West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

DRAFT Summary report			
Date of meeting: **5 November 2019**	Agenda item: 61/19		
Report title:	**Joint Committee governance**		
Joint Committee sponsor:	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 paper seeks the Joint Committee's guidance on key governance issues relating to the extension of the Memorandum of Understanding for Collaborative Commissioning (MoU).

The Joint Committee has delegated authority from individual CCGs to take decisions on their behalf. The MoU which formalises the role of the Committee and the scope of the delegation expires on 31st March 2020. Changes in the West Yorkshire and Harrogate (WY&H) commissioning landscape mean that some substantive changes in the MoU will be required. These changes will need to be agreed by the individual CCGs and the timescale for this process can be lengthy. It therefore makes sense to use the opportunity presented by the MoU extension to:

- consider any other amendments – such as changes to the Committee's work plan - which will move collaborative working further forward.
- 'future proof' the MoU as far as is possible, in what is a rapidly changing environment.

The review of arrangements to enable the MoU to be extended from 1st April 2020 is progressing in parallel with wider commissioning development work, which aims to identify opportunities to commission more strategically across WY&H and work more closely with providers. The proposals in this report are designed to support this direction of travel, but at this stage are only a 'step along the way'. Any further proposed changes in the Joint Committee work plan and its ToR which might be needed to reflect the direction of travel will be brought to the Joint Committee for consideration on completion of the commissioning development work.

Recommendations and next steps

The Joint Committee is asked to:

a) Consider the future voting mechanism for the Joint Committee in the light of forthcoming changes in the configuration of the WY&H CCGs.
b) Support further work to develop the Joint Committee work plan, including the addition of any new matters.

c) Consider the proposal to change to a quarterly cycle of meetings in public'. d) Consider the benefits of introducing a more systematic approach to monitoring implementation of the delivery of the Joint Committee work plan. e) Agree that all proposed changes to the MoU are included in an amended draft for consideration at the Joint Committee development session in December. f) Agree that following further discussion at the development session in December, the proposed changes to the MoU are presented to the CCGs, so that they can be considered in accordance with local governance arrangements.	
Delivering outcomes: describe how the report supports the delivery of priority outcomes (Health and wellbeing, care and quality, finance and efficiency)	
The MoU and work plan focuses on the delivery of priority outcomes.	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	A key element of the work plan and decision path for Joint Committee decisions.
Public involvement:	As above.
Finance:	As above.
Risk:	The Committee receives regular updates on the risks to delivery of its work plan.
Conflicts of interest:	None identified.

Joint Committee Governance

Background

1. The MoU for Collaborative Commissioning commenced in May 2017, with an expiry date of 31 March 2019. In June 2018, the CCGs agreed amendments which included a refreshed work plan and changes to the voting arrangements following the creation of the new Leeds CCG. In March 2019, Accountable Officers agreed to extend the MoU to 31 March 2020.

2. A number of changes in the WY&H commissioning landscape mean that some substantive changes in the MoU will be required from 1st April 2020. Organisational changes include the proposals for the merger of the 3 Bradford District and Craven CCGs and for Harrogate and Rural District CCG to become part of a single North Yorkshire CCG. The forthcoming Health and Care Partnership 5 year plan will re-frame the Partnership priorities towards which the Committee is working.

3. The individual CCGs must approve any substantive changes to the MoU and the approval process can be lengthy. It is therefore timely to consider any other potential changes alongside those required as a result of organisational changes.

Membership and voting arrangements

4. Clause 13.2 of the MoU allows that statutory successor bodies of one or more of the CCGs, including merged bodies, shall be deemed to be parties to the MoU without the need for the formal agreement of the remaining parties. However, CCG mergers have a potentially significant impact on the voting arrangements for the Committee.

5. In the spirit of collaborative working, the Joint Committee Terms of Reference require decisions to be made by consensus wherever possible. Where consensus cannot be reached, there is provision for decisions to be made by a 75% majority of voting members. Following the merger of the 3 Leeds CCGs in 2018, the WY&H CCGs agreed a pragmatic, transitional approach to Joint Committee voting arrangements. This maintained the 'status quo' of 3 votes for Leeds until the commissioning landscape across the wider WY&H footprint became more settled.

