader, NHS Greater Huddersfield CCG
Carol McKenna	**CMc**	Chief Officer, NHS Greater Huddersfield CCG
Dr Alistair Ingram	**AI**	Clinical Chair, NHS Harrogate & Rural District CCG
Amanda Bloor	**ABl**	Chief Officer, NHS Harrogate & Rural District CCG
Dr Alistair Walling	**AWa**	GP Clinical Lead, NHS Leeds South & East CCG
Dr Gordon Sinclair	**GS**	Clinical Chair, NHS Leeds West CCG
Visseh Pejhan-Sykes	**VPS**	Chief Finance Officer, NHS Leeds CCGs Partnership (deputy for Philomena Corrigan)
Dr David Kelly	**DK**	Clinical Chair, NHS North Kirklees CCG
Richard Parry	**RP**	Chief Officer, NHS North Kirklees CCG
Dr Phillip Earnshaw	**PE**	Clinical Chair, NHS Wakefield CCG
Jo Webster	**JW**	Chief Officer, NHS Wakefield CCG
Apologies		
Dr Akram Khan	**AK**	Clinical Chair, NHS Bradford City CCG
Dr Jason Broch	**JB**	Clinical Chair, NHS Leeds North CCG
Philomena Corrigan	**PC**	Chief Executive, NHS Leeds CCGs Partnership
Moira Dumma	**MD**	Director of Commissioning Operations (Y&H), NHS England
In attendance	**Initials**	**Role**
Lou Augur	**LA**	Director of Delivery – West Yorkshire, North Region NHS England
Ian Holmes	**IH**	Programme Director, WY&H STP
Jonathan Webb	**JWe**	Director of Finance, WY&H STP
Stephen Gregg	**SG**	Joint Committee Governance Lead (minutes)
Karen Coleman	**KC**	WY&H STP Communication & Engagement Lead

For items 03/17 and 04/17		
Rory Deighton	**RD**	Director, Healthwatch Kirklees
Dr Graham Venables	**GV**	Clinical Director, Y&H Clinical Networks
Jacqui Crossley	**JC**	Head of Clinical Effectiveness and Governance, Yorkshire Ambulance Services
Jonathan Booker	**JBo**	STP Senior analyst
Linda Driver	**LD**	STP Stroke Project Lead

25 members of the public attended the meeting.

Item No.	Agenda Item	Action
01/17	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the first meeting in public of the Joint Committee. Apologies were noted. MB said that the Committee brought together the 11 CCGs across WY&H. She emphasised that although the Committee supported the STP, the Committee only included CCGs and did not represent all of the partners involved in the STP. MB highlighted that the role of the Committee was to make collective decisions on shared priorities across WY&H, and that it was not the business of the Committee to deal with issues in individual places. **Open Forum** Before the start of the formal meeting, there was an opportunity for members of the public to make representations or ask questions about the work of the Joint Committee. A Deputation was received from the campaign group Hands off Huddersfield Royal Infirmary (HRI): • *How do the STP and local plans fit together? Would specialist stroke services be based at HRI? Was consideration being given to the availability of community based services to support stroke patients once they had been discharged?* Members of the public asked questions about: • *Had decisions already been taken to close hyper acute stroke units? The availability of detailed STP financial information and how decisions would be made about finance gaps within the STP? The validity of the evidence collected as part of the stroke engagement exercise and case for change? Who would ultimately make decisions about the configuration of stroke services?* • *From the memorandum of understanding for the Joint Committee: what is a Lead commissioner/Contractor? What decisions are delegated to the Joint Committee? What happens when a CCG disagrees with a decision of the Joint Committee?* • *The impact of budget reductions across WY&H on plans to close the A&E department at HRI?* MB said that, where appropriate, answers to these questions would be provided as part of the relevant agenda items. If this was not possible, a full written response would be provided. These questions, and the answers to them, would be posted on the Joint Committee webpages following the meeting.	**SG/KC**

