

Attachment 05

**North East Lincolnshire CCG**

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| **Report to:** | NEL CCG Governing Body |
| **Presented by:** | Helen Kenyon |
| **Date of Meeting:** | 12th May 2016 |
| **Subject:** | Establishment of Joint Committees |
| **Status:** | OPEN  CLOSED |

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| **OBJECT OF REPORT:** |
| The Purpose of this report is to seek Governing Body approval for the establishment of Joint Committees.  The first is for a joint committee to be established for the management of the 111 & 999 services across the whole of Yorkshire, (23 CCGs) and includes ourselves for the 111 element of this arrangement only as we are not part of the same footprint for commissioning of our 999 service.  The second is a joint committee to formalise the arrangements that have been operational for some time around the North Yorkshire and Humber CCG Collaborative, renamed to Humber Coast & Vale CCG Collaborative to reflect the Sustainability and Transformation Plan (STP) name.  **Establishment of a Joint Committee for 111 (and 999)**  Under the current collaborative commissioning arrangements, the CCGs delegate authority to make decisions on certain matters to a representative who attends the Contract Management Board alongside representatives of the other CCGs who all have the same delegated authority from their respective CCGs. By establishing a joint committee structure each CCG delegates authority to the joint committee (rather than a representative) to make decisions on its behalf.  Under the updated arrangements, the existing three Sub-Regional CBUs are effectively replaced by the three Urgent and Emergency Care Networks (UECNs) which together match the Yorkshire and Humber CCG combined footprint. In respect of the 999 and 111 services, the UECNs will be regional forums for discussions of matters that affect the member CCGs. Each CCG delegates decision-making authority to two Lead Officers who represents the CCGs in the UECN at a new Joint Strategic Commissioning Board  Two MOUs (one for each service) have been drafted to capture the updated arrangements until establishment of the joint committee. Two separate MOUs are required to reflect the fact that we (and North Lincolnshire) are only included in the 111 service element. Both the MOU for 111 and 999 have been attached for information to this paper to provide assurance that the CCG is not included in the 999 arrangement.  Also included for information & context is the high level strategy commissioning strategy for the 999 & 111 service.  The proposed timescale to move to a joint committee structure is 1 October 2016.    **Establishment of a joint Committee for the Humber Coast and Vale CCG Collaborative.**  In December 2015 the 8 CCGs that make up the North Yorkshire and Humber Collaborative Commissioners (NY&HCC) (North East Lincs; North Lincs; East Riding; Hull; Vale of York; Scarborough& Rydale; Harrogate & Rural; and Hambleton Richmond & Whitby) held a development session to determine whether it would be advantageous to build stronger working arrangements between them to support the delivery of the emerging national requirements.  Through the discussion the following were identified as areas where commissioning collectively (at scale) through more formal arrangements would be beneficial:   * Major Trauma * Emergency and Urgent Care * Cancer * Specialised services pathways * Stroke * Vascular * Critical Care * Complex mental health   In addition it was felt that working together to manage the Specialised services commissioning transition to CCGs would be beneficial, and that we should be doing more re shared learning and good practice, and developing commissioning skills and expertise e.g. patient and public involvement.  It was acknowledged that for much of the collaborative agenda, patient flows would dictate the CCG construct for formal collaborative working. It was therefore agreed that for acute services; Harrogate and Rural CCG and Hambleton, Richmond and Whitby CCGs, collaborative working would be more appropriate with CCGs in West Yorkshire and Teeside respectively  In order to take this forward it was felt that the establishment of a joint committee would be the most appropriate vehicle for delivering more formal collaboration across the CCGs. |

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| **STRATEGY:** |
| The establishment of Joint Committees will support the CCG in delivering its commissioning functions for services which require a bigger population / footprint than NEL to be delivered / viable. |

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| **IMPLICATIONS:** |
| The Joint Committees would have fully devolved decision making powers, including financial authority, up to a level agreed between the member CCGs and subsequently defined within members CCG’s Schemes of Delegation and the Committee’s Terms of Reference.  Consideration of the collaborative working options between the sub-regional CCGs have been subject to two independent legal opinions (Beachcroft DAC and Capsticks). The proposal to establish a Joint Collaborative Commissioning Committee is consistent with the appraisals given by both. |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:** | |
|  | To approve the Joint Collaborative Commissioning Proposal for NHS 111 Services |
|  | To approve the proposed governance arrangements for the establishment of a Humber, Coast and Vale CCG Joint Commissioning Committee. |
|  | Note the establishment of shadow arrangements for the Committees from May 2016.  Note the need to submit to the Council of Members the necessary amendments to the CCG Constitution (including Schemes of Delegation) to establish the governance framework for the joint Committees, prior to their onward submission to NHS North of England for approval. |
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|  |  | **Yes/**  **No** | **Comments** |
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|  | Does the document take account of and meet the requirements of the following: |  |  |
| i) | Mental Capacity Act | NA |  |
| ii) | CCG Equality Impact Assessment | NA |  |
| iii) | Human Rights Act 1998 | NA |  |
| iv) | Health and Safety at Work Act 1974 | NA |  |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 | NA |  |
| iv) | Does the report have regard of the principles and values of the NHS Constitution?  [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613)  Principle 3 of the NHS Constitution:  The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population | Yes | Principle 3 |

