Yorkshire and the Humber Collaborative Commissioning – Integrated Urgent & Emergency Care (IUEC)

Governing Body meeting

7 November 2019

Author(s) | Alastair Mew – Head of Commissioning (Urgent Care)
Sponsor Director | Brian Hughes – Director of Commissioning and Performance

Purpose of Paper

- Explain the rationale for revising the Integrated Urgent & Emergency Care (IUEC) commissioning arrangements across the Yorkshire & Humber region.

- Gain approval from each of the Yorkshire & the Humber (Y&H) Clinical Commissioning Groups (CCGs) commissioning the Yorkshire Ambulance Service (YAS) to provide 999 ambulance and/or Integrated Urgent Care (IUC) services to a revised partnership framework and collaborative commissioning agreement.

- Set out how the IUEC commissioning intentions will be enacted in the context of the revised approach.

Key Issues

Regional commissioning arrangements for the 999 and 111 contracts have been revisited to reflect the national Integrated Urgent Care (IUC) agenda.

Is your report for Approval / Consideration / Noting

Noting.

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

- Note the progress made to date on developing the needs of IUEC across Y&H.

- Support the 2019/21 Ambulance partnership framework.

- Endorse the Y&H IUEC collaborative commissioning MOU.

- Support the plans to drive forward the strategic intentions and timeline.

What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?

Which of the CCG’s Objectives does this paper support?
This region wide collaborative approach supports the delivery of key national performance targets at place, system and region and specifically risk 1.2 of the CCG ensuring provider performance.

### Description of Assurances for Governing Body
Assurance at place is provided by Sheffield’s Urgent and Emergency Care Transformation Delivery Board, at sub-region via the Urgent and Emergency Care Steering board and at a regional level via the Yorkshire & Humber wide Contract Management Board and Joint Strategic Partnership Panel (see main paper for details).

### Are there any Resource Implications (including Financial, Staffing etc)?
Sheffield CCG is the SYB contracting and commissioning lead.

### Have you carried out an Equality Impact Assessment and is it attached?
Not required. This paper set out joint commissioning arrangements across the region with any service changes subject to EIA as appropriate.

### Have you involved patients, carers and the public in the preparation of the report?
Not required.
Yorkshire and the Humber Collaborative Commissioning – Integrated Urgent & Emergency Care (IUEC)

Governing Body

7 October 2019

1.0 Purpose

The purpose of this paper is to:

- Explain the rationale for revising the Integrated Urgent & Emergency Care (IUEC) commissioning arrangements for Y&H.

- Gain approval from each of the Yorkshire & the Humber (Y&H) Clinical Commissioning Groups (CCGs) commissioning the Yorkshire Ambulance Service (YAS) to provide 999 ambulance and/or Integrated Urgent Care (IUC) services to a revised partnership framework and collaborative commissioning agreement.

- Set out how the IUEC commissioning intentions will be enacted in the context of the revised approach.

2. Background

In the spring of 2016, Y&H CCGs each approved a Governing Body paper setting out the then ambulance commissioning strategy and the associated collaborative commissioning agreements (Memoranda of Understanding (MOU)). The strategy and MOUs have been updated taking into account changes to the evolving commissioning geographies and the journey towards integration captured under the umbrella of Integrated Urgent and Emergency Care (IUEC).

3. What is the scope of integrated urgent and emergency care in Y&H?

IUEC encompasses a wide range of services beyond those directly provided by YAS. A key feature is that no matter whether someone seeking help has done this via 999 or 111 or through NHS 111 on line, the pathway of care should be seamless whether the clinical end point is a service within a primary care network, a GP out of hours service, an acute trust service, a mental health service or some other service. The scope is set out in the partnership framework at Appendix 1.

To ensure this happens changes are being made to back office processes for example, improved access to patient records, improved access to clinical support, the ability to book immediately into appointment slots and access to a wide range of local clinical and social care services on a 24/7 basis.
4. What has been achieved since 2016?

Notable progress has been made in the past three years in respect of ambulance commissioning across Y&H:

a) YAS was rated by the Care Quality Commission (CQC) as ‘requires improvement’ in 2015 and has since been rated as ‘good’.

b) The NHS 111 service in Y&H was launched in 2013 as a stand-alone clinical service for those needing urgent help fast. The service, provided by YAS and commissioned across all Y&H CCGs had become (until the service ceased in March 2019) one of the better performing NHS 111 services in England.

c) Y&H CCGs have, from April 2019, replaced the NHS 111 services with an Integrated Urgent Care (IUC) service. This, in line with national guidance, includes a NHS 111 call handling and clinical advice service (CAS). YAS provide a ‘core’ CAS within the context of a Y&H wide CAS made up of different providers across Y&H (all of whom are expected to work collaboratively). The service reflects our belief that it isn’t about what number has been dialled but what sits behind the entry point.

d) A NHS 111 on line service, which provides an alternative into IUEC without necessarily making a call, is fully available across Y&H.

e) Further investment has been made into YAS 999 services. Y&H CCGs invested £180.2m in 2015/16 into YAS 999 services and this had increased to £211.6m in 2019/20.

f) A Joint Partnership Panel (JPP) was established to coordinate the renegotiation of the 999 contract with YAS. For 2020/21 it will be expanded to cover both the 999 and IUC contracts for 2020/21.

g) The YAS 999 service has evolved in line with the national direction of travel and is fast becoming one of the best performing trusts in England against the new (Ambulance Response Programme (ARP)) national quality indicators. YAS are contracted to provide a service on a Y&H footprint. YAS met all national performance standards in March 2019 with the exception of category 4 (low acuity) where it was 9 seconds off.

h) Y&H commissioners established a Joint Strategic Commissioning Board (JSCB) to oversee the strategic commissioning of IUEC services on a Y&H footprint. This has evolved to become a Joint Strategic Partnership Board (JSPB).

i) Y&H commissioners have established an IUEC Clinical Assurance Group (CAG) in line with national guidance looking along IUEC pathways of care.

j) Y&H CCGs have agreed a revised decision making process for YAS IUEC matters and this is included in a revised collaborative commissioning agreement (Appendix 2) covering YAS 999 and IUC services commissioned from YAS.
5.0 Rationale for revising our commissioning arrangements

The current ambulance commissioning strategy for Y&H was developed in 2016 (extant until April 2019) alongside a MOU for YAS 999 and 111 collaborative commissioning. Together, these frameworks set the broad strategic direction for NHS 111 and 999 commissioning and the associated scheme of delegation for coordinating commissioners and associate CCGs.

Since 2016, four fundamental changes to the commissioning landscape have impacted on ambulance commissioning arrangements, meaning that they required review. These are:

(i) The development of Sustainability Transformation Partnerships (STP) and Integrated Care System (ICS) footprints.

(ii) The requirement to move away from a stand-alone NHS 111 ‘service’ to deployment of the 111 and 999 telephone numbers as a gateway to a single integrated urgent and emergency care system (encompassing multiple providers).

(iii) The implications of the Ambulance Response Programme (ARP) upon existing ambulance operational models, blurring traditional boundaries between A&E and PTS services and requiring greater integration with place based care pathways.

(iv) The publication of a national commissioning framework

6.0 Our New Approach

In context of the above, YAS and commissioners have committed to a more collaborative and strategic approach moving forward. The need to involve a wider range of urgent and emergency care providers and the new approach will see all parties working together to:

- **Vision** - Agree a shared vision for the ambulance service’s role in IUEC, exploring opportunities for greater provider integration beyond traditional organisational or contractual boundaries. This may evolve into a more formal alliance of providers working together. A work programme builds upon a joint set of commissioning intentions, key phases of work with appropriate linkages to STP/ICS plans and milestones to transform the service as part of an IUEC system.

- **Action** – Provide strategic level oversight and assurance to the development (through contract management board) of (i) investment to deliver the ambulance service.
response standards (ARP) and (ii) transformation of the ambulance service to achieve the aims of IUEC as part of the whole system

- **Evaluation** - Agree a shared set of metrics which we will collectively use to evaluate the system-wide impact of investment and resultant transformation as well as overall demand and performance of the ambulance service.

**Role of the Joint Strategic Partnership Board (JSPB)**

In light of an agreement reached at a joint workshop with Y&H commissioners and YAS in June 2018, it was agreed that we continue to develop a more partnership approach at JSCB - now to be renamed JSPB - and contractual matters are to be taken through the IUEC Contract Management Board (CMB).

The role of the JSPB will be to provide strategic oversight and assurance in relation to investment decisions and delivery plans implemented through the CMBs. This approach will specifically encompass:

- Oversight of the delivery of the commissioners strategic intentions
- Co-production and assurance of delivery of the providers responses to the agreed commissioning intentions as a whole system
- Oversight of the national IUC and 999 specification and associated performance standards

The revised JSPB arrangements will aim to address and balance multiple and potentially conflicting requirements as follows:

- The need for commissioning and for Y&H IUEC provider organisations to collaborate to deliver genuine transformation of health and social care systems
- The need to appropriately reflect and balance a diversity of requirements, models and views including regional resilience, STP / ICS / NHS E and place based delivery plans
- The need to maintain separate contract governance arrangements for IUEC and PTS and other services contributing to our integrated urgent and emergency care system in order to provide assurance to commissioners

The JSPB will support the development of trust and transparency across all parties through:

- Appropriate senior leadership and stewardship
- Wider system engagement
- Clear and co-ordinated work plans with the IUEC CMB, ensuring a strong evidence base to inform decision-making
- Senior and consistent representation at relevant groups
- Consistent engagement with STP/ICS Urgent & Emergency Care Programme Boards/Networks
Revised governance arrangements

The onus is on the sub-regional representative at both the JSPB and CMB meetings to bring a mandate for the area they represent and to have fully discussed the financial implications of any recommendations prior to the meetings of the JSCB. Sub-regional groups, where these exist, need to gather intelligence from their ICS/STP partnership boards and networks thereby informing the JSPB. The JSPB membership sets the strategy and it is enacted through the IUEC CMB and the IUEC Development Group. This ensures there is a bottom up approach connecting sub-regional leadership across Y&H.

