North Kirklees Clinical Commissioning Group
Wakefield Clinical Commissioning Group

EXTRAORDINARY GOVERNING BODY MEETING
IN PARALLEL WITH NHS NORTH KIRKLESS CCG AND NHS WAKEFIELD CCG

Thursday 22 June 2017
Dewsbury Town Hall, Reception Room, Wakefield Old Road, Dewsbury, WF12 8DG
3.00pm – 4.00pm

AGENDA

1.	**3:00pm**	**Welcome and Introductions Chairs opening remark**	**Chairs**
2.	**3:05pm**	**Apologies**	**Chairs**
3.	**3:10pm**	**Vision & Values** **Declarations of Interest**	**Chairs**
4.	**3:15pm**	**Questions from the Public** **Members of the public may raise issues of general discussion (10 minutes)**	
5.	**3:25pm**	**Formal Decision Making: Receive recommendations from the Star Chambers**	**Pat Keane, Chief Operating Officer, NHS North Kirklees and NHS Wakefield CCGs.**
6	**3:50pm**	**Questions from the Public** **Members of the public may raise issues of matters arising which relate to the agenda (10 minutes)**	
7.	**4:00pm**	**Close**	**Chairs**

NHS
North Kirklees
Clinical Commissioning Group

Definition of an interest

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship.
In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of hours commissioning and involvement with integrated care organisations, as clinical commissioners may find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

Interests can be captured in four different categories:

1. **Financial interests:**

This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A shareholder(of more than 5% of the issued shares or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A management consultant for a provider, this could also include an individual being:
- In secondary employment;
- In receipt of secondary income from a provider;
- In receipt of a grant from a provider;
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

2. **Non-financial professional interests:**

This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.

GPs and practice managers, who are members of the governing body or committees of the CCG, should declare details of their roles and responsibilities held within their GP practices.

3. **Non-financial personal interests:**

This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.

4. **Indirect interests:**

This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend;
- Business partner.

A declaration of interest for a “business partner” in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the CCG.

CCGs should provide clear guidance to their employees, members and governing body and committee members on what might constitute a conflict of interest, providing examples of situations that may arise.

The above categories and examples are not exhaustive and the CCG should exercise discretion on a case by case basis, having regard to the principles set out in the next section of this guidance, in deciding whether any other role, relationship or interest which would impair or otherwise influence the individual's judgement or actions in their role within the CCG. If so, this should be declared and appropriately managed.

Our Values

1. **Patient First**
2. **Strive for excellence**
3. **Value each other**
4. **Lead from every seat**
5. **Engage, involve and include**

Behaviours That Define Our Values

1. Patient first

We will:

- Achieve the best for our community
- Consult, engage and involve patients as part of our day-to-day business
- Put our community at the heart of our decision-making
- Ensure good quality and best value
- Learn from and respond to patient and community feedback
- Advocate for our patients

2. Strive for excellence

We will:

- Be clear about our goal and vision
- Commission safe, good quality, clinically-effective and best value services
- Hold our providers to account with rigour
- Continually improve
- Learn from our mistakes

3. Value each other

We will:

- Treat each other with respect
- Give timely, honest and sincere appreciation
- Bring a positive attitude to work – take responsibility for our actions and reactions
- Support each other, especially when times are hard
- Work as one team

4. Lead from every seat

We will:

- Embrace improvement and innovation
- Embrace opportunities
- Take pride in the work we do
- Be consistent in our messages
- Be clear about our objectives
- Be personally accountable in our role and function
- Hold each other to account
- Commit to learning: we are a learning organisation

5. Engage, involve and include

We will:

- Work fully in partnership with our community, members and colleagues
- Be open, honest and transparent in our processes
- Listen and encourage feedback because everyone's feedback counts
- Recognise and respect differences amongst us