**Updated Collaborative Commissioning Arrangements**

**for 111 and 999 Services**

**Paper for Governing Bodies**

**Purpose**

This note provides details of proposed updating of the existing collaborative commissioning arrangements for commissioning 111 and 999 services from Yorkshire Ambulance Service NHS Trust ("**YAS**") across Yorkshire and Humber.

**BACKGROUND**

The current collaborative commissioning arrangements for 111 and 999 services are structured around the Contract Management Board and a lead commissioner arrangement.

The CCGs have in principle agreed to further strengthen the arrangements by establishing a joint committee structure whereby each CCG delegates authority to the joint committee (rather than a representative) to make decisions on its behalf. The proposed timescale to move to a joint committee structure is 1 October 2016. In order to achieve this timescale, the terms of reference for the joint committee, amended scheme of delegation and updated collaborative commissioning agreement will need to be in final draft form by 31 July 2016.

This note focuses on the updating of the existing arrangements for the interim period until October 2016 to facilitate the move to a joint committee arrangement later in the year.

**UPDATED COLLABORATIVE ARRANGEMENTS**

Under the current collaborative commissioning arrangements, the CCGs delegate authority to make decisions on certain matters to a representative who attends the Contract Management Board alongside representatives of the other CCGs who all have the same delegated authority from their respective CCGs. Certain matters are delegated to the Lead Commissioner under the current arrangements.

Under the updated arrangements, the existing three Sub-Regional CBUs are effectively replaced by the three Urgent and Emergency Care Networks (UECNs) which together match the Yorkshire and Humber CCG combined footprint. In respect of the 999 and 111 services, the UECNs will be regional forums for discussions of matters that affect the member CCGs. Each CCG delegates decision-making authority to two Lead Officers who represents the CCGs in the UECN at a new Joint Strategic Commissioning Board.

The role of the Joint Strategic Commissioning Board (“JSCB”) will be to consider and make decisions relating to transformational matters, in line with the updated scheme of delegation in the draft MOU. Transactional matters will, broadly, be delegated to the Lead Commissioner / Contractor in line with the revised scheme of delegation.

In this interim phase prior to the establishment of a joint committee, the Lead Officers who are members of the JSCB make the decisions, not the JSCB. This approach can be inefficient as each Lead Officer must have the appropriate authority from the CCGs it represents to make that decision – any non-alignment in delegated authority will require a representative to go back to the CCG to seek approval. Additionally there must be unanimous decision-making. Where one Lead Officer dissents, the decision cannot be made so as to bind the dissenting party.

Whilst the Contract Management Board will continue to exist under the updated arrangements, neither it, nor its members, will have delegated authority to take decisions which bind the CCGs. It will be chaired, as it is currently, by the Lead Commissioner / Contractor, and will continue to be the forum through which the Lead Commissioner / Contractor will hold YAS to account for the delivery of the Services and implement decisions made by individual CCGs, the JSCB and the Lead Commissioner / Contractor (in line with the revised scheme of delegation).

**Updated documentation**

Two MOUs (one for each service) have been drafted to capture the updated arrangements until establishment of the joint committee. Two separate MOUs are required as there are additional CCGs who are commissioners of the 111 service and to amalgamate the two arrangements would be likely to result in unwieldy documentation that is difficult to navigate.

The MOUs include the following updated terms:

the principles and objectives of collaboration;

clarity on what is expected from each Party in terms of discussion, participation and attendance at meetings;

the service variation procedure where a variation is proposed by the CCGs or YAS;

detailed explanation of how matters are dealt with at different levels (CCG level, JSCB level, Lead Commissioner / Contractor level);

how costs are dealt with for commissioning support services;

a dispute resolution procedure;

a process for new CCGs to join or leave the collaboration;

terms of reference for the JSCB; and

a detailed Scheme of Delegation setting out which decisions are made at which level.

The Scheme of Delegation is critical as it provides information to the CCGs to amend their respective schemes of delegation to ensure aligned delegation to the Lead Officers which is necessary for efficient and lawful decision-making.

Each CCG is advised to review its constitution and schemes of delegation to identify what amendments may be required to give effect to the scheme of delegation in the MOUs.

**Joint Collaborative Commissioning Committee**

**Humber, Coast and Vale CCGs**

#### 1. Introduction

#### 1.1 The purpose of this report is to consider the governance arrangements and next steps for the establishment of a Joint Collaborative Commissioning Committee for the six Humber, Coast and Vale CCGs.