A scheme of delegation (to coordinating commissioner(s)) incorporated within a revised Y&H IUEC collaborative commissioning MOU will reflect that decisions with financial implications will be made at ICS/STP and CCG level.

A revised governance structure for joint strategic commissioning of the ambulance service and IUEC is shown at Appendix 3. The arrangements are reflected in the revised terms of reference for each group. The structure and membership of each group aims to reconcile the need for regional and sub-regional discussions, and the need to develop a transformational dialogue alongside the performance management arrangements already in place.

Sitting below the JSPB the key groups include:

<table>
<thead>
<tr>
<th>Group</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y&amp;H IUEC Development Group (SG)</td>
<td>Monthly as required</td>
<td>Service and clinical development</td>
</tr>
<tr>
<td>Y&amp;H IUEC Contract Management Board (CMB)</td>
<td>Bi-monthly</td>
<td>Contractual matters</td>
</tr>
<tr>
<td>Y&amp;H IUEC Clinical Assurance Group (CAG)</td>
<td>Bi-monthly</td>
<td>Quality and patient safety along the total pathway of care</td>
</tr>
<tr>
<td>YAS Joint Partnership Panel (JPP)</td>
<td>Fortnightly as required during the period of contract negotiations</td>
<td>Task and finish group overseeing contract negotiations for the YAS 999 and IUC contracts</td>
</tr>
</tbody>
</table>

The responsibility for meeting our obligations for place based patient and public engagement lies with local system leaders. Service reconfiguration and development will be clinically led using the skills and experience of our local teams.

New commissioning intentions 2019/21

Appendix 1 sets out the Y&H partnership framework (commissioning intentions) for IUEC for the three years 2019-21. We intend that the JSPB owns the framework for the IUEC system across Y&H. Strategic decisions will therefore be enacted at this level.
7.0 How we aim to execute the strategy

A work programme (Appendix 4) owned by the ICS/STPs and NHS E, covering the key IUEC transformation priorities for 2019/20 has been developed and implemented overseen through the IUEC CMB with key milestones and risks overseen by JSPB.

Following the publication of the NHS England national ambulance commissioning framework a review was undertaken by Audit Yorkshire of the Y&H IUEC contracting and commissioning support functions. A plan to take forward the recommendations, published in May 2019, is being developed and will be brought to a future JSPB meeting.

This paper was approved in draft by the Y&H JSPB in June 2019.

8.0 Recommendations

Members of the Governing body are asked to:

- Note the progress made to date on developing the needs of IUEC across Y&H
- Support the 2019/21 Ambulance partnership framework
- Endorse the Y&H IUEC collaborative commissioning MOU
- Support the plans to drive forward the strategic intentions and timeline

Appendices

Appendix 1: Y&H IUEC strategic partnership framework 2019-21
Appendix 2: Y&H IUEC collaborative commissioning MOU
Appendix 3: Y&H IUEC governance structure
Appendix 4: JSPB work programme 2019/20
Memorandum of Understanding

for the

Collaborative Commissioning of Integrated Urgent and Emergency Care Services

Between

Clinical Commissioning Groups

Across

Yorkshire and the Humber

11th September 2019

This agreement is dated the 11th day of September 2019

between

The Clinical Commissioning Groups listed in Schedule 5, each a "Party" and together the "Parties".
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1. **Introduction and background**

1.1. The Clinical Commissioning Groups (CCGs) across Yorkshire and the Humber (Y&H) share a vision to deliver the best possible care and outcomes for their local populations. This Memorandum of Understanding sets out how the CCGs will work together to commission integrated urgent and emergency care services.

1.2. The CCGs have worked together over a number of years to plan, procure and manage the performance of integrated urgent and emergency care services. The establishment of Integrated Care Systems/Sustainability and Transformation Partnerships (ICS/STPs) has changed the architecture that supports this collaborative working.

1.3. The Partiers have agreed to develop this revised Memorandum of Understanding to clarify collaborative decision making and strengthen joint working arrangements. The Parties have agreed that they will use the governance arrangements in their respective ICS/STP to agree an ICS/STP level position on all relevant decisions. The Y&H Joint Strategic Partnership Board (JSPB) will act as the forum for bringing together ICS/STP positions into a collaborative decision across Yorkshire and Humber. This Agreement also underpins the wider governance arrangements that have been established across Y&H and which are set out at Schedule 3.3.

1.4. This Agreement shall commence on the date of signature of the Parties and will be reviewed annually.

2. **The services**

2.1. This Agreement sets out a framework for collaborative decision-making for commissioning Integrated Urgent and Emergency Care Services. Not all of the Parties commission all of these services collaboratively in Yorkshire and Humber. The Parties, and which services they commission collaboratively, are set out in Schedule 5.

2.2. NHS Greater Huddersfield CCG, on behalf of those Parties indicated in Schedule 5, is a signatory to a single contract with Yorkshire Ambulance Service NHS Trust for the provision of Integrated Urgent Care (IUC) services in each Party’s area.

2.3. NHS Wakefield CCG, on behalf of those Parties indicated in Schedule 5, is a signatory to a single contract with Yorkshire Ambulance Service NHS Trust for the provision of 999 services in each Party’s area.

2.4. For the avoidance of doubt, this Agreement covers only those services that are commissioned jointly. It excludes all services that are commissioned locally by the Parties.

3. **Objectives**

3.1. The overarching objective of this Agreement is to enable the collaborative commission of Integrated Urgent and Emergency Care Services which meet the health needs of the people of Yorkshire and Humber, in accordance with local and ICS/STP plans.
3.2. This collaborative approach will enable the Parties to take a strategic view of issues affecting local populations, ensuring a clear focus on health outcomes. It will enable the integration of other health and social care services to achieve the outcomes set out in relevant ICS/STP strategic system plans, and/or Urgent and Emergency Care Network (UECN) delivery plans.

3.3. It will enable the delivery of the national Integrated Urgent Care and urgent and emergency ambulance specifications and ensure that services meet all relevant national standards and guidance and that:

- services provide the best possible performance and quality
- services are cost effective and provide best value for money
- patients, service users, their carers and families have been appropriately engaged

4. Decision-making and resolving disagreements

4.1. The Parties agree that there are two different levels of decision-making covered by this agreement and set out in Schedule 4 - CCG decisions made in collaboration and Lead Contractor decisions. Decisions on matters which relate only to one Party are reserved to that Party.

CCG decisions made in collaboration

4.2. The Parties agree to establish ICS/STPs as the forums for establishing a collective view. They agree that they will use the governance and decision-making arrangements in their respective ICS/STP to agree an ICS/STP level position on the collaborative decisions set out in Schedule 4. The Y&H Joint Strategic Partnership Board will act as the forum for bringing together these ICS/STP positions. The terms of reference of the JSPB are set out in Schedule 3.

4.3. The agreed decision making process is as follows:

- Each ICS/STP will agree a collective ICS/STP level view, using the decision making mechanisms of that ICS/STP (for example, a Joint Committee of CCGs)

- The views of each ICS/STP will be brought together at Yorkshire and Humber level for consideration by the JSPB.

- For a collaborative decision to be agreed across Yorkshire and Humber, unanimity will be required across all ICS/STP areas. (For the avoidance of doubt, this means that each ICS/STP has an equal veto on any proposal)

- Where the JSPB is unable to agree a collaborative position across Yorkshire Humber, the dispute resolution set out in Clauses 4.9-4.11 will be applied.
4.4. The Parties agree that this approach is compatible with, but does not require, formal delegation by the Parties of their commissioning responsibilities to an ICS/STP forum. The Parties acknowledge that in the absence of formal delegation, decisions remain reserved to each CCG, but agree that they will make every endeavour to agree a common position through their ICS/STP governance arrangements.

4.5. The Parties agree that, over time, and where not already in place, they will move towards formal delegation to an ICS/STP forum.

4.6. The Parties agree that this approach relies on a shared commitment to collaborative working and that they will work in accordance with the roles and responsibilities set out in Section 5 and the principles and behaviours set out in Section 6. The Parties agree that the dispute resolution procedure at Clauses 4.9-4.11 will be applied if collaborative agreement cannot be reached.

**Lead Contractor Decisions**

4.7. Each Party agrees to ensure that the matters set out as Lead Contractor Decisions in Schedule 4 are delegated effectively and lawfully to the Lead Contractor. The Parties acknowledge that the Lead Contractor is able to:

- make Lead Contractor Decisions and such decisions will bind all of the Parties;
- take appropriate action under the Commissioning Contract in relation to Lead Contractor Decisions without reference to the Parties or the Lead Officers

4.8. The Lead Contractor shall chair meetings of the Contract Management Board (CMB), through which the Provider shall be held to account, for example by developing improvement plans with providers, including hospital trusts, integrated care organisations and primary care networks via the appropriate ICS/STP representative. The CMB shall not have any authority in and of itself to make decisions which bind the Parties, it is a forum in which:

- Lead Contractor Decisions may be made and/or implemented by the Lead Contractor; and
- CCG Decisions made in collaboration may be implemented by the Lead Contractor.

