Paper A

Item 18d

Joint Committee of Clinical Commissioning Groups

Meeting held 21 March 2017, 9:30 – 11:30 am, at Sheffield CCG

Decision Summary for CCG Boards

1	**Decision making business case – children's surgery and anaestheia**	
13/17	(a) that the presentation developed for the Sustainability and Transformation Plan Collaborative Partnership board (STP CPB) would be shared with the Joint Committee of Clinical Commissioning Groups (JCCC)	**HELEN STEVENS**
	(b) that full public consultation report would be shared also when finalised	**HELEN STEVENS**
	(c) that full assurance would be given to JCCC that each of the seven acute units met the national standards to enable the full decision on 24 May and any issues would be brought to the attention of the JCCC	**WILL CLEARY-GRAY**
2	**Matters Arising from the previous meeting**	
15/17	(a) discussions were still ongoing with NHS Hardwick Clinical Commissioning Group (CCG) to support collective decision making approach and the Chair would write to the NHS Hardwick CCG Chief Officer	**TIM MOORHEAD**

Minutes of the meeting of Joint Committee of the Clinical Commissioning Group, held 21 March 2017, 9:30 – 11:30, Sheffield CCG

Present:
Dr Tim Moorhead, Clinical Chair, NHS Sheffield CCG (Chair)
Dr Andrew Perkins, Clinical Chair, NHS Bassetlaw CCG (Chair)
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw Sustainability and Transformation Partnership
Chris Edwards, Accountable Officer, NHS Rotherham CCG
Idris Griffiths, Interim Accountable Officer, NHS Bassetlaw CCG
Debbie Hilditch, Healthwatch Representative
Pat Keane, Interim Chief Operating Officer, NHS Wakefield CCG
Alison Knowles, Locality Director – North, NHS England
Dr Ben Milton, Clinical Chair, NHS North Derbyshire CCG
Julia Newton, Director of Finance, NHS Sheffield CCG
Jackie Pederson, Accountable Officer, NHS Doncaster CCG
Matt Powls, Interim Director of Commissioning and Performance, NHS Sheffield CCG (Deputy for Maddy Ruff, Accountable Officer)
Lesley Smith, Accountable Officer, NHS Barnsley CCG

Apologies:
Steve Allinson, Accountable Officer, NHS North Derbyshire CCG
John Boyington, Lay Member
Sir Andrew Cash, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust/South Yorkshire and Bassetlaw Sustainability and Transformation Partnership Lead
Dr David Crichton, Clinical Chair, NHS Doncaster CCG
Dr Phillip Earnshaw, Clinical Chair, NHS Wakefield CCG
Andy Gregory, Accountable Officer, NHS Hardwick CCG
Steve Hardy, Lay Member
Dr Julie Kitlowski, Clinical Chair, NHS Rotherham CCG
Dr Steve Lloyd, Clinical Chair, NHS Hardwick CCG
Maddy Ruff, Accountable Officer, NHS Sheffield CCG
Jo Webster, Accountable Officer, NHS Wakefield CCG

In attendance:
Kate Woods, Programme Office Manager, Commissioners Working Together
Rachel Gillott, Deputy Director of Transformation, South Yorkshire and Bassetlaw Sustainability and Transformation Partnership
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together
Diane Jordan, Senior Finance Manager, Commissioners Working Together
Dr Peter Anderton, Clinical Lead for Stroke, Commissioners Working Together
James Scott, Project Lead Childrens, Working Together Partnership Vanguard
Linda Daniel, Project manager – Childrens, Commissioners Working Together