NHS Calderdale Clinical Commissioning Group

NHS Greater Huddersfield Clinical Commissioning Group

NHS North Kirklees Clinical Commissioning Group

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Name of Meeting	Joint Meeting of the Governing Bodies North Kirklees & Wakefield CCG	**Meeting Date**	22/06/2017
Title of Report	Recommendation from the Star Chamber to consider changes to hospital services	**Agenda Item No.**	
Report Author	Ruth Unwin, Associate Director of Corporate Affairs	**Public / Private Item**	Public
GB / Clinical Lead	Dr Phillip Earnshaw, Clinical Chair	**Responsible Officer**	Jo Webster, Chief Officer

Executive Summary	
Please include a brief summary of the purpose of the report	Under the Meeting the Challenge programme, changes to hospital services across North Kirklees and Wakefield were approved by the Secretary of State for Health in March 2014 following public consultation. The first major changes to services were implemented in September 2016 and included changes to maternity, children's inpatient care and surgical services. It was agreed in April 2017 that the remaining changes would be delivered in a phased way between May 2017 and September 2017 with a series of enabling projects being completed over that time period before changes to acute inpatient medical care were implemented. Relocation of critical care beds and complex surgery from Dewsbury Hospital to Pinderfields Hospital will coincide with the relocation of acute medical beds. Star Chamber is a process developed by the National Quality Board (NQB) to assess the safety implications of significant service changes and has been used as a mechanism for clinically assuring changes at every stage of implementing the Meeting the Challenge programme. A Star Chamber met on June 9th to quality assure three projects which will facilitate the reconfiguration of acute inpatient care. These changes include: • Introduction of a dedicated pathway for patients who meet the frailty criteria • Relocation of acute respiratory inpatient beds within the Pinderfields hospital site and extension of the unit to manage other acute patients • Development of a clinical decisions unit (CDU) at Dewsbury Hospital The paper sets out the findings of the Star Chamber and their recommendation to proceed with these changes. A further quality assurance process will be undertaken prior to the implementation of changes to acute inpatient care.

Previous consideration	**Name of meeting**	The Full Business Case for Meeting the Challenge was approved by the Governing Body in July 2014. The Governing Body has received regular updates on implementation of the changes and approved previous phases following assurance through the Star Chamber process.	**Meeting Date**	July 2014

Recommendation (s)	It is recommended that the Governing Body: Approve the recommendation from the Star Chamber held on June 9th 2017 to proceed with the following changes to hospital services: ▪ Introduction of a dedicated pathway for patients who meet the frailty criteria ▪ Relocation of acute respiratory inpatient beds within the Pinderfields hospital site and extension of the unit to manage other acute patients ▪ Development of a clinical decisions unit (CDU) at Dewsbury Hospital Note the further assurance process that will take place before further changes to acute inpatient care proceed						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications			
Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)			
Public / Patient / Other Engagement		Formal public consultation was undertaken to support development of the Full Business Case. There has been regular on-going dialogue with the Joint Health Overview and Scrutiny Committee.	
Resources / Finance implications (including Staffing/Workforce considerations)		There are no resource implications specifically relating to these changes	
Strategic Objectives (which of the CCG objectives does this relate to)	***Wakefield CCG:*** Reduction in hospital admissions where appropriate leading to reinvesting in prevention. New Accountable Care Systems to deliver new models of care. Transforming to become a sustainable financial economy. Organising ourselves to deliver for our patients. ***North Kirklees CCG***: Our patients are at the heart of our commissioning decisions. Commissioning equitable services that are fit for everyone which are fit for purpose. Improving the lives of everyone who lives in North Kirklees. Building a sustainable organisation based on the aspirations of our members.	**Risk** (include link to risks)	The Star Chamber process is designed to assess the safety impact of changes to hospital services

Legal / Constitutional Implications		**Conflicts of Interest** (include detail of any identified/potential conflicts)	There is a potential conflict of interest in relation to the primary care elements of the service model