The Terms of Reference of the CMB are attached at Schedule 3.2.

**Dispute resolution**

4.9. Where any dispute arises between the Parties (including the Lead Contractor) the Parties must use their best endeavours to resolve that dispute informally.

4.10. If any dispute is not resolved under Clause 4.9, any Party in dispute may refer the dispute to the Chief Officers of the relevant Parties, who will co-operate to recommend a resolution to the dispute within ten (10) Working Days of the referral.
4.11. Where any dispute is not resolved under Clauses 4.9 or 4.10, any Party in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the Parties in dispute.

5. **Roles and responsibilities**

5.1. Each Party will:

- participate in discussions at meetings of the ICS/STP of which they are a member;

- agree with other members of the relevant ICS/STP two representatives ("Lead Officers", as set out at Schedule 2), ideally one clinical and one managerial, to represent the ICS/STP at meetings of the JSPB;

- ensure the relevant Lead Officers have considered all documentation and are fully prepared to discuss matters at meetings of the JSPB;

- make all reasonable efforts to require their Lead Officers to inform the other Lead Officers in advance if a relevant Lead Officer is unable to attend meetings of the JSPB;

- ensure its Lead Officers engage with all other Lead Officers and attendees, if relevant, in matters related to this Agreement;

- communicate openly and in a timely manner about concerns, issues or opportunities relating to this Agreement; and

- respond promptly to all requests for, and promptly offer, information or proposals relevant to the operation of the Collaboration.

The Lead Contractor

5.2. The Lead Contractor, on behalf of the Parties, will focus on transactional and contract management matters in relation to the Commissioning Contract. In line with Schedule 4 (Scheme of Delegation), the Lead Contractor, will manage and maintain the Commissioning Contract. It will monitor quality, activity and finance so as to obtain best performance, quality and value from the Services on behalf of the Parties. The Lead Contractor will act reasonably in undertaking its role and will have regard to guidance from the JSPB in exercising its delegated authority.

5.3. The Lead Contractor shall chair the Contract Management Board, which shall be the primary mechanism through which the Lead Contractor will hold the Provider to account on behalf of the Parties and enact Lead Contractor Decisions and CCG Decisions made in collaboration.
6. **How the parties will work together**

**Principles**

6.1. The Parties have agreed a set of principles and behaviours that shape how they will work in collaboration. They will:

- act in the best interests of patients and the public;
- work toward a reduction in health inequality and improvement in health and well-being;
- focus on quality;
- seek best value for money, productivity and effectiveness;
- act in good faith and behave in a positive, proactive and inclusive manner;
- learn from best practice and seek to develop as a collaborative to achieve the full potential of the relationship;
- share information and resources and work collaboratively to identify solutions, eliminate duplication, mitigate risk and reduce cost; and
- promote innovation and develop towards a level of commissioning that is equal to best international practice.

**Ways of working**

6.2. The Parties agree to adopt ways of working that support this collaborative approach. They will account to the other Parties for the performance of their respective roles and responsibilities set out in Clause 5.1. In particular they will:

- feed back in a timely way on all relevant ICS/STP level discussions and require their respective ICS/STP leads to respond in a timely way to draft Yorkshire and Humber-level documents and proposals.
- highlight at an early stage any issues where they envisage difficulties in agreeing a common position across Yorkshire and Humber and, where appropriate, propose an alternative approach.

6.3. To support this way of working, proposals and documents presented to the Parties and their respective ICS/STP leads for comment and response shall be concise and indicate clearly the action required and timescales for response.

**7. Collaborative costs and resources**

7.1. The Parties agree to make payments due in accordance with the provisions of the Commissioning Contract/s.

7.2. Parties to the 999 Commissioning Contract will set aside £22,000 per year to reimburse costs incurred by the Lead Contractor as set out at 7.3 below. Parties which are not parties to the 999 Commissioning Contract each agree to set aside £11,000 per year to reimburse costs incurred by the Lead Contractor as set out at 7.3. below.
7.3. The Lead Contractor will agree and pay the following costs in respect of the Collaborative:

- audit fees;
- legal fees;
- fees for consultancy fees including expenses;
- booking of facilities for meetings of the JSPB; and
- fees relating to initiatives and contributions to support the National Ambulance Commissioners Network.

7.4. The Lead Contractor shall pay such costs incurred as set out in Clause 7.3 and recharge each Party its share of the costs proportionately according to the relevant Party’s CCG population as a proportion of the total population of all of the CCGs combined.

7.5. Staff costs associated with the management of the Commissioning Contract will be managed separately to the costs set out in Clause 7.3. Each Party agrees to pay their share of the costs proportionately according to the Party’s CCG population as a proportion of the total population of all of the CCGs.

7.6. The Parties shall ensure prompt payment of their share of such costs set out in this Clause 7.1 to the Lead Contractor and in any event shall pay such shares within 30 days of receipt of a claim for payment from the Lead Contractor.

8. Charges and liabilities

8.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement. Parties shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

9. Variations, joining the collaborative and termination

9.1. This Agreement, including the Schedules, may only be varied by written agreement of all the Parties.

9.2. The Parties may agree to include additional CCGs as Parties. In such cases, the Parties will cooperate to enter into the necessary documentation and revisions to this Agreement if required.

9.3. Where a Party terminates its participation in the Commissioning Contract/s, that Party’s participation in this Agreement shall automatically terminate on the same date. Any Party may terminate its participation in this Agreement by giving the other Parties notice in writing.

9.4. In the event that this Agreement expires, is terminated (whether in full or in part) or a Party leaves the Collaborative (the "Exiting Party"), the Parties agree to cooperate to ensure an orderly wind down of their joint activities as set out in this Agreement.
9.5. The Parties shall at all times act in such a manner as not to adversely affect the delivery of the Services.

10. **Confidential Information and data protection**

10.1. Except as required by law, each Party agrees at all times to keep confidential any and all information, data and material which that Party may receive or obtain in connection with the operation of this Agreement.

10.2. The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions to enable the efficient operation of the Collaborative.

10.3. The Parties acknowledge their respective duties under the Data Protection Act (DPA) and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties. The Parties shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation.

11. **Freedom of information**

11.1. Each Party acknowledges that the other Parties are subject to the requirements of the Freedom of Information Act and each Party shall assist and co-operate with the others (at their own expense) to enable the other Parties to comply with their information disclosure obligations.

12. **Status**

12.1. The Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this Agreement shall be treated as an NHS Contract and shall not be legally enforceable.

12.2. Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render any Party directly liable to any third party for the debts, liabilities or obligations of any other Party.

13. **Signatures**

13.1. This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same document.

13.2. The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

13.3. No counterpart shall be effective until each Party has executed at least one counterpart.
This Agreement is effective on the date stated at the beginning of it.

IN WITNESS OF WHICH the Parties have signed this Agreement on the date shown below

HUMBER COAST AND VALE

NHS EAST RIDING OF YORKSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS HULL
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS NORTH EAST LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS NORTH LINCOLNSHIRE
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS SCARBOROUGH AND RYEDALE
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date

NHS VALE OF YORK
CLINICAL COMMISSIONING GROUP
Authorised Officer  Date
**Schedule 1**

**Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>“Agreement”</td>
<td>This agreement between the Parties, comprising the Memorandum of Understanding together with all Schedules.</td>
</tr>
<tr>
<td>“CCG decisions made in collaboration”</td>
<td>Has the meaning set out in Schedule 4.</td>
</tr>
<tr>
<td>“CMB”</td>
<td>The Yorkshire and Humber Contract Management Board, the role and Terms of Reference for which are set out in Schedule 3.2.</td>
</tr>
<tr>
<td>“Commissioning contract/s”</td>
<td>The contract between NHS Greater Huddersfield CCG and the Parties indicated in Schedule 5 for the provision of Integrated Care Services in each Party’s area.</td>
</tr>
<tr>
<td></td>
<td>The contract between NHS Wakefield CCG and the Parties indicated in Schedule 5 for the provision of 999 services in each Party’s area.</td>
</tr>
<tr>
<td>“Dispute resolution”</td>
<td>Has the meaning set out in Clauses 4.9-4.11</td>
</tr>
<tr>
<td>“ICS/STP”</td>
<td>The health and care partnerships in:</td>
</tr>
<tr>
<td></td>
<td>• Humber, Coast and Vale</td>
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<tr>
<td></td>
<td>• South Yorkshire and Bassetlaw</td>
</tr>
<tr>
<td></td>
<td>• Wet Yorkshire and Harrogate.</td>
</tr>
<tr>
<td>“JSPB”</td>
<td>The Yorkshire and Humber Joint Strategic Partnership Board, the role and Terms of Reference for which are set out in Schedule 3.1.</td>
</tr>
<tr>
<td>“Lead Contractor/s”</td>
<td>NHS Greater Huddersfield CCG for the provision of Integrated Care Services.</td>
</tr>
<tr>
<td></td>
<td>NHS Wakefield CCG for the provision of 999 services.</td>
</tr>
<tr>
<td>“Lead Contractor decisions”</td>
<td>Has the meaning set out in Schedule 4.</td>
</tr>
<tr>
<td>“Lead Officer”</td>
<td>The 2 representatives who represent their respective ICS/STP at meetings of the JSPB, as set out at Schedule 2.</td>
</tr>
<tr>
<td>“Provider”</td>
<td>Yorkshire Ambulance Service NHS Trust</td>
</tr>
</tbody>
</table>
Schedule 2
Lead Officers for ICS/STP sub-regional footprints

