West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

DRAFT Minutes of the meeting held in public on Tuesday 6th March 2018

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

Members	Initials	Role and organisation
Marie Burnham	MB	Independent Lay Chair
Fatima Khan-Shah	FKS	Lay member
Richard Wilkinson	RW	Lay member
Dr James Thomas	JT	Chair, NHS Airedale, Wharfedale and Craven CCG
Dr Akram Khan	AK	Chair, NHS Bradford City CCG
Dr Andy Withers	AW	Chair, NHS Bradford Districts CCG
Helen Hirst	HH	Chief Officer, NHS Bradford City, Bradford Districts and AWC CCGs
Dr Alan Brook	ABr	Chair, NHS Calderdale CCG
Dr Matt Walsh	MW	Chief Officer, NHS Calderdale CCG
Dr Steve Ollerton	SO	Chair, NHS Greater Huddersfield CCG
Carol McKenna	CMc	Chief Officer, NHS Greater Huddersfield CCG and North Kirklees CCG
Dr Alistair Ingram	AI	Chair, NHS Harrogate & Rural District CCG
Amanda Bloor	ABl	Chief Officer, NHS Harrogate & Rural District CCG
Philomena Corrigan	PC	Chief Executive, NHS Leeds CCGs Partnership
Dr David Kelly	DK	Chair, NHS North Kirklees CCG
Dr Phillip Earnshaw	PE	Chair, NHS Wakefield CCG
Apologies		
Dr Jason Broch	JB	Chair, NHS Leeds North CCG
Dr Alistair Walling	AWa	GP Clinical Lead, NHS Leeds South & East CCG
Dr Gordon Sinclair	GS	Chair, NHS Leeds West CCG
Jo Webster	JW	Chief Officer, NHS Wakefield CCG
Emma Fraser	EF	Programme Director, Mental Health
Ian Holmes	IH	Programme Director, WY&H STP
In attendance		
Lou Auger	LA	Director of Delivery, West Yorkshire, North Region NHS England
Karen Coleman	KC	Communication Lead, WY&H STP
Stephen Gregg	SG	Governance Lead, Joint Committee of CCGs (minutes)
Anthony Kealy	AKe	Policy Lead, WY&H STP
Martin Pursey	MP	Head of Contracting, Greater Huddersfield CCG
Jonathan Webb	JWe	Director of Finance, WY&H STP

14 members of the public were also in attendance.

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Item No.	Agenda Item	Action
39/18	**Welcome, introductions and apologies**	
	MB welcomed all to the meeting and reminded everyone of the role of the Joint Committee. Apologies were noted. MB highlighted the sustainability benefits of paperless meetings and that many Committee members would be using electronic devices to access agenda papers.	
40/18	**Open Forum**	
	MB invited members of the public to ask questions about items on the agenda. 4 members of the public asked questions. MW responded on elective care and standardisation and CMc on urgent care: **Elective care and standardisation** Q. *How would the supporting healthier choices programme be commissioned, funded and provided?* A. The aim was to build capacity in existing organisations and collaborate at local level across WY&H. The emphasis was on prevention, choice and directing people towards the most appropriate care to produce better outcomes. It was too early in the process to consider possible approaches to tendering and contracting. Q. *How was the Academic Health Science Network involved and would advertising and digital technology play a part in encouraging behaviour change?* A. We are working closely with the AHSN, which has significant expertise in behaviour change. Advertising and digital technology would both be used to encourage healthier lifestyles. Q. *How was the programme addressing the risk that access to eye and orthopaedic procedures would be restricted?* A. Clinicians would continue to make decisions about access, on the basis of the needs of individual patients. The programme would not change this. **Urgent and emergency care** Q. *Concern that the re-procurement of integrated urgent care services would lead to the break-up of the NHS.* A. Partners in Yorkshire and the Humber were responding to a national specification. Whatever service model was selected, the aim was to secure greater integration of NHS services, not fragment them. Q. *Was evidence from previous Vanguard projects being used to shape the design of services?* A. Yes, the aim was to learn from all of the available evidence and spread best practice. MB said that the questions would also be taken into account in the relevant agenda items. The full questions and written responses would be provided after the meeting and would be published on the Joint Committee webpage.	**SG**
41/18	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. There were no additional declarations.	

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42/18	**Minutes of the meeting in public – 9th January 2018**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 9th January 2018.	
43/18	**Actions and matters arising**	
	The Joint Committee reviewed the updated action log. There were no matters arising.	
	The Joint Committee: Noted the action log.	
44/18	**Mental Health**	
	HH presented the report. She highlighted how MH providers were working together to share beds and improve access to local services. CCGs were reviewing commissioning plans, working to reduce variation and establish common levels of community services across WY&H. Each CCG was now leading on a specific area of work. HH also highlighted: • Work to improve collaboration on providing locked rehabilitation units. Proposals for alternative models would be brought back to the Joint Committee. • The development of a new Child and Adolescent Health services (CAMHs) pathway aimed at improving community provision and reducing the use of tier 4 beds. • Collaborative work which was leading to a richer commissioning picture of learning disabilities, adoption services and dementia. HH noted the need to assess the overall value for money of services. Reducing out of area placements and increasing the availability of local services improved VFM, but there was a need to reinvest savings into community based services. In response to a question from PC, HH recognised the need to understand the case mix for CAMHs, particularly in relation to eating disorders. Responding to questions from FKS, HH advised that local authorities and the police were involved in a number of workstreams. HH would ask the MH team to advise on how the programme was ensuring a focus on the needs of young people and BME communities. HH noted that work to reduce out of area placements was driven by direct patient experience. A lot of local public engagement was taking place at local level, but that there was further work to do at WY&H level. MB noted the good progress being made by the MH workstream and welcomed the focus on learning disabilities.	**HH**
	The Joint Committee: 1. **Noted** the report and **endorsed** continued collaborative commissioning work to support the delivery of the mental health programme.	
45/18	**Urgent and emergency care**	
	CMc presented the report. In WY&H, the Joint Committee had delegated authority from the CCGs to agree future arrangements for 111 and Urgent Care services. CMc had previously advised the Committee that NHS England required all CCGs to have an Integrated Urgent Care (IUC) programme by 1 April 2019.	