Minute reference	Item	ACTION
12/17	**Welcome, introduction and apologies** The meeting was opened with an outline of the approach for the session, which would be to work through the next eight weeks to the point of decision on the proposed service changes for Children's Surgery and Anaesthesia and Hyper Acute Stroke Services on 24 May 2017. The JCCC would address: - The current clinical case for change - The engagement and consultation section of the business case - The financial elements of the business cases The outstanding issues and next steps would be considered by JCCC and the proposals to work through these over the coming weeks. The JCCC was asked to note that the financial detail was still being developed and the level of risk needed to be noted by the group to be able to make a decision on the proposed configuration of the service.	
13/17	**Decision making business case update – Children's Surgery and Anaesthesia** The JCCC was presented with an update, covering the work to date, the clinical case for change, the proposed reconfiguration, options on this proposal, the public and stakeholder feedback, impact on pathways of care, the financial funding impact and an assessment of next steps. A query was raised around the standards from 2013/14/15 and assurance around whether there remained a clinical case for change. It was confirmed that a peer review would take place using a designation toolkit. The focus of the work would be on out of hours evenings and weekends and there was variation across the patch within the case for change, and standardisation and consistency must be reached across the patch. It was confirmed that there remained a clinical case for change for this work. The interdependencies on maternity, neonates and acutely ill child and the point at which these interdependencies needed to be addressed. The JCCC noted that the position had progressed for this work, with changes in provider practice, resulting in smaller numbers of children impacted. This helped to understand the impact on pathways. The outcome of the consultation exercise was reflected on. It was agreed that the presentation developed for the STP CPB would be shared with the JCCC. The full report would be shared also when finalised. This would be presented to the Joint Overview and Scrutiny Committee on 3 April 2017. The methodology behind the consultation was outlined to JCCC. It was noted that where the public and stakeholders agreed to the proposed changes, the views of the case for change were around better care, equal access, better use of allocation of resources, and that people trust the NHS to make decision on their behalf. Where there was	**HELEN STEVENS** **HELEN STEVENS**

	disagreement with the proposed changes, concerns were expressed around not being able to access care close to home, concerns around a possible adverse impact on safety, and skepticism about the motivation for the work. Alternative suggestions were requested from the public and the responses to this were to keep services as is. The themes outlined above remained the same throughout public meetings and discussion groups also. The JCCC were updated on the numbers being impacted by this work noting they were lower than initial projections. A query was raised as to why the Barnsley figure was higher than for other areas. JS confirmed that this was due to clinical coding and the inclusion of undifferentiated abdominal pain diagnosis. In response to a query raised, it was confirmed that detail behind the lower figures being looked at than initially projected, was also being shared with provider organisations. The numbers had changed due to change in the commissioning specification. This is due to i) revised assumptions suggesting that only out-of-hours non-elective work would be affected, rather than all non-day case works, and ii) clinical discussions leading to clarity on diagnoses which would require urgent surgery and those which could be managed locally. A discussion took place around the governance processes for this work, and it was confirmed that the consultation documentation had stated that based on review of current numbers, the figure of patients affected was small, and therefore the fundamental principles of the consultation had not changed and the process was robust. The JCCC discussed assurance around the proposal being based on all providers meeting and maintaining national standards given the trends in workforce development. It was confirmed that this was a standards driven approach. It was confirmed that an initial baseline/peer review had been carried out, and a formal annual review would take place against standards. This would be undertaken by the managed clinical network (MCN). One of the roles of the MCN was to ensure decision points in the pathways of care were correct. It was noted that the proposed change was the result of work with clinicians in local hospitals as well as consultation with public should be made explicit. How clinicians supported the clinical case for change would be crucial. JCCC were presented with a summary and next steps: • Ongoing development of decision-making business case – Financial model – Commissioning approach and contract award – system wide • Quality Reviews - peer review visits via MCN, for baseline assessment against service specification, May - summer • Further refinement of clinical pathways, leading to standardised protocol via MCN, May • Move to implementation phase (if decision proceeds) – further engagement of COOs and Trust operational teams. To be finalised in line with mobilisation schedule.	

