NHS Vale of York Clinical Commissioning Group

Governing Body: 2 June 2016

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:

i. The governing bodies of individual member CCGs will need to consider and approve the proposals as set out within this paper.

ii. 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).

iii. 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.

iv. 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.

v. A partnership agreement be drawn up and agreed between member CCGs which covers, amongst other things:

   a. How the parties will work together – principles, behaviours and shared values;
   b. The duties and responsibilities of the parties;
   c. How risks will be managed and apportioned between the parties; and,
   d. 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:

i. The *formal functions* of the committee;

ii. The *scope of service areas* to be considered: including,

a. Major trauma;
b. Emergency and urgent care;
c. Cancer;
d. Specialised services path ways;
e. Stroke;
f. Vascular; and
g. Critical care.

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

iii. Linkages to other system-wide programmes of work such as the health and social care agenda and STP planning footprint should be articulated.

iv. *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.

v. *Quorum* – the absolute number, and mix, of members needed to be in attendance in order for formal decisions to be made. This is typically set at 1/3 the full membership (6 members) but may wish to be set at a higher level

vi. 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:

i. Whole system steering group;
ii. Clinical;
iii. Financial; and
iv. Patient / service user experience and formal public consultations.

In addition, the Joint Committee will need to establish how existing planning fora, 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.

4. RECOMMENDATIONS

It is recommended that member CCGs:

a Approve the proposed governance arrangements for the establishment of a Yorkshire Coast and Humber CCG Joint Commissioning Committee.

b. Note the establishment of shadow arrangements for the Committee from May 2016.

c. Note the submission to the Council of Members / Representatives the necessary amends to the CCG Constitution (including Schemes of Delegation) to establish the governance framework for the joint Committee, prior to their onward submission to NHS North of England for approval.

APPENDIX: GOVERNANCE STRUCTURE