1. Parties

The table below sets out the ICS/STPs, the managerial and clinical Lead Officers for each ICS/STP and the Parties that are included in each ICS/STP and are represented by the Lead Officers:

<table>
<thead>
<tr>
<th>ICS/STP</th>
<th>Contact details of Lead Officers</th>
<th>Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humber Coast and Vale</td>
<td>Clinical lead</td>
<td>NHS East Riding of Yorkshire Clinical Commissioning Group (&quot;East Riding of Yorkshire CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Andrew Phillips</td>
<td>NHS Hull Clinical Commissioning Group (&quot;Hull CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:andrew.phillips4@nhs.net">andrew.phillips4@nhs.net</a></td>
<td>NHS North East Lincolnshire Clinical Commissioning Group (&quot;North East Lincolnshire CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Managerial lead</td>
<td>NHS North Lincolnshire Clinical Commissioning Group (&quot;North Lincolnshire CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Richard Dodson</td>
<td>NHS Scarborough and Ryedale Clinical Commissioning Group (&quot;Scarborough and Ryedale CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:richard.dodson@nhs.net">richard.dodson@nhs.net</a></td>
<td>NHS Vale of York Clinical Commissioning Group (&quot;Vale of York CCG&quot;)</td>
</tr>
<tr>
<td>South Yorkshire and Bassetlaw</td>
<td>Clinical lead</td>
<td>NHS Barnsley Clinical Commissioning Group (&quot;Barnsley CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
<td>NHS Bassetlaw Clinical Commissioning Group (&quot;Bassetlaw CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Managerial lead</td>
<td>NHS Doncaster Clinical Commissioning Group (&quot;Doncaster CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
<td>NHS Rotherham Clinical Commissioning Group (&quot;Rotherham CCG&quot;)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Sheffield Clinical Commissioning Group (&quot;Sheffield CCG&quot;)</td>
</tr>
<tr>
<td>West Yorkshire and Harrogate</td>
<td>Clinical lead</td>
<td>Managerial lead</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Adam Sheppard</td>
<td>Email:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Adam.Sheppard@wakefieldccg.nhs.uk">Adam.Sheppard@wakefieldccg.nhs.uk</a></td>
</tr>
</tbody>
</table>

NHS Airedale, Wharfedale and Craven Clinical Commissioning Group ("Airedale, Wharfedale and Craven CCG")

NHS Bradford City Clinical Commissioning Group ("Bradford City CCG")

NHS Bradford Districts Clinical Commissioning Group ("Bradford Districts CCG")

NHS Calderdale Clinical Commissioning Group ("Calderdale CCG")

NHS Greater Huddersfield Clinical Commissioning Group ("Greater Huddersfield CCG")

NHS Harrogate and Rural District Clinical Commissioning Group ("Harrogate and Rural District CCG")

NHS Leeds Clinical Commissioning Group ("Leeds CCG")

NHS North Kirklees Clinical Commissioning Group ("North Kirklees CCG")

NHS Wakefield Clinical Commissioning Group ("Wakefield CCG")

For IUC/999 decision-making only:

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group ("Hambleton, Richmondshire and Whitby CCG")
Schedule 3.1
Yorkshire and Humber Clinical Commissioning Groups/ICS/STP

Yorkshire and Humber Joint Strategic Partnership Board

Terms of Reference

<table>
<thead>
<tr>
<th>Name of Group:</th>
<th>Yorkshire and Humber Joint Strategic Partnership Board (Y&amp;H JSPB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Definitions:</td>
<td>Yorkshire and Humber Joint Commissioning Committees</td>
</tr>
<tr>
<td>Accountable To:</td>
<td>Yorkshire and Humber Joint Commissioning Committees</td>
</tr>
<tr>
<td>Role and Purpose:</td>
<td>The primary role of the JSPB shall be to determine transformational decisions regarding the Services, including:</td>
</tr>
<tr>
<td></td>
<td>• Oversight of the delivery of the commissioners strategic intentions;</td>
</tr>
<tr>
<td></td>
<td>• Co-production and assurance of delivery of the providers responses to the agreed commissioning intentions as a whole system;</td>
</tr>
<tr>
<td></td>
<td>• Delivery of the national IUC specification and associated performance standards for clinical advice and direct booking;</td>
</tr>
<tr>
<td></td>
<td>• the medium to long term planning for the integration of the Service; and</td>
</tr>
<tr>
<td></td>
<td>• service redesign to further integrate the Services with other health and social care services to achieve the outcomes set out in the relevant Sustainability and Transformation Plans and associated Digital Roadmaps and Urgent and Emergency Care Network Delivery plans of the Parties.</td>
</tr>
<tr>
<td></td>
<td>Patient transport services are excluded from the remit of the JSPB except insofar as they have an impact on the services in scope.</td>
</tr>
<tr>
<td>Accountability and Reporting:</td>
<td>In accordance with this Agreement the JSPB will undertake the following actions:</td>
</tr>
<tr>
<td></td>
<td>Planning for the provision and transformation of the Services to meet the health needs of the relevant local population on a place basis in accordance with the local ICS/STP plans and respective commissioning intentions and ambitions;</td>
</tr>
<tr>
<td></td>
<td>Oversight of Strategic Commissioning Intentions of the CCGs in Yorkshire and the Humber in relation to work undertaken around Urgent and Emergency Care Networks, including Ambulance Services;</td>
</tr>
<tr>
<td></td>
<td>Ensure that strategic intent agreed by the CCGs in Yorkshire and the Humber is captured and reflected contractually; and</td>
</tr>
<tr>
<td></td>
<td>Consider different delivery models to seek to provide equity of performance across both urban and rural area.</td>
</tr>
<tr>
<td>Accountability and Reporting:</td>
<td>The JSCB is accountable to the Y&amp;H CCGs on financial matters and will provide copies of approved meeting minutes to JSPB members to inform commissioning decisions.</td>
</tr>
</tbody>
</table>
| Chair and Membership:  | Chairperson
|                        | A representative of the YAS 999 or IUC coordinating commissioner will be responsible for chairing the CMB. |
|                        | Membership
|                        | The Core membership is as described below. In the event that a member is unable to attend an appropriate deputy should represent them. Members are expected to make all reasonable efforts to attend meetings. |
| **Conduct:** | Members of the JSPB and those in attendance will abide by the ‘Principles of Public Life’ (The Nolan Principles) and the NHS Code of Conduct and the Standards for members of NHS boards and governing bodies, Citizen’s Charter and Code of Practice on Access to Government Information.

All members will have due regard to, and operate within, the prime financial policies, Standing Orders, the constitution and other policies and procedures of their employing organisation. |
| **Voting:** | Each two Lead Officers from each ICS/STP shall have one vote between them. If the Chief Officers of the two Lead Commissioner / Contractors are members of the JSPB (but not Lead Officers) then they will not have a vote. The Parties acknowledge that there needs to be unanimity across all Lead Officers in order for JSPB Decisions to be determined. Where unanimity is not reached, the Parties agree that the matter will be referred to dispute resolution. Decisions regarding finance and investment that affect only that Party will be made by each Party. |
| **Quoracy:** | Meetings shall be quorate when the Chair, a YAS executive Director and a representative of each ICS/STP are present. In circumstances where a Lead Officer is unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the Chair of their nominating ICS/STP may send to a meeting of the JSPB a deputy (a "Deputy") to take the place of a Lead Officer. Where a Deputy is sent to take the place of the Lead Officer, references in these terms of reference to Lead Officer shall be read as references to the Deputy. Members of the JSPB may participate in meetings by telephone or by the use of video conferencing facilities where they are available and with prior agreement from the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. |

Apologies for absence from meetings shall be notified, in advance of the relevant meeting wherever possible, to either the Chair or administrative support and will be formally recorded in the minutes. Non-attendance were apologies have not been received will also be formally recorded.

- CEO YAS
- Director of Urgent Care & Integration YAS
- Medical Director YAS
- Director of Operations YAS
- Provider lead clinician – NHS 111 call handling and core clinical advice service
- AO Coordinating commissioner - YAS
- AO Coordinating commissioner - NHS 111 call answering and core CAS
- SYB Representatives: CCG JCC representative and ICS UEC representative
- HCV Representatives: CCG JCC representative and ICS UEC representative
- WYH Representatives: CCG JCC representative and ICS UEC representative
- HRW CCG representative on behalf of the D, D, T, H,R and W STP
- Y&H Programme Lead – IUEC & YAS Commissioning
- ICS/STP clinical leaders x 3
- NHS England Commissioning Representative
- NHS England by invitation
<table>
<thead>
<tr>
<th>Servicing and Administration:</th>
<th>NHS Wakefield CCG will service the meetings. Meetings will be formally recorded. Finalised meeting agendas, previous draft minutes and papers will be circulated to members at least five working days in advance of the meeting. All parties may submit agenda items for inclusion with a view to agreeing a joint agenda. The final agenda for each JSPB meeting will be agreed by the Chair prior to circulation to the wider group membership. Each party will nominate a representative who will be responsible for agreement of the agenda on behalf of their organisation. Minutes will be drafted within five working days following the meeting and approved by the Chair for sharing with the Members within 7 working days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declarations of Interest:</td>
<td>Declarations of Interest will be made at the first meeting and amendments/changes requested at subsequent meetings. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Board’s consideration has been completed. Declaration of interest will be a standing agenda item at every meeting. A Declaration of Interest (DOI) Register will be maintained and updated according.</td>
</tr>
<tr>
<td>Distribution of Minutes:</td>
<td>Minutes will be circulated to JSPB members.</td>
</tr>
<tr>
<td>Frequency of Meetings:</td>
<td>Bi-monthly as appropriate. Meetings will be booked annually in advance of the start of the financial year, and a schedule of meetings circulated to all members.</td>
</tr>
<tr>
<td>Linkages with other for a including sub-groups:</td>
<td>The JSPB has the authority to establish formal sub-groups and/or short-term working groups as and when required to support the effective delivery of the contract. The scope, membership and frequency of any such groups must be jointly agreed by the Coordinating Commissioner and Provider prior to commencement of the group. The JSPB may receive matters from the IUEC Programme Steering Group in reference to the design and delivery of integrated urgent and emergency care services. The JSPB will receive feedback, as appropriate, from any sub regional fora such as local IUEC quality and performance groups, A&amp;E Delivery Board or UECNs. In this instance the relevant representative will be invited to attend the JSPB.</td>
</tr>
<tr>
<td>Monitoring and Compliance:</td>
<td>An annual work programme will be developed to monitor the operation and effectiveness of the JSPB.</td>
</tr>
<tr>
<td>Review Date:</td>
<td>These Terms of reference will be reviewed annually, or as and when legislation or best practice guidance is updated. Any amended Terms of Reference will be agreed by the Board prior to sharing. The next scheduled review date is September 2020</td>
</tr>
<tr>
<td>Date of Approval:</td>
<td>These Terms of Reference have been approved and signed off by on the 2019</td>
</tr>
</tbody>
</table>
## Terms of Reference

