West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

DRAFT Minutes of the meeting held in public on Tuesday 5th June 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 Sohail Abbas	SA	Clinical Board member, Bradford City CCG (Deputy for Akram Khan)
Dr Andy Withers	AW	Chair, NHS Bradford Districts CCG
Helen Hirst	HH	Chief Officer, NHS Bradford City, Bradford Districts and AWC CCGs
Dr Steven Cleasby	SC	Chair, NHS Calderdale CCG
Dr Matt Walsh	MW	Chief Officer, NHS Calderdale CCG
Dr Steve Ollerton	SO	Chair, NHS Greater Huddersfield CCG
Ian Currell	IC	Chief Finance Officer, NHS Greater Huddersfield CCG and North Kirklees CCG (Deputy for Carol McKenna)
Dr Alistair Ingram	AI	Chair, NHS Harrogate & Rural District CCG
Amanda Bloor	ABl	Chief Officer, NHS Harrogate & Rural District CCG
Dr Gordon Sinclair	GS	Chair, NHS Leeds CCG
Jo Harding	JH	Director of Quality and Safety, NHS Leeds CCG (Deputy for Philomena Corrigan)
Dr David Kelly	DK	Chair, NHS North Kirklees CCG
Dr Phillip Earnshaw	PE	Chair, NHS Wakefield CCG
Jo Webster	JW	Chief Officer, NHS Wakefield CCG
Apologies		
Dr Akram Khan	AK	Chair, Bradford City CCG
Carol McKenna	CMc	Chief Officer, NHS Greater Huddersfield CCG and North Kirklees CCG
Philomena Corrigan	PC	Chief Executive, NHS Leeds CCG
Ian Holmes	IH	Programme Director, WY&H STP
In attendance		
Sue Baughan	SB	Independent consultant, funded by Academic Health Science Network
Yousef Beanini	YB	Clinical Lead, Bradford Healthy Hearts
Anne Burrows	AB	Public Health England
Karen Coleman	KC	Communication Lead, WY&H STP
Stephen Gregg	SG	Governance Lead, Joint Committee of CCGs (minutes)

Shane Hayward-Giles	**SHG**	Rightcare Delivery Partner
Anthony Kealy	**AKe**	Locality Director, West Yorkshire, North Region NHS England
Martin Pursey	**MP**	Head of Contracting, Greater Huddersfield CCG
Michelle Turner	**MT**	Programme Director, Bariatric surgery
Jonathan Webb	**JWe**	Director of Finance, Wakefield CCG

10 members of the public were also in attendance.

Item No.	Agenda Item	Action
48/18	**Welcome, introductions and apologies**	
	MB welcomed all to the meeting and reminded everyone of the role of the Joint Committee. Apologies were noted. MB welcomed the announcement on 24th May that WY&H was one of 4 systems added to the national Integrated Care System development programme. This was recognition of the progress the Partnership was making. The work of the Joint Committee had played an important part in this and MB thanked everyone who had been involved with the Committee for their contributions.	
49/18	**Open Forum**	
	MB invited members of the public to ask questions about items on the agenda. SG advised that one written question had been received. 3 members of the public asked verbal questions. **Elective care and standardisation** Q. *What was the impact on the training of ophthalmologists of changes in eye care pathways?* A. This was a complex question and a written response would be provided. Q. *Is the Committee aware of criticisms of the Rightcare methodology, and if so, how is it taking account of them?* A. SHG said that Rightcare does not provide 'perfect solutions', but is a tool to support improvement. It highlights variation, and the data is then used with localities to explore whether the variation is warranted. MW confirmed that there was significant challenge of the data locally. AW added that Rightcare was used as a basis for discussion. **Urgent and emergency care** Q. *How will 111 services link with Clinical Advisory Services in the new Integrated Urgent Care service?* A. IC said that NHSE have produced a detailed service specification. It is a very complex area, and we have chosen a dialogue with providers to ensure that our response is the right one. A more detailed written response would be provided. Q. *How are Attain involved in the procurement process and how much are they being paid?* A. IC advised that Attain have been engaged to provide additional procurement capacity and expertise. A written response would be provided on the costs. Q. *What stage has the procurement process reached?* A. MP advised that expressions of interest had been sought. There had been 18 initial expressions. Fewer than 5 selection questionnaires had been received, and these were now being evaluated	**SG** **IC** **IC**