Outcome of Integrated Impact Assessment completed (IIA)	Integrated Impact Assessment was undertaken to support development of the Full Business Case
Assurance departments/ organisations who will be affected have been consulted:	Insert details of the people you have worked with or consulted during the production of this paper : Chief Finance Officer Clinical Chair and Deputy Clinical Chair Clinical cabinet members Chief Nurse and Chief of service delivery Chief Operating Officer Clinical leads (insert job title) Mid Yorkshire medical director and clinical leads Yorkshire Ambulance Service operational and strategy leads
Previously presented at committee / governing body:	The Full Business Case for Meeting the Challenge was approved by the Governing Body in July 2014. The Governing Body has received regular updates on implementation of the changes and approved previous phases following assurance through the Star Chamber process.
Reference document(s) / enclosures:	Board Briefing on the Meeting the Challenge programme (attached) Description of the Star Chamber process: www.wp.dh.gov.uk/health/files/2012/07/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

Recommendations from the Star Chamber held on June 9th 2017 to quality assure changes to hospital services

1.0 Background

Changes to hospital services across North Kirklees and Wakefield were approved by the Secretary of State for Health in March 2014 following formal public consultation.

Work started on making these changes in September 2014, with the opening of a children's assessment unit at Dewsbury Hospital. A new specialist eye centre opened at Pinderfields in June 2015. Changes to acute cardiology were implemented in September 2015. Changes to women's, children's and some surgical services were implemented in September 2016.

There has been an ongoing programme of work to enhance primary and community care services to reduce the needs for people to be admitted to hospital and to support earlier discharge.

In April 2017, the Governing Bodies of NHS North Kirklees CCG and NHS Wakefield CCG agreed that a greater number of beds than originally planned should be retained across the system. The impact of this will mean more beds will remain on the Dewsbury Hospital site than in the original plan.

The changes that were reviewed by the Star Chamber on June 9th are part of the enabling projects that will facilitate reconfiguration of acute medicine by ensuring inpatient services are appropriately distributed across the Dewsbury and Pinderfields Hospital sites.

2.0 Star Chamber

Star Chamber is a formal part of the Quality Impact Assessment (QIA) process developed by the National Quality Board to assess provider cost improvements and assure safety and effectiveness of services when changes are being implemented. It is designed to provide a forum for timely, open and constructive challenge by clinicians and managers to identify potential risks and unintended consequences.

A Star Chamber was held on June 9th 2017 to peer review and critique the Quality Impact Assessments for three services changes:

- Development of a frailty pathway for patients presenting at hospital
- Relocation of acute respiratory inpatient care within Pinderfields Hospital and expansion of the unit to accommodate other acutely ill patients
- Development of a clinical decision unit (CDU) at Dewsbury Hospital

The purpose of the Star Chamber was to

- Review the phased approach being taken by Mid Yorkshire Hospitals:
- Review developments since April 2017;
- Seek assurance around plans for enabling projects to be delivered in the next phase;
- Consider the assurance requirements and process for changes to acute inpatient care.
- Review the impact of ambulance 'drivetime' on YAS, MYHT and other acute Trusts;
- Review the impact of YAS 'drivetime' and intra-site transfers on YAS capacity for 999 response and transfers, performance and activity.

3.0 Evidence presented to the Star Chamber

The following information was presented to the Star Chamber

- Quality Impact Assessment for development of the frailty pathway
- Quality Impact Assessment for relocation of the acute respiratory unit

- Quality Impact Assessment for the development of a clinical decision unit
- Details of the impact of the changes to date on Yorkshire Ambulance Service (A&E Operations and PTS)
- The anticipated impact of future changes to on Yorkshire Ambulance Services.

The impact for ambulance and hospital services were considered by two separate discussion groups.