<table>
<thead>
<tr>
<th>Name of Group:</th>
<th>Yorkshire and Humber IUEC Contract Management Board (YAS IUEC CMB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Definitions:</td>
<td>The Coordinating Commissioners – NHS Wakefield and NHS Greater Huddersfield CCGs will act as a Coordinating Commissioner to bring together commissioners from across the Yorkshire and Humber region to deliver a coordinated YAS IUEC contract management function.</td>
</tr>
<tr>
<td>Accountable To:</td>
<td>Yorkshire and Humber Joint Strategic Partnership Board (Y&amp;H JSPB).</td>
</tr>
<tr>
<td>Role and Purpose:</td>
<td>The primary purpose of the YAS IUEC CMB will be overseeing the management of the contracts between Yorkshire &amp; Humber commissioners and Yorkshire Ambulance Service NHS Trust, for the provision of IUEC services. This includes responsibility for two distinct service contracts:</td>
</tr>
<tr>
<td></td>
<td>• Yorkshire and Humber 999 Service</td>
</tr>
<tr>
<td></td>
<td>• Yorkshire &amp; Humber Integrated Urgent Care: 111 Call Handling &amp; Core Clinical Advice Service</td>
</tr>
<tr>
<td></td>
<td><em>It is recognised that the geographic boundaries and relevant commissioners for each service will differ. Whilst the IUEC CMB is a single body, it will at all times ensure that these differences in contractual scope are recognised and respected. This will include ensuring that decision making reflects the different constituencies and requirements of each contract, and that particular attention is paid to areas where only one contract may apply.</em></td>
</tr>
<tr>
<td></td>
<td>The YAS IUEC CMB will be responsible for the overall governance of the above contracts, ensuring that service performance, quality and delivery of outcomes are in accordance with the terms of each agreement.</td>
</tr>
<tr>
<td></td>
<td>In particular CMB will:</td>
</tr>
<tr>
<td></td>
<td>• Provide Executive Director leadership for the governance of each contract, including oversight of service activity, quality, finance and performance, and joint management of arising issues.</td>
</tr>
<tr>
<td></td>
<td>• Work in partnership to provide a robust and consistent approach to contract management in compliance with the governance requirements of the NHS Standard Contract and national guidance. Work in conjunction with the Joint Strategic Partnership Board (JSPB) to develop and implement the strategic direction for IUEC Services in Yorkshire and Humber, including service developments and compliance with local, regional and national strategic aims.</td>
</tr>
</tbody>
</table>
Responsibilities:

- Make recommendations to Y&H JSPB regarding strategic direction and priorities for service development and/or investment.
- Ensure appropriate communication between the Commissioners of each service, as well as the Y&H JSPB, Y&H Urgent and Emergency Care Networks (UECNs) and other local fora.

The YAS IUEC CMB has responsibility for:

**Contract Assurance**

- Review, on an exceptions basis (where the likely impact is considered to be material), contract performance including local and national performance requirements, quality indicators, CQUIN and activity and finance, as set out within each contract.
- Monitor the progress of the delivery of agreed service developments through service development and implementation plans.
- Monitor information and data quality under the provisions of the contracts, ensuring delivery of agreed data quality implementation plans.
- Ensure that provider and commissioner adhere to national tariff and planning guidance, as applicable; and jointly agree any local deviations. Resolve pricing and activity queries for locally priced activity.
- Receive reports and review any recommendations made by the Y&H Clinical Assurance Group (CAG) with regard to service quality and risks, including: complaints, incidents, compliance with contract quality and patient safety standards, as well as input from regulators and professional bodies.
- Oversee reconciliation processes associated with contract finance and activity plans, CQUIN or local incentive schemes, as appropriate for the terms of each agreement.

**Contract Development**

- Identify contractual priorities and ensure the development of revised specifications for incorporation into the contracts.
- Oversee the effective implementation of relevant national guidance, service developments and performance standards.

**Performance Management**

- Receive escalation reports from other relevant groups e.g. CAG, or directly from either party, where quality or performance deviates materially from agreed standards and specifications, investigate the causes and agree remedial actions including regular reporting where appropriate.
- Oversee any contractual performance management process and monitor delivery of any actions agreed to resolve contractual notices.
• Receive regular reports on progress against current Remedial Action to ensure delivery of actions agreed within Remedial Action Plans and where necessary ensure that non-compliance is escalated within their respective organisations and mitigation is put in place where actions and not delivered.

**Contract Variations**
• Track the progress of contract variations and ensuring any variations follow agreed contractual processes and timescales; ratifying contract variations where appropriate.

**Contract Negotiation**
• Provide oversight of any contract negotiation process, including identification of key negotiation priorities and establishment of negotiation teams / working groups as required.

**Accountability and Reporting:**
The YAS IUEC CMB is accountable to the Y&H JSPB and will provide copies of approved meeting minutes to the JSPB to inform commissioning decisions.

See the June 2019 organisational chart.

**Chair and Membership:**

**Chairperson**
A representative of one of the coordinating commissioner (s) will be responsible for Chairing the CMB.

**Membership**
The Core membership is as described below. In the event that a member is unable to attend an appropriate deputy should represent them. Members are expected to make all reasonable efforts to attend meetings although a dial in facility may be provided upon request.

Apologies for absence from meetings shall be notified, in advance of the relevant meeting wherever possible, to either the Chair or administrative support and will be formally recorded in the minutes. Non-attendance were apologies have not been received will also be formally recorded.

**YAS IUEC CMB Membership**

| On behalf of Commissioners | Chief Finance Officer Coordinating Commissioner  
| Y&H IUEC Programme Lead  
| IUEC quality lead  
| 999/IUEC Contracts lead  
| 999/IUEC Finance lead  
| Nominated representatives – WYH, SYB and HCV ICS/STPs  
| Coordinating commissioner – Director of Quality  
| Other commissioning representatives as required  
| NHSs England  
| NHS England (dental) |
| Conduct: | Director of Finance  
          | Operational Director  
          | Director of Quality, Governance & Performance Assurance  
          | Contracts Lead  
          | YAS representatives (999 and IUC) including clinical representation |

It is essential that place/sub-regional discussions (which will be within sub committees of local Urgent and Emergency Care Programme Boards (UEPB)) and those within NHS E Dental are appropriately reflected in CMB and JSPB.

**Commissioner representation**
Each ICS/STP footprint is required to send one representative at Executive Director level to the IUEC CMB meetings. This person is also responsible for liaison on IUEC matters across their UECN/STP/ICS footprint.

**Conduct:**
Members of the YAS IUEC CMB and those in attendance will abide by the ‘Principles of Public Life’ (The Nolan Principles) and the NHS Code of Conduct and the Standards for members of NHS boards and governing bodies, Citizen’s Charter and Code of Practice on Access to Government Information. All members will have due regard to, and operate within, the prime financial policies, Standing Orders, the constitution and other policies and procedures of their employing organisation.

**Quoracy:**
The YAS IUEC CMB will be quorate with at least one Executive Director from the coordinating commissioners and at least two representatives from any other Y&H CCG/ACS/STP footprint and one YAS Executive Director.

Members of the YAS IUEC CMB may participate in meetings by telephone or by the use of video conferencing facilities where they are available and with prior agreement from the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

**Servicing and Administration:**
NHS Greater Huddersfield CCG will service the meetings. Meetings will be formally recorded. Finalised meeting agendas, previous draft minutes and papers will be circulated to members at least five working days in advance of the meeting.

All parties may submit agenda items for inclusion with a view to agreeing a joint agenda. The final agenda for each CMB meeting will be agreed by the Chair prior to circulation to the wider group membership. Each party will nominate a representative who will be responsible for agreement of the agenda on behalf of their organisation.

Minutes will be drafted within five working days following the meeting and approved by the Chair for sharing with the Members within 7 working days.

**Declarations of Interest:**
Declarations of Interest will be made at the first meeting and amendments/changes requested at subsequent meetings.
If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Board’s consideration has been completed.

Declaration of interest will be a standing agenda item at every meeting.

A Declaration of Interest (DOI) Register will be maintained and updated according.

