Joint Committee of Clinical Commissioning Groups

Public Meeting held 15 November 2017, 4.15pm- 5:30pm, at NHS Sheffield CCG

Action Summary for CCG Boards

	There were no actions to progress resulting from this meeting.	

Public Minutes of the meeting of the

Joint Committee of the Clinical Commissioning Group Meeting

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Present:
Dr David Crichton, Clinical Chair, NHS Doncaster CCG (Chair)
Dr Nick Balac, Clinical Chair, NHS Barnsley CCG
Dr Chris Clayton, Chief Executive Officer, NHS Derbyshire CCG
Chris Edwards, Accountable Officer, NHS Rotherham CCG
Andrew Goodall, Healthwatch Representative
Idris Griffiths, Accountable Officer, NHS Bassetlaw CCG
Gareth Harry, Interim Director of Contracting and Performance, NHS Derbyshire CCG and Executive Lead, NHS Hardwick CCG
Pat Keane, Chief Operating Officer, NHS Wakefield CCG (Deputy for Jo Webster, Accountable Officer)
Alison Knowles, Locality Director – North, NHS England
Priscilla McGuire, Lay Member
Dr Ben Milton, Clinical Chair, NHS North Derbyshire CCG
Philip Moss, Lay Member
Julia Newton, Director of Finance, NHS Sheffield CCG
Hayley Tingle, Chief Finance Officer, NHS Doncaster CCG
Lesley Smith, Accountable Officer, NHS Barnsley CCG

Apologies:
Sir Andrew Cash, Lead, South Yorkshire and Bassetlaw Accountable Care System
Will Cleary-Gray, Director of Sustainability and Transformation, SYB ACS
Dr Richard Cullen, Clinical Chair, NHS Rotherham CCG
Dr Phillip Earnshaw, Clinical Chair, NHS Wakefield CCG
Eric Kelly, Clinical Chair, NHS Bassetlaw CCG
Dr Steve Lloyd, Clinical Chair, NHS Hardwick CCG
Dr Tim Moorhead, Clinical Chair, NHS Sheffield CCG
Jackie Pederson, Accountable Officer, NHS Doncaster CCG
Maddy Ruff, Accountable Officer, NHS Sheffield CCG
Jo Webster, Chief Officer, NHS Wakefield CCG
Karen Whittaker, NHS Wakefield CCG

In attendance:
Dr Peter Anderton, Stroke Consultant at Doncaster and Bassetlaw teaching Hospitals NHS Foundation Trust and Regional Stroke Lead for Commissioners Working Together
Jane Anthony, Corporate Committee Administrator, Executive PA and Business Manager, SYB ACS
Jeremy Cook, Interim Finance Director, SYB ACS
Marianna Hargreaves, Transformation Programme Lead, SYB ACS
Lisa Kell, Director of Commissioning Reform, SYB ACS
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together/ SYB ACS
Dr Lisa Wilkins, Consultant in Public Health Medicine, SYB ACS

Members of the Public
Kathryn Nuffett, Trax FM

Minute reference	Item	ACTION
53/17	**Welcome and introductions** The Chair welcomed members to the meeting.	
54/17	**Apologies** Apologies were received and noted.	
55/17	**Declarations of Interest** There were no declarations of interest.	
56/17	**Previous minutes of the meeting:** The minutes of the meeting held on 18 October 2017 were accepted as a true and accurate record. **Matters Arising** The Chair noted that an update report on the Children's Surgery and Anaesthesia will be prepared for the meeting in January 2018 and all other action points had been resolved. There were no other matters arising.	
58/17	**Hyper Acute Stroke Decision Making Business Case** The Chair invited Peter Anderton to start the presentation entitled 'Review of proposals to change hyper acute stroke services in South and Mid Yorkshire, Bassetlaw and North Derbyshire' to the meeting. The Chair thanked Peter Anderton, Marianna Hargreaves and Helen Stevens for the information presented and he invited comments and questions from members present. Gareth Harry enquired about the consultation exercise and in particular any in depth details regarding the telephone survey. Helen Stevens responded to Gareth Harry' s enquiry stating that the telephone survey had exactly the same questions as the on-line survey and paper survey, so the same data was being analysed. The method of selection regarding calls per area was to look at census demographics which were then broken down to percentage of respondents and minority groups. All information regarding the research is contained in the independent analysis report which is one of the appendices of the business case. Helen Stevens responded to a further enquiry by saying that the questions for the online poll we checked with a market research company and the questions for the consultation went through a process of being checked by CCGs engagement leads, Healthwatch and lay	