Item No.	Agenda Item	Action
	Q. *Why do the WY CCGs not want urgent care services to be part of the Integrated Urgent Care service?* A. MP said that in WY, 111 services have historically been linked to the out of hours service. This is a different service model to that in Yorkshire and Humber. JW added that the aim of the IUC procurement process was to connect services, to make it easier for the public to understand and navigate the system and to improve access to services. Q. *How can the CCGs consult on the proposals when the procurement process has already started?* A. JW said that local consultation was not appropriate because all commissioners are being required by NHS England to fulfil the national IUC service specification. Q. *How will the impact of patient choice be addressed and how is the learning from the WY Urgent Care Vanguard being used?* A. JW said that the Vanguard learning has underpinned the work in WY and nationally. For example, the approach to clinical advice was based on the Vanguard learning. SO added that learning on 111 referring into GP in-hours services was also being rolled out nationally. **CVD and diabetes** Q. *Was the Committee aware of concerns that use of statins may build up problems for the future?* A. AW said that the learning from Bradford Healthy Hearts showed a demonstrable reduction in the number of people suffering heart attacks and strokes. More detail would be provided as part of the item later on the agenda. **Joint Committee governance – risk management** Q. *Why was the risk relating to cancer so high?* A. ABI advised that this related to financial penalties relating to the 62 day performance targets. Plans were in place to address this. Q. *Why did new stroke models of care create workforce risks?* A. AW said that workforce was a risk in relation to existing models of care and would continue to be a risk for new models. Q. *What did the 50% target refer to in relation to urgent care, and why was it a risk?* A. JW advised that this referred to access to clinical advice. This was being addressed through the current procurement process. Q. *What were the urgent care risks in relation to system integration and inter-operability?* A. MP – the current procurement was designed to ensure that there was interoperability between all parts of the system, including information technology. Q. *Standardisation of commissioning policies – why was public and politician resistance a risk?* A. MW said that the risk related to change management, and the need to ensure that all parts of the system supported effective prevention. **Action:** review with risk owners the wording and description of all risks to ensure a clear read across from the risk to the mitigation action. MB said that the questions would also be taken into account in the relevant agenda items. The questions and the responses would be published on the Joint Committee webpage	**SG**

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Item No.	Agenda Item	Action
50/18	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. In relation to item 55/18 on Urgent and Emergency Care, SO declared that he worked occasional sessions for Local Care Direct. DK advised that he was a member of a GP federation that might potentially provide the services. Other WY based GP members of the Committee also declared similar interests. The Chair ruled that the nature of the interest was not sufficiently material to affect the decision and ruled that the GP members could participate in the discussion.	
51/18	**Minutes of the meeting in public – 6th March 2018**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 6th March 2018.	
52/18	**Actions and matters arising**	
	The Joint Committee reviewed the action log. There were no matters arising.	
	The Joint Committee: Noted the action log.	
53/18	**Joint Committee governance**	
	SG presented the report, which covered the following: **Variations to the MoU for Collaborative Commissioning** – 2 variations had been agreed by the member practices of each CCG: revisions to the Joint Committee work plan, clarifying the decisions that the CCGs have delegated to the Joint Committee and the continuation of current voting arrangements following the merger of the 3 Leeds CCGs. **Joint Committee risk management framework –** this highlighted the significant risks to the delivery of the revised Joint Committee work plan. SG noted that the key risks had been explored in detail under the Open Forum agenda item. He noted that this was the first time that the framework and the risks had been presented and asked the Committee to confirm the level of risk that it would like to be reported in future updates. Members felt that it was important that the Committee continued to review risks scored at 12 and above. **Joint Committee Annual Report –** was presented for formal approval, alongside a 'public-friendly' version.	
	The Joint Committee: 1. **Noted** that following the merger of Leeds North, South and East and West CCGs, NHS Leeds CCG was now a Party to the MoU. 2. **Noted** the variations to the MoU agreed by the Parties, namely the revised work plan and the continuation of current voting arrangements, maintaining the 'status quo' of 3 votes for Leeds. 3. **Noted** the Committee's revised Terms of Reference. 4. **Reviewed** the risk management framework and the actions being taken to mitigate the risks identified and **requested** that future updates continue to cover risks scored at 12 or above after mitigation. 5. **Approved** the Joint Committee Annual Report.	**SG**