6. The merger proposals for the Bradford and Craven and Harrogate CCGs mean that the voting arrangements now need to be reviewed. The main options are:

   a) A further variation to the current transitional arrangements, with Bradford CCG retaining the 3 votes of its predecessor CCGs.
   b) One vote per place.
   c) One vote per CCG.

7. **Option a)** would continue what is explicitly a transitional approach. It would produce a very unbalanced Committee, with Leeds and Bradford each alone able to veto a decision and together having more votes than the other 5 CCGs combined.

8. **Option b)** aligns with the place-based approach of the wider Health and Care Partnership and is relatively simple and straightforward to apply. No single place would have a veto. However, the statutory responsibilities of all CCGs are not currently fully aligned with all of our places, which makes the option difficult to apply at this stage.

9. **Option c)** is simple to understand, straightforward to apply and aligns with the statutory responsibilities of the constituent CCGs. No single CCG would have a veto. However, one place (Kirklees) would effectively be able to veto a Joint Committee decision should Greater Huddersfield and North Kirklees CCGs vote together.

10. Taking into account the advantages and disadvantages of the options, **Option c)** - one vote per CCG - is recommended.

Work plan

11. The work plan sets out the matters that the CCGs have agreed to delegate to the Joint Committee. The original work plan was developed in late 2016 and refreshed in spring 2018.

12. The Joint Committee has made significant progress in delivering its existing work plan. Key achievements include:

    - agreeing the configuration of hyper acute stroke services
    - agreeing the commissioning approach to Integrated Urgent Care services
    - agreeing WY&H clinical thresholds, commissioning policies and pathways

13. The extension of the MoU provides a good opportunity to refresh the work plan to ensure that it both reflects progress made to date, the Partnership's changing priorities and direction of travel. A draft refreshed work plan, showing the existing delegation along with proposed changes, is attached at **Appendix A.**

14. The **Cancer** and **Elective care and standardisation of commissioning policies** programmes have proposed amendments to better reflect their changing priorities and ways of working. The **Urgent and Emergency Care** programme proposals seek to align the Joint Committee work plan with the new approach to collaborative commissioning at Yorkshire and Humber level, which is in the process of being agreed by individual CCGs. The **Mental Health and Learning Disability** programme is currently developing proposals for consideration at the Joint Committee development session in December.

15. The **Maternity** programme has proposed that some new commissioning decisions be delegated to the Joint Committee. Schedule 4 of the MoU outlines the process by which the work plan will be reviewed and agreed by the CCGs. This process includes CCGs testing whether proposals for any ***new*** matters to be added to the work plan meet agreed 'Gateway conditions'.

16. It is proposed that the 'Gateway conditions' should consist of the '3 tests' that we use consistently to determine whether working at WY&H level will add value:

    a) Delivery at scale (e.g. acute stroke reconfiguration, Integrated Urgent Care procurement)

b) Tackling wicked issues (e.g. standardising commissioning policy, evidence based interventions, ending the postcode lottery)
c) Learning from each other (e.g. atrial fibrillation, Healthy Hearts, Quality and equality impact assessment)

Frequency of meetings

17. The MoU states that meetings will be 'held monthly, or other such frequency as agreed by the Parties'. In practice, the Committee has met monthly, with formal meetings in public alternating with informal development sessions. As their role becomes more strategic, some CCGs are considering moving towards a quarterly cycle of meetings in public. Members are asked to consider whether the Joint Committee should move to a similar cycle.

18. Should the Committee move to a quarterly cycle of formal meetings, this would create more space in development session for members to shape the Partnership's wider commissioning development work including, for example, sessions to explore closer joint working with providers. The main disadvantage would be a loss of agility in our formal governance arrangements. This would impact most significantly on the Elective care/standardisation programme, but might also impact other Programmes if the scope of the Committee's work plan is expanded.