<table>
<thead>
<tr>
<th>Distribution of Minutes:</th>
<th>Minutes will be circulated to YAS IUEC CMB members.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Meetings:</td>
<td>Bi-Monthly. Meetings will be booked annually in advance of the start of the financial year, and a schedule of meetings circulated to all members.</td>
</tr>
<tr>
<td>Linkages with other fora including sub-groups:</td>
<td>The YAS IUEC CMB has the authority to establish formal sub-groups and/or short-term working groups as and when required to support the effective delivery of the contract. The scope, membership and frequency of any such groups must be jointly agreed by the Coordinating Commissioner and Provider prior to commencement of the group.</td>
</tr>
<tr>
<td></td>
<td>The YAS IUEC CMB will receive feedback from the IUEC Clinical Assurance Group (CAG) formally ‘Joint Quality Board’ on escalated matters. This does not waive the requirement for the YAS IUEC CMB to address all quality and patient safety matters within its remit.</td>
</tr>
<tr>
<td></td>
<td>The YAS IUEC CMB may receive feedback, as appropriate, from any sub regional fora such as local YAS IUEC/YAS IUEC quality and performance groups, A&amp;E Delivery Board or UECNs. In this instance the relevant representative may be invited to attend the YAS IUEC CMB.</td>
</tr>
<tr>
<td>Monitoring and Compliance:</td>
<td>An annual work programme will be developed to monitor the operation and effectiveness of the YAS IUEC CMB.</td>
</tr>
<tr>
<td>Review Date:</td>
<td>These Terms of reference will be reviewed annually, or as and when legislation or best practice guidance is updated.</td>
</tr>
<tr>
<td></td>
<td>Any amended Terms of Reference will be agreed by the Board prior to sharing.</td>
</tr>
<tr>
<td></td>
<td>The next scheduled review date is September 2020</td>
</tr>
<tr>
<td>Date of Approval:</td>
<td>These Terms of Reference have been approved and signed off by on the 2019</td>
</tr>
</tbody>
</table>
Schedule 3.3
Yorkshire & Humber Integrated Urgent & Emergency Care (IUEC)
Governance structure from April 2019

1. JSPB - Strategic co-ordination of IUEC commissioning
2. Y&H IUEC Contract Management Board - Responsible for contractual matters in respect of the IUC and YAS 999 contracts.
4. IUEC Joint Partnership Panel - Co-ordinates annual contracting round across YAS 999 and IUC contracts.

ICS Sub Region

Meaning of arrows and lines:
- Reporting up to
- Liaison across fora (info, etc.)
- Membership is represented on
- Doesn’t directly report to but membership liaises with or attends
- Reports to (upwards) or can delegate to (downwards)

CCG/Place

YH & H UEC Network
SY&B UEC Network
HCV UEC Network
HR&W Network

Yorkshire & Humber Joint Strategic Partnership Board (JSPB)

Yorkshire & Humber IUEC Contract Management Board

Yorkshire & Humber IUEC Clinical Assurance Group (CAG)

IUEC Joint Partnership Panel (JPP)

NHS England
WY&H JCC
SY&B JCC
NY JCC
Humber JCC

Contract Management Boards e.g.
ODH
A&E Delivery Boards
Local fora
## Schedule 4

### Scheme of delegation

1. **CCG decisions made in collaboration**

1.1. The table below sets out CCG Decisions which will be made in collaboration. The Parties agree to make every endeavour to take these decisions in accordance with a common position agreed through the governance arrangements of their respective ICS/STP and the JSPB, as set out in Section 4.

<table>
<thead>
<tr>
<th>Transformational</th>
<th>Finance</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree arrangements for delivery of the commissioners' strategic intentions.</td>
<td>Negotiate and recommend the Finance schedule for the annual Commissioning Contract</td>
<td>Final approval of the terms of the annual Commissioning Contract</td>
</tr>
<tr>
<td>Agree arrangements for assuring the delivery of the providers responses to the agreed commissioning intentions as a whole system</td>
<td>Agree the re-investment of in year contractual penalties (financial) in terms of spend and reasons for spend</td>
<td>Ratify variations to the Commissioning Contract (excluding variations that only affect a single Party)</td>
</tr>
<tr>
<td>Agree the range of services to be commissioned from the Provider and how they are to be commissioned.</td>
<td>Additional in-year investment from CCGs</td>
<td>Agree communications activity relating to matters governed by the Commissioning Contract</td>
</tr>
<tr>
<td>Agree medium to long term planning for the integration of the Service</td>
<td></td>
<td>Approve proposals for CQUIN indicators</td>
</tr>
<tr>
<td>Agree service redesign to further integrate the Services with other health and social care services.</td>
<td></td>
<td>Agree actions if concerns are identified about actual and contracted activity levels.</td>
</tr>
</tbody>
</table>

1.2. The table below sets out the matters that the Parties have agreed are CCG Decisions which are reserved to each Party.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment of Extra Contractual Journeys that only relate to that Party</td>
<td>Ratify variations to the Commissioning Contract that only affect that Party</td>
</tr>
<tr>
<td></td>
<td>Resolve issues between the Party and the Provider that do not impact on any other Party</td>
</tr>
</tbody>
</table>
2. **Lead Contractor Decisions**

2.1. The table below sets out Lead Contractor Decisions which are delegated to the Lead Contractor. Under the agreed collaborative working arrangement these matters will normally have been the subject of wider consultation and will have been discussed as part of regular CMB business. However, to avoid doubt, by exception, Lead Contractor Decisions can be made by the Lead Contractor without reference back to each Party or to the Lead Officers.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Quality</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award of additional central funding investment e.g. SRG monies</td>
<td>Approval of in-year evidence and make recommendation for payment</td>
<td>Issue of formal notices under the contract e.g. application of contractual sanctions</td>
</tr>
<tr>
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<td>Issue of in-year contract variations</td>
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<td>Agree measures to manage demand for services if demand is increasing</td>
<td>Contract negotiations</td>
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<td>Agree actions if clinical quality concerns are identified</td>
<td>Resolve issues escalated from UECN meetings</td>
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<td></td>
<td>Agree changes in clinical and quality assurance practice to enhance patient care</td>
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<td>Agree actions relating to high level external enquiry reports if concerns are identified</td>
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<td>Agree action to be taken to address key issues in relation to incidents and serious incidents</td>
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## Schedule 5
### Parties for IUC and YAS 999 services

<table>
<thead>
<tr>
<th>Party</th>
<th>Address of principal office of Party</th>
<th>Services covered by this Agreement</th>
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<tr>
<td>Humber Coast and Vale</td>
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<tr>
<td>NHS East Riding of Yorkshire Clinical Commissioning Group</td>
<td>Health House, Grange Park Lane, Willerby, East Yorkshire, HU10 6DT</td>
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<tr>
<td>NHS Hull Clinical Commissioning Group</td>
<td>2nd Floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY</td>
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<tr>
<td>NHS North East Lincolnshire Clinical Commissioning Group</td>
<td>Athena Building &amp; Olympia House, Saxon Court, Gilbey Road, Grimsby, South Humberside, DN31 2UJ</td>
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<tr>
<td>NHS North Lincolnshire Clinical Commissioning Group</td>
<td>The Health Place, Wrawby Road, Brigg, South Humberside, DN20 8GS</td>
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<tr>
<td>NHS Scarborough and Ryedale Clinical Commissioning Group</td>
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<td>NHS Vale of York Clinical Commissioning Group</td>
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<tr>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>722 Prince of Wales Road, Darnall, Sheffield, South Yorkshire, S9 4EU</td>
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<td>West Yorkshire and Harrogate</td>
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<td>NHS Airedale, Wharfedale and Craven Clinical Commissioning Group</td>
<td>Millennium Business Park, Station Road, Steeton, West Yorkshire, BD20 6RB</td>
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<tr>
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<td>5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX</td>
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<td>NHS Greater Huddersfield Clinical Commissioning Group</td>
<td>Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ</td>
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<tr>
<td>NHS Harrogate and Rural District Clinical Commissioning Group</td>
<td>1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB</td>
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<tr>
<td>NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group</td>
<td>Hambleton District Council, Civic Centre, Stone Cross, Northallerton, North Yorkshire, DL6 2UU</td>
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<td>NHS North Kirklees Clinical Commissioning Group</td>
<td>4th Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ</td>
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<tr>
<td>NHS Wakefield Clinical Commissioning Group</td>
<td>White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT</td>
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1.0 Purpose
This document is designed to provide an overview of the Strategic Commissioning Intentions of the STPs/ICSs in Yorkshire and the Humber (Y&H) in relation to integrated urgent and emergency care (IUEC) services 2019-2021. The document is for use by both commissioners and providers.

Significant work has been undertaken over the past 18 months and this document builds upon the outputs of these endeavours and the national ambulance commissioning framework with the intention that this links clearly and builds upon local plans.

The aim of this document is to support and complement:
- Our local place (ACPs) / STP/ ICS strategies and plans.
- Our contract negotiation arrangements and procurement plans.
- Providers’ strategic intentions.
- Delivery of the national integrated urgent care specification and associated KPIs and standards.

2.0 Introduction
IUEC services involving health and social care partners is paramount for sustainability, reducing duplication, improving clinical care and patient experience. Availability of resources is a significant challenge to the health and social care system and therefore heighten our ambition to work more collaboratively. We need to ensure we add value and are more efficient in our planning.

Why we are doing this:
The Y&H model of IUEC commissioning and provision is changing. The new NHS standards helpfully suggest greater working across geographies. Opportunistically, we are working with two ambulance trusts in Y&H. This enables us as a group of commissioners to share our collective ambitions, benchmark and reduce variation and enable us to deliver more consistency to the public and our citizens.