4.0 Changes to Mid Yorkshire Hospital (MYHT) services

4.1 Frailty Model

The proposed change involves development of frailty units at Dewsbury and Pinderfields Hospital, which would be delivered by a consultant and multi-disciplinary Rapid Assessment and Care of the Elderly Team (REACT). All appropriate patients would be screened on arrival at hospital using a frailty scoring tool and those who meet the frailty criteria would be transferred directly to the Frailty Unit. The unit would be open from 8am to 8pm daily with access to clinicians on an on-call arrangement outside these times.

The Frailty Units have been planned in accordance with the Royal College of Physicians 'Future Hospital' principles using a scoring tool which is designed to work in a complementary way to frailty assessment tools used by professionals in the community.
The service has been operating as a pilot.

It was acknowledged that there was an opportunity to further enhance the frailty model by aligning it to management of frail and elderly people in the community. It was agreed that there was consistency between the assessment tools used in community, primary and secondary care settings. The Star Chamber was also assured that a joined up system was being developed to ensure community and primary care is linked into acute models and that the patient's frailty score would be available through the Summary Care Record, which is accessible to all relevant professionals. Strong links to community and social care would enable people to be offered care at or close to home as an alternative to being admitted to hospital, where appropriate. This approach is supported by evidence that frail and elderly patients are more likely to decompensate (lose ability to function or become more unwell) if they spend time as a hospital inpatient.

It was noted that the development of the frailty units would have a significant beneficial impact on quality, performance and patient experience by reducing unavoidable admissions for older people and ensuring people who do require admission are moved promptly to an appropriate setting.

4.2 Acute Care Unit

Pinderfields currently has eight high dependency respiratory beds (ARCU). The proposal is to move these beds from Gate 27 to Gate 45A and to create a 14 bed acute care unit capable of accommodating other associated specialties.

There is evidence that acute care for patients with ventilatory failure is better delivered in a high dependency area resulting in shorter length of stay and better recovery rates.
It was noted that the development of an acute care unit would result in better outcomes for respiratory patents and those with acute kidney injury. Availability of isolation rooms would enhance care for patients with infections or reduced immunity.

4.3 Clinical Decision Unit

The proposal is to develop a clinical decision unit (CDU) on the Dewsbury Hospital site. This unit would be complementary to the ambulatory emergency care unit (AEC) providing ten beds for patients who are unlikely to need an extended admission to hospital but need to be in a bed while they are being assessed or treated.

Data analysis shows that during 2015/16 there were 1064 patients who stayed in hospital for less than 24 hours who were not managed through ambulatory care but potentially could have been. Selection of patients to be managed in the ambulatory emergency care unit and CDU is based on national guidance.

It was noted that the AEC and CDU would have a significant beneficial impact on quality and performance by ensuring patients are safely managed without admission, where appropriate and were provided with care at or close to home. The unit would also improve patient experience by reducing the need for patients to be transferred from Dewsbury to Pinderfields for a short admission.

4.4 Staffing

The most significant area of concern raised through the Star Chamber related to the availability and deployment of appropriately skilled staff to support the new models. MYHT colleagues advised that internally staff have been consulted to identify people with the requisite skills who have a preference for working in these particular environments. It is anticipated that allocating staff to a defined clinical area of their choice will lead to increased job satisfaction and better retention of existing staff. It will also facilitate recruitment of new staff to units which have a clearly defined function.

Rotas have been reviewed to match anticipated demand. It was acknowledged that in spite of the significant, innovative work done by the Trust to recruit and retain staff, staffing challenges were already present in the existing models, and the proposed changes would go some way towards mitigating this risk. The Trust agreed to share details of their approach to developing a robust staffing establishment to support the proposed models of care.

4.5 Implementation of changes to acute medical inpatient care

MYHT colleagues confirmed that the benefit of some of the changes under consideration would not be fully realised until full reconfiguration had been implemented. However, it was noted that it would be helpful to be able to see that these enabling services were in place and operating effectively when considering the final phase of the Meeting the Challenge programme, which would result in inpatient care for patients requiring acute and specialist care being centralised at Pinderfields.