	The report today sought approval to undertake a formal procurement process. The current NHS 111 contract with the Yorkshire Ambulance Service (YAS) ended in March 2018. A one year interim contract was being negotiated with YAS for 2018 -19, and it was recommended that there also be allowance for a 6 month extension to ensure service continuity and minimise risk. The work was being overseen by the Y&H Joint Strategic Commissioning Board (JSCB), which had sought expressions of interest from prospective providers. The JSCB recommended a structured dialogue approach. MP advised that this approach enabled discussion with potential providers to define and refine the service model. This was particularly important given the complexity of delivering services in 3 STP areas across Y&H. RW welcomed the structured dialogue approach, but also noted the potential risk of destabilising YAS. CMc acknowledged the risk and that steps were being taken to mitigate it. MP noted that work was ongoing to ensure the continuity of current services at the same time as managing the commissioning process. Responding to questions from SO, MP noted that the aim was to ensure a collaborative approach to the provision of GP Out of Hours services. In relation to a Clinical Advice Service, MP noted the difficulties in integrating a range of providers, but the aim was to ensure a fully integrated service. The time needed to complete the procurement process would only become clearer when the number of interested providers was clearer. LA noted the deadline of April 2019 for putting the service in place. She felt that there was a need to increase pace, which might need additional resource. AW asked whether other STP areas had agreed the proposal. CMc advised that CCGs in other STPs would need to take the proposal through their individual governing bodies. Work was ongoing with the urgent care leads in the other STP areas to minimise the risks. In response to a question from DK, MP said that the WY&H urgent and emergency care workstream was exploring options for GP out of hours services and would link into the commissioning process ABr asked whether proposals shared by providers in a structured dialogue were subject to 'commercial in confidence' restrictions. MP said that this would depend on the nature of the proposal, but that the overall approach would encourage sharing, so as to arrive at the optimum service model. Responding to a comment from SO, LA acknowledged the need for NHSE to clarify the commissioning approach to dental services. HH asked queried the total financial resource that was available and the financial model that was being applied. MP confirmed that the presumption was that there would be no additional monies. There might be flexibility between the components, but this would be within the overall affordability envelope. The Finance workstream was developing the detail.	**LA**
	The Joint Committee: 1. **Ratified** the recommendation of the Commissioner- only JSCB that the appropriate route to market is through a competitive procurement process and instruct the JSCB to implement this decision. 2. **Ratified** the recommendation of the use of a dialogue based process to deliver the service model. 3. **Ratified** the recommendation to negotiate an interim contract with the current 111 provider for 18/19 that has the ability to be extended for six months as a means of mitigating any risks relating to continuity of service, should unavoidable slippage occur.	

	4. **Noted** the risks associated with the procurement process and supported the core team to mitigate these.	
46/18	**Elective care and standardisation of commissioning policies**	
	Matt Walsh presented the report, noting the need to maintain focus and resist pressures to expand the scope of the programme. A Programme Director had been appointed and the Programme Board enjoyed good involvement from CCG commissioning managers. 2 Lay members were being sought. He presented proposed high level eye care and musculoskeletal / elective orthopaedic pathways and proposals for Procedures of Limited Clinical Value (PLCV) and prescribing. The aims of the programme included changing the relationship between people and services and developing local capability to reduce unnecessary dependency on hospital care and improve outcomes.. There were governance risks attached to the 'Do once and share' approach to new policies. Robust equality and quality impact assessments would be important and Joint Committee would need to develop an agreed approach. AW noted a potential role for the Clinical Forum. MW would bring back proposals for initial discussion in a Joint Committee development session. MW noted the need to explore the detail of the financial efficiency opportunities of £50m that had been identified. He said that the primary driver of the approach would be to improve quality. SO noted the need to develop capacity for high volume eyecare procedures in the community, and to ensure that specialised care was available in acute hospital settings. He highlighted an error in the orthopaedic pathway diagram. FKS supported the ambition to improve quality and reduce variation and asked if exemptions would be applied to mitigate any adverse effects on individuals. MW said that the programme had a strong focus on the effects of poverty and addressing health inequalities. Clinicians would continue to focus on the individual needs of patients. ABr supported the objectives of the programme, highlighting the need to address the workforce issues that were leading to capacity problems in some hard pressed specialties. MW acknowledged that the need to work closely with the STP workforce programme.	**MW**
	The Joint Committee agreed: 1. The high level pathway for eye care. 2. The consideration of emergency eye care services where these interface indivisibly with planned care services for eye health. 3. The high level pathway for elective orthopaedic services. 4. The recommendation to exclude non-clinical services from the PLCV work programme. 5. The clinical inclusion, exclusion and prioritisation proposals for the PLCV programme. 6. The 'Do Once and Share' approach to delivery of the PLCV programme. 7. The proposals for the ongoing development of the prescribing programme.	
47/18	**Any other business**	
	There was none.	

Next Joint Committee in public – Tuesday 5th June 2018, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF.

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