It is essential that our strategic intentions support STP/ICS plans and local place based plans whilst meeting local needs and local realities though ‘bottom up’ design. Commissioning intentions need to be bold and focussed and support consistency across the Y&H footprint where this makes sense. We recognise that commissioners and providers have a great deal in common between them and this document aims to ensure that we deliver on the
commonality acknowledging that there will always be differences (due to geography, population health, etc) around the margin.

This document sets our clear priorities which we agree need to be undertaken at a Y&H level to ensure our patients get the right care when they need it. Our commissioning intentions wish to highlight a consistent urgent and emergency care response particularly across the Y&H patch for cardiac, stroke, respiratory, frailty, fallers and those with mental health conditions ensuring evidence improved outcomes for our patients.

Delivering this vision requires whole system transformation. We recognise the need to work differently to deliver urgent and emergency care in this context. Our approach will be clinically focussed, ensuring high quality care for patients and developing the future workforce to meet the changing and complex landscape of health and social care.

2.1 Local Structures
It is explicit that STPs/ICS have a coordinating role, working interdependently with their local places.

We recognise that local A&E Delivery Boards which sit in each place have a significant role to play. This covers issues around A&E, Delayed Transfers of Care (DTOCs), stranded and super stranded patients and seasonal planning. This document predominately focusses on an integrated approach across the Y&H patch working with our 999/IUC providers and in and Out of Hours (OOH) primary care.

![Fig.1 Commissioning framework](image)

Y&H system leaders (both commissioners and providers) will work in partnership and collaboration and our governance arrangements will reflect this.
The commissioning of IUEC services will be overseen by a Joint Strategic Partnership Board (JSPB) (formerly known as the JSCB) working in association with the Y&H Urgent and Emergency Care Programme Boards of each of the STP/sICs. Contractual transactions will sit with the relevant contract management boards.

Complementing and building on the service developments across the Yorkshire and Humber region, this strategy is intended to bring thinking together in a way that enables commissioners and providers to collaborate on service strategies to make the vision set out in this document a reality.

2.2 Scope of this Framework

Within the scope of this framework are the following:

a) 111 on line
b) 111 call handling
c) The ‘core’ Clinical Advice Service (CAS) and wider CAS
d) Direct booking from 999/111
e) 999 ambulance matters
f) IUC services including GP OOH services
g) Digital services and enablers where they impact IUEC
h) Pathway redesign including social care which has an impact on the above
i) Mental health services which have an impact on the above
j) DOS development and management

Excluded from scope (except where there is an impact on the above) are:

1. Development of Urgent Treatment Centres (UTCs)
2. Hospital services including A&E 4 hour waits, length of stay and super stranded patients and hospital to home services
3. GP access including extended access
4. Care home services

3 Strategic Context

This document sits within the context of a number of strategic influences. These include:

- National priorities.
- Evolving commissioning geographies.
- The impact of service reconfigurations.
- Challenge of integration within constrained resources.
• System interoperability.
• Reduction in variation on clinical care and outcomes.
• Regional (ambulance, patient transport, 111, blood and transplant, specialised commissioning) vs local (place).
• Movement to capitated budgets and associated contractual arrangements (risk share).
• Differing demographic issues including urban vs rural.
• Development of provider alliances/ integrated local clinical hubs.
• Stakeholder collaboration (integration, openness and transparency).
• The NHS Long Term Plan.
• The Ambulance Improvement Programme and its subgroups

A further key development is the evolution of Integrated Care Systems (ICS), which will increasingly take on responsibility for transacting the regulatory and oversight functions of NHSE and NHSI, managing their own resources and performance through a mutual accountability framework. The further integration of NHSE and NHSI themselves will lead to the introduction of a more streamlined single oversight framework.

4. Our Y&H Integrated Urgent & Emergency Care Vision

Our vision is:

To improve the outcomes and experience for the local populations by providing the right care at the right time in the right place on 100% of occasions.

Transformation of our IUEC services will enable us to achieve our ambition of financially and clinically sustainable health and social care services designed around the patient.

We want to deliver the above in a way that meets the needs of local people and support them to lead healthier lives for longer. As more people develop long-term conditions it is crucial that our focus is as much about promoting population health and wellbeing as it is about preventing disease.

By 2021 we aim to:

• Deliver on an ambitious integrated urgent care (IUC) specification providing a single point of access for patients, carers and health care professionals.
• Ensure local areas can deliver the NHS constitution standards relevant to IUEC and national contractual requirements relating to IUC and 999 services including the new ambulance quality standards.
• Have implemented the national recommendations on ambulance commissioning and provision (published September 2018).
• Contribute to an improvement in outcomes for patients including but not limited to cardiac, trauma, sepsis, stroke, mental health, respiratory and falls.
• Create an effective balance between regional and local service provision.
• Ensure robust and effective collaborative provider arrangements.
• Support local community engagement to ensure services meet the needs of local populations, building and strengthening community resilience.
• Drive the opportunities new technology, such as access to health and care records to enhance patient care.
• Maximise the opportunity that an integrated care workforce offers.
• Reduce variation in clinical practice without stifling innovation.
• Ensure systems are resilient in accordance with national EPRR standards.

5. Commissioner Intentions

To support the aims above we intend to focus on three core areas:

Prevention: Interventions that safely reduces avoidable demand
• We expect and encourage patients to self-care wherever possible and use the available resources such as online services and local pharmacy services.
• We expect commissioners to look at the opportunities to manage services ‘upstream’ e.g. population health management, those with long term conditions, non-injury falls and with end of life needs.
• We expect providers to consider the needs of their service users and opportunities that might exist to make every contact count.

Triage and advice: Assessment of need and signposting to the most appropriate services
• Simplification of the ‘single point of telephone or digital access’ in line with the requirements of the NHS Long Term Plan.
• Manage calls and digital contacts in a way that more appropriately places the patient in either health and/or social care.
• From the patients’ perspective, seamless services which will be achieved via integration and reduced duplication.
• Utilisation of technology and the continued development of a shared care record to enable simultaneous viewing.
• Enhancing our multidisciplinary approach for example linking services to pharmacies, drug and alcohol and mental health services.
• Providing the facility for direct booking from 111/999 into urgent and planned services.
• Provision of suitable clinical advice services to those who need it, ensuring patients are not passed from one clinician to another (consult and complete model of care).
**Treatment and flow:** Streamlining pathways and processes

- Provide alternatives to traditional A&E care such as the provision of care by non-ambulance staff or at different facilities such as Urgent Treatment Centres (UTCs). This is particularly pertinent to low acuity 999 calls which make up about 25% of call volumes.
- Development of alternative pathways of care which are effective and safe.
- Maximise flow within care pathways to enhance patient experience and reducing hospital stay where appropriate.
- Services will be provided locally however as medicine advances this might mean some services are better provided in specialist centres.
- Treatment services provided locally, at scene or coordinated with partners including the voluntary sector.
- Where transport is required consideration is given to safe non-ambulance transportation.

**6. Governance**

This document is aligned to the changes that are currently taking place access Y&H in relation to the development of STPs/ICS. To ensure that this happens we intend to undertake a number of actions including:

- A commissioned external review of current arrangements against the national ambulance commissioning framework.
- A review of the various existing fora used for contracting and commissioning to ensure these are fit for purpose.
- Revision of existing Memorandum of Understanding (MOUs) to support decision making.
- Review the support resources required to support commissioning processes detailed above.

**7. Next steps**

In light of the developing commissioning landscape, commissioners will need to review and strengthen their governance arrangements and support structures. Additionally, local ICS/STP work plans may also need to be revised. There will need to be some enabling actions taken to support providers in remodelling services and support then as we move to a more integrated urgent & emergency care service response across health and social care.

This document will be considered for approval by the STP/sICS and their local governance arrangements following discussion within each sub region during spring 2019 and, as necessary, at CCG governing bodies.
Yorkshire & Humber Integrated Urgent& Emergency Care (IUEC) Governance structure from April 2019

1. JSPB - Strategic co-ordination of IUEC commissioning
2. Y&H IUEC Contract Management Board - Responsible for contractual matters in respect of the IUC and YAS 999 contracts.
4. IUEC Joint Partnership Panel - Co-ordinates annual contracting round across YAS 999 and IUC contracts.

Meaning of arrows and lines:
- Reporting up to .........................
- Liaison across fora (info, etc)......
- Membership is represented on.....
- Doesn’t directly report to but membership liaises with or attends........
- Reports to (upwards) or can delegate to (downwards)......................

- Yorkshire & Humber
  - Yorkshire & Humber Joint Strategic Partnership Board (JSPB)
  - Yorkshire & Humber IUEC Contract Management Board
  - Yorkshire & Humber IUEC Clinical Assurance Group (CAG)
  - IUEC Joint Partnership Panel (JPP)
- Yorkshire & Humber
- ICS Sub Region
- IUEC Clinical Assurance Group (CAG)
- IUEC Joint Partnership Panel (JPP)
- WY&H UEC Network
  - SY&B UEC Network
  - HCV UEC Network
  - HR&W Network
- NHS England
  - WY&H JCC
  - SY&B JCC
  - NY JCC
  - Humber JCC
- CCG/Place
- Contract Management Boards e.g., OOH
  - A&E Delivery Boards
  - Local fora
Introduction

The Ambulance Response Programme (ARP) was initially published as a national ambition in July 2017. ARP has since been embedded as a fundamental pledge within the NHS constitution, with the expectation that local systems would implement the new standards from 2018/19.