DRAFT

Item No.	Agenda Item	Action
54/18	**Improving outcomes for people with CVD and diabetes**	
	Youssef Beaini and Sue Baughan presented the report, which invited the Joint Committee to recommend the WY&H CCGs to support a WY&H programme to deliver improved outcomes for people with CVD and Diabetes. SB advised that the WY&H Clinical Forum had identified the potential to make significant improvements in outcomes through joint working. The proposals drew on the successful Bradford Healthy Hearts programme. If implemented across WY&H this would reduce both strokes and heart attacks and contribute to the WY&H target of reducing CVD incidents by 10% by 2021. Joint work would enable economies of scale and shared learning. YB explained that Phase 1 of the programme focused on identifying and treating more effectively people with high blood pressure. Phase 2 would focus on better treating people already on statins and also identifying people who could benefits from statins. Phase 3 would be targeted on reducing risk for people with diabetes. Clinical leadership and engagement was critical. It was important to minimise any additional work for healthcare professionals by working smarter and more efficiently. SB said that the work would be delivered in localities, building on work already underway. This would be supported by a small central team to ensure a 'do once and share' approach. Funding was already in place for 2018/19. Progress would be reported to the Joint Committee in public every 6 months. FKS supported the approach. She asked how it would support self-care and how the voluntary and community sector and patient representatives would be involved. YB responded that high blood pressure was very amenable to self-care. He welcomed voluntary and community sector involvement. SB was already talking to local leads about engagement. ABI highlighted the clinical support for the work and its role in helping to deliver shared WY&H aspirations. HH noted the importance of public and patient engagement in Bradford and that the learning from this would be shared. AW said that it would be important to engage with acute providers and YB confirmed that this was already underway. MW acknowledged the strong clinical case for the approach and noted that CCGs would be required to prioritise and contribute resources to it. He asked whether the approach would help to deliver savings. HH said that the quality of life, health and economic benefits were considerable, but that it was not possible to identify specific cost savings. DK supported the clinical case and asked what the impact would be on CCG resources and the primary care workforce. ABI noted that this was an existing priority for the Partnership and said that doing the work jointly would deliver economies of scale. MW said that if this was to succeed, the CCGs needed to commit to prioritising the work and ensure that it had local leadership. It was important that the wider benefits of the approach were demonstrated clearly. JW said that it was important that all reports to the Committee were clear on how they contributed to the Partnership 'triple aim', including the financial impacts. She noted the links to the atrial fibrillation work and said that in Wakefield, tackling CVD was a key priority identified in the health and wellbeing plan. There were significant benefits from sharing best practice.	