Item No.	Agenda Item	Action
	JW emphasised that this was a meeting in public, not a public meeting. Local issues should be taken up at place level. WY&H stroke questions would be addressed under the specific agenda items, and there would be a further opportunity for questions later in the meeting.	
02/17	**Declarations of Interest**	
	The register of interests of members of the Joint Committee was tabled at the meeting. The Chair reminded Committee members of their obligation to declare any interests they may have on any issues arising at meetings which might conflict with the business of the Committee. No further declarations were made.	
03/17	**Learning from patients and the public – Stroke**	
	MB emphasised the importance of public engagement in informing and shaping the design of care pathways, and introduced AW, who chaired the stroke Task and Finish Group. AW presented the background to the work and introduced the stroke specialists, including clinical advisors, who were in attendance today. In 2013, the 10 WY CCGs had identified stroke as a priority for West Yorkshire. 3 elements had been highlighted – prevention, discharge and hyper acute stroke units (HASU). At that time, Airedale HASU had been forced to close as it had not been sustainable, and services had transferred to Bradford. This had emphasised the importance of sustainability across WY&H, which became a priority for the STP. There were 3600 admissions a year across WY&H, which was expected to increase by 10%. There were 2 big issues involved with ensuring access to specialist care – workforce and capacity. The case for change recognised the need to further improve and ensure the sustainability of services. Referencing 2 of the questions posed earlier, AW emphasised that no specific recommendation or decisions had yet been taken on the number of HASUs. Although the focus of today was on HASUs, he emphasised the need to address the whole stroke pathway and ensure that the right support services were available close to people's homes. AW highlighted the need to engage with people to identify their needs. This would then be used to review the existing pathway and develop new clinical models over the coming months. The Committee watched a short video featuring Malcolm and Sue. Malcolm had suffered a stroke, and the video presented the challenges that he and his family had faced. RD then presented the results of a public engagement exercise led by Healthwatch in February and March 2017. Healthwatch had used a variety of methods to engage the public. Feedback from social media indicated that 98,000 people were aware of the engagement exercise. 940 surveys had been returned. 75% of respondents had direct lived experience of stroke, either as a patient or carer. The work had also included consultant-led focus groups and interviews. RD noted the main messages, which included immediate access to tests and treatment, effective discharge and follow up services, the role of voluntary organisations, and the need to join up services and provide ongoing support and review. The importance of prevention work had also been highlighted.	

Item No.	Agenda Item	Action
	RD said that the approach to stroke services met the Healthwatch principles of engagement. There had been transparent engagement from the start, with people with lived experience of stroke. FKS congratulated Healthwatch on the report and methodology. The quality of engagement had been good. There was a recognised need to engage more effectively with some minority groups, including Eastern European and BME groups. JW felt that it was an excellent piece of engagement work. She questioned whether more focus was needed on recognizing the signs of stroke. SO highlighted some powerful messages, including the variation in care between weekdays and weekends and that some respondents had been diagnosed but not admitted. DK questioned the variation in survey response rates. RD said that there were fewer in Bradford, as similar work had already been done in that area. In response to a question from MB, RD said that there had been feedback to everyone who had participated in the engagement. Responding to a question from FKS, KC said that engagement colleagues were exploring a variety of options for involving patients in the Task and Finish Group. MB invited questions from members of the public: • *How could quality stroke support be provided in the community in the light of financial challenges?* • *How could Healthwatch be seen as independent?* AW responded that the aim of the redesign was to improve quality and outcomes. There may be cost impacts, but the focus was firmly on quality. RD said that Healthwatch was an independent charity, funded by local authorities. They had set out to listen to local people, and had no preconceived 'agenda'.	**KC**
	The Joint Committee: Noted the Stroke Services Engagement Report key findings and next steps.	
04/17	**Improving stroke outcomes**	
	JW presented the report, highlighting three main objectives: improving stroke outcomes, using resources efficiently and effectively and ensuring that stroke services were sustainable and fit for future. The focus of today was on specialist services, but there was a need to cover the whole pathway in future work. The case for change recognised that high quality care in the first few hours was critical. There were significant workforce challenges in ensuring high quality services, 24 hours a day, 7 days a week. Clinical outcomes varied across WY&H and there was a need to learn from best practice and experience elsewhere, which indicated that outcomes were better when treatment was provided in specialist centres. Key factors to be taken into account included NICE guidelines and opportunities provided by new technology. The case for change highlighted clearly the need to review existing services. There had been extensive engagement with key stakeholders, including the Clinical Senate, patients and the public, providers and Overview and Scrutiny Committees.	