	• Formal review via MCN, built into implementation schedule A discussion took place around the principles for undertaking this work, given the low numbers involved and the wider issues around quality standards and staffing and how the wider services would be addressed. It was agreed that this work was being undertaken on the clinical consensus being development through the network that changes were required. As this was being worked through, it was clear that a significant change in terms of the impact of people was not at the scale originally envisaged. The current journey had highlighted major concerns around out of hours services and this is why this was being addressed. This should be made explicit as part of the narrative of this work. A further comment on the interdependencies with paediatrics aligning with acute medical pediatrics was made, noting as possible impact on surgery as the Acutely Ill Child progressed. It was confirmed that the analysis of the consultation would be fully fed back to all stakeholders and to the public. JCCC requested full assurance that each of the seven acute units met the national standards to enable the full decision on 24 May.	**WILL CLEARY-GRAY**
14/17	**Decision making business case update – Hyper Acute Stroke Services** JCCC were presented with an overview of the work on Hyper Acute Stroke Services to date, noting that this work predated the work of the Sustainability and Transformation Plan. The presentation covered the clinical case for change, options, considered, the proposed reconfiguration, public and stakeholder feedback, the financial and funding implications and a summary of next steps. The JCCC were updated on the consultation elements, noting that where respondents agreed with the proposals the key themes were being able to access better quality of care with improved outcomes and a more effective allocation of resources. Where the public and stakeholders disagreed with the proposals, key themes were around not being able to access care closer to home, the social impact of the need for further travel, (this did not show through on the children's survey, and a comment was made that this suggested a misunderstanding about the way that the changes were presented to the public), and concerns around the pressure on the ambulance service. The ambulance concerns had also been a theme from the Joint Overview and Scrutiny Committee who had requested reassurance on ambulance services. The mixed responses from the public were noted. Financial initial summary was presented to the JCCC. It was noted that a finance working group was formed in September 2016, led by DJ with representation from each provider organsiation and supported by deputy CFOs as part of this process. This group had addressed activity data, stroke best practice tariffs, implications of a service change for providers, transportation funding, and looked at potentials around introducing local funding model versus national tariff. A summary of the issues were presented to the JCCC. Figures were indicative and based	

	on business cases. A discussion took place around national staffing standards to improve quality indicators and concerns were noted around money assumptions to recruit staff. DJ confirmed that this was aspirational. It was noted that the tariff implications from the provider business cases would be helpful. It was confirmed that no assumptions were made on mortality implications at this point. Length of Stay would not affect the tariff. The impact of excess bed days and social care would not be factored into this business case at the present time. The work around excess bed days was crucial and work on HASU should not be seen in isolation. Next steps were outlined to the JCCC: • Share very early draft Decision Business Case (DBC) with commissioners • Transport cost and modelling finalised • Revisit provider financial issues/risks • Agree financial principles • Commissioning Approach agreed • Finalise DBC • Joint Committee Decision A comment was made that the whole pathway needed to be addressed to secure flow through the system to optimise any changes to HASU. Capacity to deal with the changes should be addressed. It was noted that positive engagement with providers was taking place, looking at the implications of centralising HASU and looking at the interface with other parts of system. It was noted that a stroke clinical network to support mobilisation of work around standardisation and consistency of services would be established. In response to a query it was confirmed that a decision would be taken in May based on all of the information presented to them, including the clinical case for change as well as the views of the public. A discussion took place around telemedicine and it was confirmed that this technology was being utilised currently for out of hours and this had been in place since 2012. The JCCC noted that there remained a strong clinical case for change, noting further work needed to be done on financials and affordability noting that long term, the affordability for this work must be sustainable. The financial business case to move to the next stage of the process needed reconsidering with different approach. It was noted that having the draft business cases to consider prior to the meeting would have helped discussions and this was acknowledged.	
15/17	**The minutes of previous meeting** The minutes of the meeting held 21 February were accepted as a true and accurate record subject to a change to the discussion on the Joint Committee.	
16/17	**Matters arising**	

	NHS Hardwick CCG JCCC were updated on the position of NHS Hardwick Clinical Commissioning Group (CCG) with regards to formal delegation to the JCCC for decisions on stroke and Children's Surgery and Anaethesia. An early discussion had taken place with NHS Hardwick CCG which was helpful in providing clarification and also NHS England. The JCCC supported a recommendation for the Chair to write to NHS Hardwick CCG to summarise shared understanding to agree a supportive collective decision making approach for the current proposals. **Lay membership** HS advised the group that discussions with interested parties had taken place around the role. AP, MR and HS would be undertaking the interviews for the position.	**TIM MOORHEAD**
17/17	**Any other business** The JCCC were asked to note that all organisations must engage and consider how to work differently, as transformation funding would not necessarily be available for future pieces of work. Careful consideration was required to ensure that a culture and context of working where any small system change was made would be supported by transformation funding. This formed part of a wider discussions on commissioners and providers working as a system.	