**2. BACKGROUND**

2.1 The NHS England planning guidance 2016 - 2021 requires every local health and care system to develop a five year Sustainability and Transformation Plan. This is place-based and drives the five year forward view within localities.

2.2 The footprint of individual health and care systems is locally determined but it is influenced by a range of factors, including; natural communities, existing working relationships, patient flows and the scale needed to deliver services, transformation and public health programmes as well as best fit with other local footprints such as digital roadmaps and learning disability units of planning.

2.3 Initial consideration of a STP footprint for the Humber, Coast and Vale area reflected the emergence of larger scale collaboration and integrated planning in relation to the development Urgent and Emergency Care Networks (UECN), wider collaborative commissioning and local authority devolution. It also recognised that larger scale plans would to a great extent be a synthesis of smaller health and care community plans. The final footprint will be confirmed after the completion of the STP plan itself.

2.4 The Humber, Coast and Vale CCGs comprise:

* NHS Vale of York CCG;
* NHS Scarborough and Ryedale CCG;
* NHS East Riding of Yorkshire CCG;
* NHS Hull CCG;
* NHS North Lincolnshire CCG; and,
* NHS North East Lincolnshire CCG.

2.5 It is also noted that whilst NHS Harrogate and Rural CCG and NHS Hambleton, Richmond and Whitby CCG patient flows for acute care were more naturally aligned to the West Yorkshire and Teesside localities respectively, they also maintained interests on a diverse range of services within the Humber, Coast and Vale footprint and should therefore contribute to a wider planning construct on a service by service basis.

2.6 The senior officers and clinical leaders of the Humber, Coast and Vale CCGs met and agreed that there were compelling grounds for exploring formal collaborative commissioning arrangements at a scale consistent with the emerging STP footprint. Following consideration of the potential models available it was agreed that a Joint Collaborative Commissioning Committee was the preferred option.

**3. INFORMATION**

3.1 A Joint Collaborative Commissioning Committee carries collective responsibility for decision making and, on behalf of member CCGs, would have delegated authority such that majority decisions would apply. Decisions reached by the committee would bind the individual CCGs to the collective judgement, subject to the scope and limits of the committee’s terms of reference.

3.2 The advantage of a joint committee over alternative options is that it facilitates effective and timely decision making, without the need to defer back to individual CCG’s hierarchy for formal approval of decisions. This, in turn, also provides a single focal point in the event of legal challenge as opposed to all constituent members.

3.3 The following steps would be required to establish a joint committee:

1. The governing bodies of individual member CCGs will need to consider and approve the proposals as set out within this paper.
2. Individual CCG’s Constitutions will need to be checked to confirm that there is provision within each to allow delegation of “authority to act” to other groups or entities (such as joint committees).
3. CCG Constitutions to be updated to include reference to the joint committee and schemes of delegation amended to set a common level of authority and to define the decisions within the remit of the joint committee.
4. Amendments to CCG Constitutions to be approved by their respective Council of Members / Representatives (as per Constitutional requirements) and submitted to NHS North of England for final approval.
5. A partnership agreement be drawn up and agreed between member CCGs which covers, amongst other things:
   1. How the parties will work together – principles, behaviours and shared values;
   2. The duties and responsibilities of the parties;
   3. How risks will be managed and apportioned between the parties; and,
   4. Financial arrangements, including, if applicable, financial payments towards a pooled fund;

3.4 Subject to the agreement to the proposal by the individual member CCGs, terms of reference would be established for the committee incorporating the following key aspects:

1. The *formal functions* of the committee;
2. The *scope of service areas* to be considered: including,
   1. Major trauma;
   2. Emergency and urgent care;
   3. Cancer;
   4. Specialised services path ways;
   5. Stroke;
   6. Vascular; and
   7. Critical care.

In addition, the wider planning construct would also consider complex mental health and specialised commissioning transitions to CCGs.

1. Linkages to other system-wide programmes of work such as the health and social care agenda and STP planning footprint should be articulated.
2. *Membership* – to comprise equal representation from member CCGs, recommended for reasons of practicality to be up to three members per CCG giving a total membership of 18. These would be drawn across the spectrum of senior officer, clinical and lay members.
3. *Quorum* – the absolute number, and mix, of members needed to be in attendance in order for formal decisions to be made. It is proposed one member per CCG must be present for quoracy to be achieved.
4. Other practical arrangements such as voting, notice period for meetings and minimum distribution period for circulation of papers.

3.5 Consideration may also be given to the identification of support structure arrangements which can inform the decision making of the committee. This could include:

1. Whole system steering group;
2. Clinical;
3. Financial; and
4. Patient / service user experience and formal public consultations.

In addition, the Joint Committee will need to establish how existing planning, such as Urgent and Emergency Care Networks, will inform the considerations of the joint committee. The mobilisation of such arrangements could commence in parallel to the formal steps set out above to establish the joint committee.