DRAFT

Item No.	Agenda Item	Action
	PE noted the clinical, ethical and moral benefits of the proposals and also its value in helping clinical staff to 'let go' and encourage self-care. MB highlighted that prevention was at the heart of the approach, but said that it was important to understand the resource implications. SO confirmed that significant learning, literature and engagement resources were available from Bradford to support the approach.	
	The Joint Committee agreed to recommend to the CCGs that they: 1. **Adopt** this WY&H wide improvement project. 2. **Identify** a clinical and a project lead to work with the Clinical Lead and central project team to implement the actions identified in Phase 1, 2 and 3 of this project. 3. **Support** the reporting and governance arrangements to enable the impact of this project to be measured and assured at CCG and HCP level.	
55/18	**Urgent and emergency care**	
	Martin Pursey presented a recommended approach to procuring Out of Hours Primary Medical Care Services across West Yorkshire. MB noted that different arrangements applied in Harrogate. MP clarified the financial value and the need to comply with relevant NHS procurement and legal requirements. The potential procurement options had been considered by the commissioner-only WY&H Urgent and Emergency Care Programme Board at its meeting on 21st May 2018. The Programme Board had considered the need to fully understand the implications of changes currently taking place in the wider urgent and emergency care system. The Board had concluded that the most pragmatic approach was to extend the current out of hours service to enable a clear picture to emerge of the desired future service. The Board had fully supported the recommended option being presented to the Joint Committee today. SO noted the need to align the service with GP extended hours services. MP said that approaches to extended hours differed across WY and that it was important to fully understand the gaps that existed. JW noted the need to manage risks across WY and that wherever possible, a consistent approach was needed. Extending the current contract would provide the time needed to ensure that a fully integrated urgent care system was commissioned. SO noted the existing capacity challenges in primary care. DK questioned whether the proposed extension would give sufficient time to complete the wider procurement process. MP confirmed that it would.	
	The Joint Committee: 1. **Approved** the recommended option and provide authority to negotiate a direct award of contract to Local Care Direct (LCD) to expire on 31st March 2020 and publish a VEAT notice stating the commissioners' intentions to reprocure the services from 2020 and enter into market engagement on service design in due course	
56/18	**Complex and severe obesity**	
	Michelle Turner presented a report outlining recommendations made by the Clinical Forum in March 2018. The Clinical Forum had identified a strong case for commissioning more Tier 4 bariatric surgery across WY&H.	

DRAFT

Item No.	Agenda Item	Action
	The report had been considered at a development session of the Joint Committee in April 2018, when more information on the financial implications for each CCG had been requested. The key proposal was that each CCG work towards commissioning bariatric surgery at the level of the highest performing CCG in WY&H, which was currently 4% of those patients likely to be 'eligible and accepting of surgery'. This would ensure a more consistent approach and reduce inequity. A collaborative approach was recommended, with a single service specification. The financial implications for each CCG were presented. SO asked how the proposals dealt with Royal College of Surgery recommendations on minimum activity levels for performing bariatric surgery, and questioned whether CCGs should aim to go 'further, faster'. GS asked whether a new service specification could be developed in time to have an impact in 2018/19. DK queried whether standard eligibility criteria needed to be developed. IC noted that investment in more surgery would deliver significant savings in future years. HH reminded the Committee that the decision on this had not been delegated to the Joint Committee and that final decisions, including whether to go 'further faster' therefore rested with each CCG. In relation to activity levels, she said that work was ongoing with existing providers to facilitate joint working. She added that this approach was a good example of the CCGs working collaboratively through the Joint Committee to achieve common goals. In relation to eligibility, SC noted that candidates for Tier 4 surgery would first come through tiers 1-3.	
	The Joint Committee **recommended** the WY&H CCGs to support the Clinical Forum's recommendations: 1. That there is a strong clinical case to commission more bariatric surgery over the next 2 to 5 years. 2. To have a new service specification for WY&H for Tier 4 services which the CCGs commission collaboratively once financial values have been agreed. This may include, depending on the financial implications, additional capacity requirements to meet the aspiration of meeting the needs of 4% of the eligible population. 3. To ask the West Yorkshire Association of Acute Trusts (WYAAT) to consider how to respond to a collaborative commissioning approach against a single service specification for WY&H 4. To ask WYAAT to consider how best to meet any additional capacity required from the CCGs. And **noted**: 5. The individual CCG financial implications of commissioning of bariatric surgery at the same rate as the highest performing CCG. 6. That the collaborative commissioning model needs to be developed and will be brought back to the Joint Committee for sign off	**MT**
57/18	**Any other business**	
	There was none.	

Next Joint Committee in public – Tuesday 3rd July 2018, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF.

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