ARP introduces an entirely new set of performance standards for ambulance services, which will deliver benefits for patient outcomes, as well as improvements in service quality and responsiveness. The new standards are also expected to bring major system benefits by reducing conveyances to hospital and supporting more patients to remain in the community. However, the scale of required change is daunting, since ARP means that Ambulance Trusts must build significant new capacity and introduce new ways of working at a time of considerable financial restraint across the NHS.

NHSE/NHSI shared planning guidance confirms that ARP delivery remains a national priority; underlined by new contract financial sanctions in 2019/20 for failure to achieve ARP standards if no provider control total has been agreed.

What was achieved in 2018/19

Within Yorkshire and the Humber, clear progress has been made towards ARP delivery during 2018/19. With Commissioner support and internal investment, YAS has expanded its frontline staffing, ambulance fleet, and has increased the clinical capacity within its Emergency Operations Centre. These changes have been delivered within planned timescales, and YAS is on target to achieve its locally-agreed trajectories for the most urgent categories of patient need.

However, despite this progress there is still a considerable gap to bridge between current performance and the required national standards.

Joint planning for 2019/20

To meet this challenge, YAS and a panel of commissioners have worked together over the last 6 months to review the implementation of the initial plans and to jointly develop proposals for the next stage of ARP implementation.

In order to sustainably deliver ARP while also responding to ongoing increases in demand, Commissioners and YAS have jointly developed a programme of transformation for 2019/20 based on three pillars:

1. System wide partnership – to deliver new integrated service models and pathways
2. YAS internal efficiencies - including Carter efficiencies and new ways of working
3. New investment in additional ambulance service capacity

2019/20 provides an opportunity to deliver system wide change that can help mitigate increasing year on year demand and improve patient outcome and experience through the achievement of ARP standards.
1.1 Introduction

ARP provides a unique opportunity to significantly enhance the existing 999 operating model to enable greater integration with emergency and urgent care across the healthcare system of Yorkshire and Humberside.

The scale of ARP means that it cannot be delivered by ambulance services working in isolation, and it cannot be realistically delivered through investment alone. Delivering the benefits of ARP affordably will require system-wide cooperation, including:

- Renewed focus on improving hospital handover times
- Developing improved pathways at the interface between YAS, primary care and community services
- Working with CCG and ICS partners to co-produce alternative service delivery models that will support patients to be treated in their own homes, or in the community, with only the sickest patients being transported to Emergency Departments
- Development of the wider Y&H IUC clinical advice model and associated digital enablers

Such an approach will allow ARP to be delivered in a cost effective way that provides benefits for patients and efficiencies across the wider healthcare system.

We will agree in advance how we will evaluate and monitor the implementation and impact of any changes proposed below.

1.2 Ambulance handovers at acute trusts

Reduction in handover delays is a key requirement of the NHS planning guidance - 100% in 30 mins in 2019/20. ORH Modelling assumes that handover targets will be consistently met across Yorkshire and Humber.

Delayed handover has an impact in both financial terms and in terms of patient experience. It is estimated that in 2018/19 the lost man hours equates to a value of c£2m.

NHS I have a lead role for issues of a provider to provider nature and specifically handover delays. NHS E/I organised a hospital handover workshop in February 2019. This brought together commissioners, acute trusts, ambulance services and system regulators develop an approach to meeting the requirements of the national handover guidance (Jan 2019). A Y&H plan to deliver the 30 minute handover target will be prepared and made available for consideration by JSCB in April 2019.
What we are recommending:

CCGs/ICSs commit to developing plans with NHSI to achieve the requirements of the 2019/20 planning guidance in respect of ambulance handover.

1.3 Care out of hospital - Alternative Care Pathways

The YAS EOC and IUC CAS are in a unique position to work jointly with commissioners to identify areas of Yorkshire and Humber where additional pathways could be developed. Increased availability of such alternatives will improve patient experience, increased ambulance service capacity and provide system wide financial benefits as a result of reduced conveyances to ED. This is a key requirement of the 2019/20 planning guidance.

Pathways should be commissioned and developed locally. We believe that there are opportunities for secondments from CCGs to work within YAS during 2019/20 to link our services into local pathways. Local knowledge and relationships are critical to speedy development of key pathways.

What we are recommending:

We recommend in priority order these following pathways are reviewed by Y&H commissioners (in association with providers) and the pathways are made accessible to YAS on a consistent and resilient basis during 2019/20:

a) Access to falls teams
b) Access to local mental health services – including preparation towards NHS 111 as the single point of access to crisis services (as per the 2019/20 planning guidance)
c) Access to Urgent Treatment Centres (UTC)
d) Access to non-clinical community support services/ social care
e) Access to COPD/Respiratory pathways
f) Access to epilepsy and diabetic services

We expect the methodology developed to redesign these pathways to be used in 2020 onwards for further redesign schemes.

1.4 New Service Delivery Models – Y&H Pilots

There are a number of schemes that are currently being tested across areas of Yorkshire and Humber that could, subject to joint evaluation, be delivered at scale providing system wide benefits.

The schemes set out below all have potential to deliver system impacts that will support ARP delivery and offset demand increases – reducing the overall cost of achieving ARP.

What we are recommending:

During 2019/20, we recommend that Y&H commissioners and YAS jointly evaluate the current pilots, share good practice and agree a service development plan to extend or embed successful service models.

1.4a Care Homes
YAS has co-produced a small number of schemes with local partners that assist care homes to support patients without the need to dispatch an ambulance. One of these has been focused on the provision of specialist equipment and training for care homes when patients fall, thus avoiding a call through to 999.

Initial evaluation has identified system wide benefits through reducing conveyances and improving patient experience. It is possible to deploy these schemes at scale. The scheme can be delivered through direct investment in care home providers rather than additional investment in YAS.

1.4b Mental Health Services

The 10 Year NHS Plan clearly articulates the need for innovation in the provision of mental health services, especially in acute situations out of hospital. YAS has been recognised as a national leader in the provision of Hear and Treat mental health services but we believe there are opportunities to maximise the benefits further. A significant number of attendances to ED are as a result of limited access to Mental Health services. In addition patients are often conveyed inappropriately (i.e. police car) to places of safety.

There are innovative schemes that have proven to be effective in other parts of England using mobile mental health teams in urban areas. Further joint work is needed to develop a pilot programme to test this service model within Yorkshire & Humber. During 2019/20 YAS and commissioners will co-produce a pilot proposal to test this model within a high volume areas of mental health demand.

1.4c Hospital/Ambulance Liaison Officers (HALO)

In addition to the hospital handover programme described in Section 1.2, we believe that the Hospital/Ambulance Liaison Officer (HALO) role is critical to reduce handover delays at emergency departments. There have been many models of HALO tried and tested within the UK and we believe the most successful model is one that is a true interface between the emergency departments (ED) and the arriving ambulances. The role should be ring fenced as to be independent and not used to fill workforce gaps in either ED or YAS.

The HALO role would also be instrumental in identifying alternative pathways that would reduce attendances and influencing ambulance crew decisions and support ‘Fit to Sit’ initiatives.

Experience suggests that all large EDs should have an HALO in place from 0800 until 0200, 7 days per week. We would suggest that Hull, York, Bradford, Leeds, Sheffield, Wakefield and Rotherham are the initial sites. Pilots have been ongoing in many of these sites throughout winter 2018/19. The results of these pilots will be shared with commissioners early in 2019/20 to inform future service development plans.

1.4d Mainstream rotational Specialist Paramedic (SP) schemes

As part of the journey to achieve ARP standards YAS recognise the challenges of growing demand, increases in patients with complex needs and general system pressures spanning health and social care.

To meet these challenges YAS will require changes to the existing skill mix and a coordinated approach to provision of education to our operational workforce. This will support
appropriate conveyance and improve retention of skilled staff. A key component of this will be gaining maximum benefit from the paramedic role and the further development of the Specialist Paramedic role.

YAS and its partners have trialled and funded various schemes that have used paramedics with additional skills working differently across the health economy. Examples include the long standing Sheffield ECP scheme and the more recent Leeds primary care rotational Specialist Paramedic role.

YAS and local commissioners have recently evaluated these schemes and have now identified preferred models for use in urban and rural areas. For example:

- Extending the existing urban ECP model across other areas of Yorkshire and Humber, linked with a rotational element into primary care, could significantly increase non conveyance (from 30% to 70%), reduce paramedic attrition and allow opportunities for the development of paramedic prescribing.

- Similarly, extending the rural scheme currently operating in Northallerton to other areas would provide increased non conveyance and also an opportunity to offer specialist support to the wider clinical team.

In 2019/20 YAS would like to work with commissioners to consolidate the schemes into a proposal for an urban and rural model that can be extended and embedded across the Trust. This will be a key proposal for transforming the workforce within YAS not only moving towards ARP delivery but also enabling YAS to play an enhanced role in out of hospital care, providing system wide benefits and efficiencies.

1.4e Fully Integrated Transport

There are models across the UK where close integration between PTS and A&E can create significant system benefits and efficiencies. Joint commissioning would reduce overhead, allow longer term investment and improve flow both in and out of hospitals.

Due to current contractual arrangements opportunities to maximise efficiency are lost especially around on-day discharge, Inter Facility Transport and HCP admissions.

In line with the NHS Long Term Plan we believe that there is an opportunity to develop an innovative and truly integrated emergency, urgent and planned patient transport service rather than independently commissioned services that encourages inefficiency and delay through its design.

This is necessarily a longer term development, however in 2019/20 we will progress the strategic discussion at JSCB with a view to jointly agreeing a proposal and initial steps which deliver benefits within the 2-3 year timeframe described in this paper.