19. If a quarterly cycle is adopted, meetings in public will be scheduled to avoid clashes with meetings of the Partnership Board. A six-month lead-in period is suggested, based on the explicit understanding that the February and May development sessions will be converted to meetings in public if needed to transact Committee business. This would give a Committee schedule over the next 18 months as follows:

Date	Type of meeting
December 2019	Development (Partnership Board Meeting)
January 2020	**Public**
February 2020	Development
March 2020	Development (Partnership Board Meeting)
April 2020	**Public**
May 2020	Development
June 2020	Development (Partnership Board Meeting)
July 2020	**Public**
August 2020	Development
September 2020	Development (Partnership Board Meeting)
October 2020	**Public**
November 2020	Development
December 2020	Development (Partnership Board Meeting)
January 2021	**Public**
February 2021	Development
March 2021	Development (Partnership Board Meeting)

20. If in the future an urgent decision is required, part or all of a development session can be converted to a meeting in public on an ad hoc basis.

Implementation

21. As it has made progress in delivering its workplan, the Committee has increasingly focused on how it obtains assurance that its decisions are being implemented consistently across WY&H. Recent reports to the Committee have included updates on implementation of the Integrated Urgent Care service and the Bariatric surgery commissioning policy. An update on implementation of the Stroke programme is due to be submitted to the Committee in Spring 2020. Further updates are scheduled on flash glucose monitoring and bariatric surgery.

22. The Committee is asked to consider whether it wishes to adopt a more structured and systematic approach to monitoring implementation. This could take the form, for example, of a high level monitoring framework which could be presented as a companion piece to the regular risk management report.

23. In most cases, responsibility for implementation resides in place, unless there is an explicit agreement that Programmes will be resourced to implement agreed decisions. The framework would therefore need to be clear about the responsibility of place to support the monitoring framework and ensure that the Joint Committee is able to hold places to account.

24. Should the Committee agree that a monitoring framework should be implemented, it is proposed that a draft framework and suggested approach be brought to the December development session for consideration.

West Yorkshire and Harrogate Health and Care Partnership

Appendix A

WY&H Joint Committee of CCGs - Work plan review 2019

DRAFT - Potential decisions to be delegated to the Joint Committee by the CCGs

Cancer

~~*Agree new strategic approaches to the commissioning and provision of cancer care, building on the 'Commissioning for Outcomes' work.*~~

Develop and agree WY&H commissioning policies impacting on cancer care, including but not limited to:

- *Lynch syndrome testing*
- *Optimal cancer pathways which deliver Constitutional standards*
- *Tele dermatology services for suspected skin cancers*
- *Rapid diagnostic centres*
- *Personalised support for people living with and beyond cancer*

Mental health ***Under review***

- *Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds across West Yorkshire and Harrogate.*
- *Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services to ensure risk and benefit can be clearly understood and managed across West Yorkshire and Harrogate.*
- *Agree plan for the provision of children and young people inpatient units, integrated with local pathways.*

Stroke

Agree the configuration of Hyper Acute and Acute stroke services

- *Review and approve outline business case. Decide on readiness to consult.*
- *Review outcomes of consultation.*
- *Approve full business case*
- *Consider and approve commissioning approach and approve delivery plan.*

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*~~

Agree for West Yorkshire and Harrogate the transformational, finance and contractual matters identified as 'CCG decisions to be made in collaboration' in the MoU for the Collaborative Commissioning of Integrated Urgent and Emergency Care Services between CCGs across Yorkshire and the Humber.

~~Elective care and standardising commissioning policies~~ Improving Planned Care

Develop and agree West Yorkshire and Harrogate commissioning policies, including, but not limited to:

- ~~*Pre-surgery optimisation (supporting healthier choices);*~~
    - *Clinical thresholds and procedures of low clinical value;*
    - ~~*Eliminating unnecessary follow-ups*~~*;*
    - *Efficient prescribing.*
- *Develop and agree service specifications, service standards and the commissioning and procurement approach to support pathway optimisation, including outpatients transformation*

Maternity

Agree the approach to commissioning maternity services across WY&H including

- *the specification, service standards and commissioning policy.*
- *the commissioning and procurement approach*
- *the configuration of services*