5.0 Ambulance journeys

Discussion groups considered the impact of the changes on:

- Ambulance journey times and distances and capacity.
- Inter and intra hospital transfers

5.1 Journey Times

The observed impact in terms of increased journey times and potential impact on overall response performance was noted.

5.2 Inter hospital transfers

The overall impact of reconfiguration changes to date and future planned changes in terms of increased numbers of transfers between sites was noted. Reassurance was sought from Mid Yorkshire Hospitals Trust and YAS regarding ongoing actions to ensure transfer times for patients do not increase adversely to affect outcomes.

It was confirmed that MYHT and YAS would continue to work closely to develop pathways for patients to transfer appropriately, safely and in a timely way.

5.3 Secondary Transfers

It was confirmed that when all the changes to inpatient medical beds are complete, ad hoc diverts of emergency ambulances from Pinderfields to Dewsbury will no longer take place intra site, however there will be an increase in transfers from Dewsbury Hospital to Pinderfields and from Pinderfields from other sites. A question was raised regarding YAS decision making from scene to A&E and there was an agreement to review the numbers of patients who were taken to DDH who were immediately transferred to Pinderfields without further intervention (pure secondary transfer from A&E)

5.4 Delays in Transfers

There was discussion around the further development of a Yorkshire Ambulance Service (YAS) transport model to minimise use of emergency crews and vehicles for non-emergency transfers between hospitals.

It was confirmed that MYHT and YAS clinicians and managers would continue to work closely to Identify and prioritise patients requiring transfer.

YAS confirmed that in the:

Short term – they would plan to support the changes set out in the paper if the resource allocation into the area could be increased using short term measures – for example by increasing the amount of overtime available to staff. However there was recognition that this would be a safe way to proceed but not a sustainable option;

Long Term – further work was needed to review resources to support the next phases of service reconfiguration at Mid Yorkshire and the wider across the Yorkshire region.

6.0 Conclusion & next steps

The Star Chamber agreed that the proposed MYHT models were agreed in principle to support phase 2 of the reconfiguration.

The Star Chamber were also content that the actions and mitigations proposed by YAS. Provided assurance that the required patient transport can be delivered safely and at the required quality during this phase but that a longer term solution was required via agreement with commissioners and YAS on a Yorkshire and Humber footprint

It was noted that the timescales for implementing the final phase were subject to assurance around delivery of the models discussed. It was agreed that a further Star Chamber would need to be arranged to quality assure the final phase.

This Star Chamber would need to be arranged to allow sufficient time for the Governing Bodies to consider its recommendations and reach a decision; and to enable the date that changes would happen to be effectively communicated to the public.

The Star Chamber would need to receive evidence that the enabling projects set out above had been implemented and that there were robust plans to address staffing challenges.

It was agreed that MYHT would provide a Quality Impact Assessment setting out the risks and mitigations of proceeding with the changes and the risks and mitigation of delaying implementation.

Assurance on plans to increase local access to planned care and outpatient appointments for North Kirklees residents was also requested.

7.0 Recommendation of the Star Chamber

On the basis of the information presented and the discussions that took place, the Star Chamber recommends that the Governing Bodies of NHS North Kirklees and NHS Wakefield CCGs:

- Approve the recommendation from the Star Chamber held on June 9th 2017 to proceed with the following changes to hospital services:
  - Introduction of a dedicated pathway for patients who meet the frailty criteria
  - Relocation of acute respiratory inpatient beds within the Pinderfields hospital site and extension of the unit to manage other acute patients
  - Development of a clinical decisions unit (CDU) at Dewsbury Hospital

- Note the further assurance process that will take place before the planned changes to acute inpatient care, critical care and complex surgery proceed

Ruth Unwin
Associate Director of Corporate Affairs
NHS Wakefield CCG
June 14th 2017