Item No.	Agenda Item	Action
	The first stage of the NHSE assurance process had been completed. The next steps were to develop an outline business case and report back to the Joint Committee in November.	**JW**
	FKS welcomed the case for change. She identified some areas for further focus, including supporting carers/families to travel to specialist centres and prevention support for BME and Eastern European groups. JW acknowledged the need to do more to engage with some populations. DK identified the need for greater consistency of post-stroke support across all places in WY&H. He felt that the Committee had an important role to play in addressing resourcing and workforce issues. JW said that this was a good example of how the STP and Joint Committee could support work across a WY&H footprint. AW added that the Task and Finish Group would be addressing the whole care pathway. HH asked whether the identified risks around workforce and the sustainability of services could be managed within the proposed timeframe. JW responded that the current services were providing safe care, but that there was a need to strengthen resilience. At present, it was planned that options for change would be presented to the Joint Committee in November. ABr noted that only a proportion of patients would benefit from HASU services, and emphasised the importance of effective ambulance care. JC added that the aim was a 'gold standard' pathway, with patients receiving the best possible care. MB welcomed the report and the engagement that supported it. FKS added that the Lay Member Reference Group of the WY&H CCGs had been updated on the process so far. MB invited questions from the public: • *The finding that outcomes for stroke patients are better from specialist services was questioned, particularly in relation to thrombolysis.* • *How will you ensure clinically led, evidence based care when dealing with financial challenges? Where is the money coming from?* • *How will you ensure high quality care at home?* • *Where will decisions be taken about the reconfiguration of services* • *A comment was made that the Healthwatch findings supported the 'basics' of good care, follow up and local services.* GV responded that thrombolysis had limited value, but that some stroke patients did benefit from it. All aspects of stroke care were much better organised in specialist centres and benefitted everyone who came through the service. Critical issues like swallowing, positioning and hydration were dealt with by specialist staff. AW responded that the stroke work was strongly clinically driven and included acute hospital stroke leads. He added that investment in prevention services could reduce the number of strokes.	

Item No.	Agenda Item	Action
	JW invited members of the public to submit any further questions outside of meeting. MB welcomed the interim report and looked forward to firmer proposals on the way forward coming back to the Committee in November.	
	The Joint Committee: • **Noted** progress to date**;** • **Noted** the Engagement Report and Strategic Case for Change**; and** • **Noted** the next steps and timelines**.**	
05/17	**The Operation of the Joint Committee**	
	SG presented the report, which set out the role, membership and purpose of the Joint Committee and how it would operate. The report set out the basis on which the 11 CCGs in WY&H had delegated WY&H-level decisions to the Joint Committee. Appendix A included the Memorandum of Understanding for Collaborative Commissioning and the membership and terms of reference of the Joint Committee. It also covered the quorum for the Committee and the voting arrangements. Appendix B presented the Committee's workplan. This set out the specific decision areas which had been delegated to the Joint Committee by the CCGs, including stroke, urgent care and cancer services. To ensure appropriate challenge and transparency, the Joint Committee was Chaired by an Independent Lay Chair and also included 2 Lay members from the CCGs. Meetings were held in public and agenda papers, minutes and decision summaries would be posted on the Committee's webpages. The Committee had set out some principles for involving the public, and would review these as the Committee developed. The Committee workplan was firmly focused on what needed to be done at WY&H level to deliver the outcomes set out in the STP. The Committee's workplan had been prepared in late 2016 and was very high level. There was now a need to be more specific about the scheduling of decisions that would be coming to the Joint Committee. HH highlighted the need to log and respond to all relevant questions and to post answers on the website. MB noted the need to distinguish clearly between issues at WY&H level for which the Committee was responsible, and work at place level, which should be addressed locally. JW noted the need to engage effectively at local place level and emphasised the '3 tests' which defined work at WY&H level. These were where WY&H – level work was needed to improve outcomes, share best practice of deal with common problems. DK emphasised the need to establish greater clarity about the Committee workplan. MB advised that the Committee needed to appoint a Deputy Chair. She proposed that Gordon Sinclair be appointed for a six months interim period. In response to a question from DK, MB explained that GS had extensive experience of chairing the Collaborative of CCGs over the past 3 years. He would act as Deputy for six months, whilst the 2 CCG Lay members gained experience of the operation of the Committee.	

Item No.	Agenda Item	Action
	GS noted that if he was required to deputise, any conflicts would be identified and managed appropriately. He reiterated that the Committee had delegated responsibility for commissioning decisions. MB invited questions from the public: • *When would the earlier questions about the MOU be answered? Why were local authorities not represented on the Joint Committee in their role as commissioner?* JW responded that the CCGs worked closely with local authorities at both place and WY&H level. Answers to all questions would be provided following the meeting.	
	The Joint Committee: • **noted** the Memorandum of Understanding for Collaborative Commissioning including the Committee's Terms of Reference, membership and Workplan • **noted** the appointment of the Independent Lay Chair and 2 Lay representatives, and **appointed** Gordon Sinclair as interim Deputy Chair for six months. • **noted** how the public will be involved and the shared outcomes and targets towards which the Committee is working. • **noted** the approach to refreshing the Committee's workplan and **requested** that an updated workplan be brought back to the Committee for approval in November 2017.	**SG**
06/17	**Any other business**	
	There was none.	

Next Joint Committee in public - Tuesday 5th September 2017, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF.