West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 6 November 2018	Agenda item: 75/18		
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

Patient and Public Involvement (PPI) Assurance

1. Meaningful patient and public involvement (PPI) is a core element of the WY&H Health and Care Partnership. It helps ensure that our proposals are person-centred as well as ensuring we meet our legal obligations. Underpinning this is the statutory duty of CCGs:

   "to make arrangements to secure public involvement in the planning of commissioning arrangements and in developing, considering and making decisions on any proposal for changes in commissioning arrangements that would have an impact on service delivery or the range of health services available".

2. At its meeting on 4 September 2018, the Joint Committee agreed to establish the Lay Member Assurance Group as a PPI Assurance Group, with clear responsibilities and reporting mechanisms. The Committee considered the draft terms of reference for the Group and requested that they be amended to further strengthen the focus on providing assurance to the Joint Committee. The draft terms of reference for the Group, with the amendments highlighted in track changes, are attached for approval at **Appendix A**.

Joint Committee risk management

3. The Joint Committee has 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 has agreed that all relevant risks scored at 12 or above *after mitigation* be reported to the Committee.

4. The updated framework, identifying the significant risks as at 30th October 2018, is attached at **Appendix B.** There are currently 5 risks scored at 12 or above after mitigation:

   Stroke
   4.1 Workforce

   Elective care/standardisation of commissioning policies
   6.1 Potential resistance to proposed changes
   6.2 Pace of implementation
   6.3 Financial return
   6.4 Clinical leadership

5. Controls, assurances and planned mitigating actions are set out for all risks. The Committee is invited to review the risks and comment on the actions being taken to mitigate them.

Health and Care Partnership: Management of System Risk

6. The Committee has raised the issue management of system risk and the responsibilities of the Committee within the context of the wider partnership arrangements.

7. Responsibility for managing most risks relating to the delivery of the WY&H Health and Care Partnership programmes does not rest with the Committee, but with the programmes that make up the WY&H Partnership. The risks reported to the Joint Committee relate to the delivery of its work plan, and draw on the risk registers at Programme level. This ensures a proportionate approach, relating directly to the Committee's decision-making responsibilities. However, delivery of the Joint Committee work plan is affected by system-wide interdependencies and risks. At its last meeting, the Committee sought clarity on the arrangements for managing these system-wide risks.

8. The principal forum for reporting and managing system-wide risks is the Partnership System Oversight and Assurance Group (SOAG), which met for the first time on 16th October 2018. The SOAG will receive a quarterly high level update on all Partnership programmes. This will include the significant risks to delivery that cannot be mitigated at programme level; and any other critical issues and interdependencies that the partnership leadership will need to collectively address. The SOAG includes representation from each 'sector' and 'place' that make up the partnership. CCGs are represented by Jo Webster and Amanda Bloor.

9. The SOAG will consider risks, issues and inter-dependencies across all programmes, and where appropriate will identify collective action for their resolution. There will be an important two way communication flow between the Joint Committee of CCGs and the SOAG. The Joint Committee will use the SOAG to escalate issues that require a system level response and cannot be managed at programme level, and the SOAG will propose system wide actions, some of which may fall on the Joint Committee of CCGs.

Recommendations and next steps

The Joint Committee is recommended to:

1. **Approve** the amended draft terms of reference for the Patient and Public Involvement Assurance Group.
2. **Review** the risk management framework and **comment** on the actions being taken to mitigate the risks identified.
3. **Note** the arrangements for managing system-wide risks.

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:	Risks are identified in the risk framework at Appendix B.
Public involvement:	The proposed PPI Assurance Group is intended to provide assurance that authentic patient and public involvement underpins the Joint Committee's work plan.
Finance:	Not applicable
Risk:	The significant risks to the delivery of the Joint Committee's work plan are attached at Appendix B.
Conflicts of interest:	Covered in the draft Terms of Reference for the PPI Assurance Group.

West Yorkshire and Harrogate Health and Care Partnership

Appendix A

West Yorkshire and Harrogate Joint Committee of CCGs

Patient and Public Involvement Assurance Group
('the Group')
DRAFT Terms of Reference
Version 2.0

1. Purpose

1.1. The purpose of the Patient and Public Involvement (PPI) Assurance Group ('the Group') is to assure the West Yorkshire and Harrogate Joint Committee of CCGs ('the Joint Committee') that authentic patient and public involvement underpins the Joint Committee's decisions about the programmes in its work plan.

1.2. The Group will help to shape and develop the strategic approach for engaging local people. It will review ~~advise on~~ patient and public engagement mechanisms, and provide assurance that programme areas of work are informed by stakeholder views in line with the WY&H Health and Care Partnership (HCP) communications and engagement strategy

1.3. By doing so, the Group will provide assurance that decisions taken by the Joint Committee comply with the statutory duty of CCGs to: *"make arrangements to secure public involvement in the planning of commissioning arrangements and in developing, considering and making decisions on any proposal for changes in commissioning arrangements that would have an impact on service delivery or the range of health services available".*

2. Roles and responsibilities

2.1 The Group will assure the Joint Committee that the public and patient voice is represented and heard, and that public and patient views and experiences inform decisions on the planning, development, design, redesign, implementation and evaluation of commissioned services.

2.2 The Group will do this by reviewing and ~~,~~ providing assurance ~~and advising~~ on PPI in the programmes in the Joint Committee work plan. It will:

I. Review and provide assurance about draft PPI strategies and delivery plans, covering all stages from initiation to implementation;
II. Review and provide assurance about PPI plans and materials to be used to inform / involve / consult patients and the public relating to specific proposals submitted to the Joint Committee;

~~III. Advise and make recommendations to the Joint Committee and the HCP on approaches to patient and public engagement, the most appropriate methods and on opportunities for improvement ;~~

~~IV.~~III. Review and provide assurance ~~Advise~~ on issues regarding PPI raised by the Joint Committee;

~~V.~~IV. Support opportunities for collaborative working on PPI between partner organisations;

~~VI.~~V. Share information about best practice in PPI.

~~VII.~~VI. Monitor intelligence gathered from patient and public engagement activities in order to inform HCP programmes with feedback and suggestions, and to identify areas of concern.

3. Membership

3.1 The membership will comprise:

- Governing Body Lay Member for Patient and Public Involvement for each WY&H CCG

3.2 In attendance:

- A representative of the HCP Communications and Engagement team
- HCP Core team Governance Lead
- HCP Healthwatch Representative

3.3 Members of the HCP core team, Programme Leads and other stakeholders may be invited to attend and participate at the discretion of the Chair.

3.4 The Group will elect a Chair and Deputy Chair from amongst its members.

4. Quoracy and voting

4.1 There will be no quorum or formal voting, but members of the Group will be expected to make their best endeavours to attend each meeting. Members may participate in the meeting by telephone or video conferencing. The Group will endeavour to provide assurance by reaching a consensus, which should also take into account the views of attendees.

5. Operation of the Group

5.1 Meetings will be held 6 times per year. To ensure the timely review of relevant PPI strategies and plans, meetings and agenda for the Group will be aligned with the forward work plan of the Joint Committee.

5.2 The HCP Core team will provide administrative support and advice, including preparing and circulating the agenda, minutes of meetings and actions. Agenda papers will normally be circulated 5 working days before the meeting.

6. Conduct of the Group

6.1 Members commit to behaving consistently in ways which promote the shared HCP values:

- We support each other and work collaboratively
- We act with honesty and integrity and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions

6.2 The Group will work in accordance with Nolan's seven principles of public life, namely selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

6.3 Group members will not make public specifically designated confidential information gained as a result of their involvement with the Group without prior written agreement

7. Conflicts of Interest

7.1 All those attending a meeting, as a member or in attendance must abide by all policies of the organisation they represent in relation to conflicts of interest and, ensure that NHS Statutory Guidance on Management of Conflicts of interest is adhered to.

7.2 Where any Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that Group member may participate in the meeting when the relevant matter is discussed.

8. Reporting

8.1 The Group shall report by providing a level of assurance about PPI in relation to relevant proposals submitted to the Joint Committee.

8.2 The minutes of each meeting will be forwarded to all Group members and attendees and to all Joint Committee members. The minutes will also be made public on the Joint Committee and HCP web pages.

8.3 The Group shall produce an annual report of its activities.

8.4 Each member is responsible for providing feedback and assurance to their respective CCG on the work and outputs from the Group.

9. Review of Terms of Reference

These terms of reference will be reviewed annually.

Date of next review: November ~~September~~ 2019

Approval of Terms of Reference

Date approved by the Group: 6th August 2018

Date approved by the Joint Committee:

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 12 or more, after mitigating controls and assurances have been taken into account.

Summary of risks 30.10.18

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.	• The Joint Committee noted at its meeting on 4th September 2018 that this risk had been downgraded from 12 to 8. No relevant risks currently scored at 12 or above.				
2. Cancer • New strategic approaches to commissioning and providing cancer care.	• No relevant risks on the Programme risk register currently scored at 12 or above.				
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. • Agree plan for the provision of children and young people inpatient units, integrated with local pathways.	• No relevant risks on the Programme risk register currently scored at 12 or above.				

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
4. Stroke • Agree configuration of Hyper Acute and Acute stroke services	4.1 Hyper acute stroke services may experience operational resilience and be unable to further improve stroke outcomes in line with national guidelines resulting in continued variation due to an inability to recruit and retain appropriately skilled workforce.	16 (4 x 4)	Please note: the WY&H Stroke T&F Group agreed the previously reported risks were closed and a new workforce risk opened reflecting the combined workforce risks. • The risks and mitigating actions are reviewed and updated accordingly at every WY&H Stroke T&F group • Risk scores of 12 were referenced in the stroke reports to Joint Committee of CCG's (4/7/17 & 7/11/17, 1/5/18, 7/8/18) • Provider operational resilience issues are being addressed via existing contractual routes via the Lead CCG e.g. local Harrogate sub group in place, WYAAT & national lead supporting local developments, Bradford/Airedale Project Lead also appointed • LWAB workforce lead attending T&F meetings & leading workforce work stream • T&F Group have contributed to development of the WY&H LWAB Strategy • Local/National developments are a standing agenda item to encourage 2 way dialogue between organisation representatives & the WY&H Stroke Programme.	12 (4 x 3)	• WY&H workforce analysis is informing local WYAAT/Harrogate provider/commissioner developments to inform discussion with key stakeholders • Meetings continue with MYHT, SY&B & NHS Wakefield CCG to discuss cross boundary flow impacts on MYHT from a demand and capacity and risk perspective. • SY& Bassetlaw and WY&H Stroke Programme Lead in regular dialogue to ensure opportunities to learn and share. • Commissioners have requested a formal response from WYAAT regarding resources & timelines for implementing clinical standards to inform Joint Committee discussion (6 Nov 18) • The Local Workforce Action Board (LWAB) is supporting workforce developments and LWAB non recurrent funding (20K) secured to re-establish stroke clinical network • Seeking views from WYAAT MD forum and WY&H Clinical Forum on resourcing clinical lead and stroke network (sustainability, role and function) • There is continued focus to prevent strokes occurring e.g. AF, hypertension and wider cardio vascular work.
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.	• No relevant risks on the Programme risk register scored at 12 or above.				

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
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). Communicating the change and People's perception of the programme and its workstreams, and addressing Patients' and Public fear of privatisation of the NHS and perception of rationing patients' access to health care services portrayed through Public Relations and Social Media, for example that forms their perception of the programme.	20 (5 x 4)	• Develop a strong stakeholder management approach as part of the comms & engagement strategy • Consider the need for consultation and type of consultation where there are significant service changes required. • Getting the narrative right and engaging with our communities as soon as possible • Implementing our communication and engagement strategy within set deadlines and timelines, and consider defined resource to focus on public relations of the programme • Utilising the programme board as a test board for actions and means to develop mitigating strategies.	16 (4 x 4) (Revised and increased since last reported to Joint Committee)	• Proactive comms and engagement. • Participation of lay members in programme board to ensure lay perspective is considered throughout • Lay representation on Clinical Thresholds and need to increase people and public participation in the Working Group • Charity involvement and need to do more. • Recruiting Comms and Engagement manager to support programme; anticipate September start (started)
	6.2 Some CCGs will want to proceed at a slower pace than the majority and some CCGs will want to proceed at a faster pace than the majority	15 (5 x 3)	• Acknowledge and accept that this will happen and agree an over-arching timetable with a common end-point. • Encourage CCGs to move together in lock-step to maximise benefit across the region and deliver economies-of-scale around e.g.comms & engagement, implementation etc. • Establish baseline thresholds and allow for some CCGs to "go-tighter" if required.	12 (3 x 4) (Revised and reduced since last reported to Joint Committee following review of programme risks)	• Encourage CCGs to move together in lock-step to maximise benefit across the region and deliver economies-of-scale around e.g.comms & engagement, implementation etc. • Establish baseline thresholds and allow for some CCGs to "go-tighter" if required. • Understanding that each Place will go at the pace it's comfortable with and dependent on the availability of its resources, and working with Places to support their speed of pace (fast/slow) and leveraging, where possible, access to resources to enable them to proceed at a faster pace and reach the end point of the programme in line with the over-arching timetable

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
	6.3 Financial return and impatience. This is a long game.	20 (5 x 4)	• Efficiency savings will be achieved in implementing changes in clinical thresholds and care pathways that will release capacity and resource to be applied elsewhere in the system. • It will take time for transformation of a systems approach and application of standardised policies to deliver efficiency savings to measure the financial gains across WY&H.	20 (5 x 4) (Added since last Joint Committee)	• PwC resource in Summer 2018 will support quantification of some of financial gains to be delivered through the programme. • Recognise that financial benefit will primarily come from future cost containment, rather than actual reduction in spend. • This will be achieved through demand reduction through supporting healthier choices, and implementation of efficient and clinically effective pathways and policies.
	6.4 Clinical Leadership and creating a movement for change	20 (5 x 4)	• Clinicians will need to be bought in to the movement of change and have an appetite for it otherwise the benefits to be achieved from this programme will not be realised. • Engagement and consultation with clinicians will need to commence as soon as possible to ensure the programme achieves its deliverables at the relevant milestones. • Furthermore, clinical consultation will be vital in determining a list of procedures of limited clinical value and agreeing revised care pathways for elective care procedures, as well as the work to be done on supporting healthier choices and the further work to be done on prescribing.	16 (4 x 4) (Added since last Joint Committee)	• Changing the conversation at locality and Place based level. Using the conversation about RTT and 52 weeks to start the conversation about the programme. • Consulting with the Clinical Forum in seeking steer and governance in revising procedures of limited clinical value, redesigning care pathways and in reviewing commissioning policies, and when encountering resistance from clinicians to the movement for change. • Active engagement from WYAAT clinicians on MSK and elective orthopaedics, and developing strategy for engagement with primary and community sector.