	members of CCGs before we went out with the survey. Philip Moss informed the meeting that he chaired some of the earlier community engagement meetings and the response of members of the public at the meetings were supportive, the main item that people were most concerned about was the quality of care. He can reassure community members that this HASU model will deliver the best care. There remain some concerns about the distance of travel, how relatives will get to hospital and how they will retain contact with hospital when a family member is admitted out of hours. However, Philip Moss felt reassured that now there is there is consideration for relatives and their need to stay in touch has been considered and addressed once we roll out the programme. The Chair noted that it is important with any implementation process we need to be mindful to make sure it is working as we go along. Travel, contact with family members and peoples' experiences will be an area that will be closely monitored. Andrew Goodall enquired about the next steps asking if the decisions and recommendations, the outcomes and changes will be clearly shared with people in local communities, and secondly, how will this be done to ensure that everybody who has an interest or who this will impact upon will have an understanding of the changes and what difference this will make to them. Helen Stevens replied that the exact same processes would be used that were employed initially to reach out and have conversations with different communities e.g. through our CCGs and reconnecting with groups that they have had communications with via their networks. Also at the outcome of this meeting, letting the media and subscribers of our newsletters what the outcome of today is and we would hope our media colleagues would report the decision as well. We have set up connectivity with the staff working in the services to ensure they are first to hear about the outcome of today and keep them involved in the process. We will work with our Healthwatch colleagues to ensure that we are doing that in the community groups and into the groups and networks that exist. Jeremy Cook offered the following points of clarity around the impact of the business case: • the business case assumes and it is not a fixed financial envelope and financial actuals are incurred they may be different to what is built into the business case. This will need to be reflected by commissioners based on the contract model that is adopted which is activity based. • Further work is required regarding the split of the costs between the cost of provision of hyper acute stroke unit and other parts of the acute stroke pathway. • The business case make the assumption 50:50 split there are two other versions 40:60 and a 60:40, further work regarding this is required.	

	• The other parts of the stroke pathway are being picked up by the Hospital Services review and there could be opportunities to offset some financial risks • Over the last few days revised indicative transport costs have been received from YAS regarding additional costs of travel and they have come out £270K more than identified in the business case, therefore further work is required to understand these increased numbers have been arrived at. He added that it was important for commissioners are aware of the above mentioned issues. Chris Clayton enquired why the specific sites been chosen over the alternative sites available and to have further assurance of why that particular site has been picked. Peter Anderton responded by saying when working up the different options of reconfiguring the hyper acute stroke unit various criteria were looked at e.g. ambulance transport time, whether it would bring the stroke unit up to critical mass, or overload the stroke unit, cross boarder impacts, current staffing levels and whether a 7 days service was offered. Based on the assumption that Sheffield would be in it as the large Teaching Hospital and Neurosciences Centre and then we modelled different options e.g. Rotherham, Barnsley or Doncaster being a hyper acute stroke unit. It naturally emerged that Doncaster, as the other largest centre and because of its geographical location, made sense to be the option put forward. As Chesterfield is not strictly within the South Yorkshire and Bassetlaw footprint it was left as it is with no increase or decrease. Pat Keane highlighted that whilst we recognise the key focus of today's discussion and decision-making is around the hyper acute stroke, for the purpose of the wider discussion with the public that he would like to emphasis much of our focus as commissioners is around primary and secondary care prevention and that will continue to be one of our key areas in local CCGs, we work together to develop hyper acute services but we remain committed to the wider issues around the primary and secondary care prevention. Lisa Wilkins reassured members that the ACS does have a prevention workstream that precisely looks at how we can improve our primary prevention and also our secondary prevention for the management of clinical risk factors e.g. hypertension and anti-coagulation for people with atrial fibrillation. Also another group of people of importance are people who have a TIA (minor stroke) and that they receive prompt assessment and secondary prevention measures and our TIA services are within the Hospital Services Review. Chris Edwards sought clarification on how this decision and process relates to the Hospital Services Review. Marianna Hargreaves replied that in addition to the hyper acute stroke element there were opportunities for us to improve care across the wider	

	pathway and that is one of the reasons why it has been included in the Hospital Services Review which is an ongoing review. Lesley Smith reminded members that a few years ago this group of Commissioners Working Together made the decision to work on hyper acute stroke services and just hyper acute. The rational at that time was that was one area that required us to work together. The view was that other elements e.g. rehabilitation and early supported discharge sat in 'place'. More recently we have looked at some the challenges that are faced in the elements of the pathway and come to the collective decision to include those in the Hospital Services Review. The Chair requested each organisation to state their decision and the Joint Committee of Clinical Commissioning Groups considered the information set out in the decision making business case and unanimously approved the recommended new model of hyper acute stroke care for South Yorkshire and Bassetlaw Accountable Care System. NHS Hardwick CCG supported the proposal and the decision of the Joint Committee of Clinical Commissioning Groups. When giving their approval the following additional comments were made: • Idris Griffiths, NHS Bassetlaw CCG, stated one of the particular things around Bassetlaw Hospital is that they are not overtly affected by this as Bassetlaw's hyper acute stroke patients already go to Doncaster Royal Infirmary. We know the volumes going through hyper acute stroke at Bassetlaw will increase and get into the range 900-1500 which should help to improve the quality of service provided and on that basis the proposal was welcomed. • Ben Milton, NHS North Derbyshire CCG, noted they are a peripheral element of this work but as a member of the committee NHS North Derbyshire CCG are happy with the work being done and happy to support the proposals. • Chris Edwards, NHS Rotherham CCG, recognised this proposal would improve health outcomes for Rotherham patients and on that basis the proposal was supported. The Chair added that this is just the start of the process as there will be a phased implementation of how this will affect patients in a safe and managed way going forward. The Chair requested regular and updates to this group as the implementation progresses.	
60/17	**Questions from the public** There were no questions from the public present at the meeting. However, written questions from the public had been received and these will be answered with the minutes as previously.	
61/17	**To consider any other business**	

	There was no other business brought before the meeting.	
62/17	**Date and Time of Next Meeting** The Chair informed the meeting that the next meeting will take place on 20th December 2017 in the Boardroom at NHS Sheffield CCG at a time to be confirmed.	

Written questions received from Mr Tony Nuttall

Question: As the changes in hyper acute stroke services were implemented 14 or 15 months ago, before any consultation, what evidence do you have by now that a) patient outcomes have improved and b) access for relatives has not worsened?

Answer: Marianna Hargreaves responded by saying there has been a specific arrangements in place with some Barnsley patients being eligible for thrombolysis being taken to other HASU centres for thrombolysis, this has been relatively small number numbers, not large enough to understand with respect to outcomes, we have not had any feedback with respect of adverse implications for relatives and families.

Peter Anderton added that informal feedback from Pinderfields is that the patients transported there and sometimes transported straight back if they have not been eligible for thrombolysis have generally been positive and supportive. Again, alluding to the Greater Manchester experience, it is worth noting that Greater Manchester centralised their stroke care in two phases so initially they only transported patients who were thought were eligible for thrombolysis and then in the second phase in 2015 they transported all patients in the hyper acute phase and it was only after that they have seen a reduction in mortality. It is worth noting that from their report published this summer they have had very good feedback from patients and carers and this is despite travelling large distances. There are 3 HASU centres in Greater Manchester and overnight only one which is Salford. So from as far north as Oldham and as far south as Macclesfield you get transported into Salford and their feedback is the patients and relatives are extremely happy with the high quality of care they are accessing so this bodes well in South Yorkshire and Bassetlaw.