MEETING DATE:	10 May 2012	North Lincolnshire Clinical Commissioning Group **CLINICAL COMMISSIONING GROUP COMMITTEE (CCGC)**
AUTHOR:	Caroline Briggs Director of Strategy & Joint Commissioning	
REFERENCE:	Item 8.1	
FOR DECISION/ NOTING/ INFORMATION:	Information and Awareness	
FREEDOM OF INFORMATION: OPEN/CLOSED	Open	

MINUTES OF THE YORKSHIRE & HUMBER SPECIALISED COMMISSIONING OPERATIONAL GROUP 24 FEBRUARY 2012 & 23 MARCH 2012

PURPOSE OF THE REPORT:
The minutes from the Yorkshire & Humber Specialised Commissioning Operational Group from 24 February 2012 and 23 March 2012 are attached, for information and awareness.
WHAT ACTION DOES CCGC NEED TO TAKE and ANY RECOMMENDATIONS?:
For information and awareness.
HOW DOES THIS REPORT SUPPORT CCG DEVELOPMENT and AUTHORISATION?:
N/A
HOW DOES THIS REPORT PROVIDE ASSURANCE TO THE BOARD? **Note: beware of the need for assurance regarding delegated responsibilities from the Humber Cluster Board including E&D, Environmental Impact, Risk, Legal Implication.**
N/A

Enclosure: A

YORKSHIRE AND THE HUMBER SPECIALISED COMMISSIONING OPERATIONAL GROUP

Meeting held on Friday, 24 February 2012
At Sandal Rugby Club, Wakefield

Decision Summary for PCT Boards

1 STRATEGY & DIRECTION

SCOG 38/11 Radiotherapy

It was agreed:

(a) that leadership and governance in respect of commissioning radiotherapy, including the expansion plan, rested with the Y&H SCOG on behalf of the North of England SCG;

(b) that further work be undertaken on developing the service model based upon national guidance taking into account value for money principles;

(c) that procurement would follow existing processes and be based on the agreed service model;

(d) that clarification be sought in respect of the capacity and case numbers relating to stereotactic body radiotherapy;

(e) that contracts include the new mandated national currencies from April 2012; and

(f) a further report be made to the Y&H SCOG in respect of the service model. **Kim Fell**

SCOG 44/11 Financial Plan 2012-13

It was agreed:

(a) that the current version of the Financial Plan 2012-13 be agreed as the basis for negotiating 2012/13 contracts.

(b) That PCTs and the SCT work together to finalise 2012/13 contract values. **Frances Carey**

SCOG 46/11 Management Budget 2012-13

It was agreed:

(a) that the constituent PCTs be refunded £133,000 in respect of Y&H management costs for 2011-12; and

(b) that PCT Finance Directors be advised of any changes. **Frances Carey**

2 POLICY

SCOG 50/11 Policy Recommendations from the Regional Policy Sub Group

It was agreed:

(a) that the policy recommendations of the Regional Policy Sub Group in respect of:-

Botulinum toxin for migraine
Lanreotide for paediatric fistula
Defibrotide for veno-occlusive disease
Stereotactic radiosurgery/radiotherapy to cerebral metastases

be noted.

(b) that a report be prepared for PCT Cluster Boards to enable consideration and approval of the policies; and

(c) that the policies are implemented and maintained and that they are made available to the public in accordance with directions of the Secretary of State. **Paul McManus**

YORKSHIRE AND THE HUMBER SPECIALISED COMMISSIONING OPERATIONAL GROUP

Meeting held on Friday, 24 February 2012
Sandal Rugby Club, Wakefield

Present:

Andy Buck	Chief Executive	NHS South Yorkshire & Bassetlaw (32/11 – 39/11) Chair
Ian Atkinson	Chief Operating Officer	NHS Sheffield, representing NHS Barnsley, NHS Doncaster and NHS Rotherham
Caroline Briggs	Director of Strategy and Joint Commissioning	NHS The Humber
Mike Potts	Chief Executive	NHS Calderdale, Kirklees & Wakefield – Chair (40/11 – 58/11)
Matt Neligan	Director of Commissioning Development	NHS Airedale, Bradford & Leeds
Annabel Johnson	Assistant Director of Specialised Commissioning	NHS North Yorkshire & York

In Attendance:

Cathy Edwards	Director	NoE SCG (Y&H)
Kevin Smith	Medical Advisor	NoE SCG (Y&H)
Paul McManus	Lead Pharmacy Adviser	NoE SCG (Y&H)
Lisa Marriott	Assistant Director of Commissioning	NoE SCG (Y&H)
Frances Carey	Deputy Director of Finance	NoE SCG (Y&H)
Ged McCann	Associate Director, Secure & Specialist Mental Health	NoE SCG (Y&H) (item 36/11 & 37/11)
Paul Crompton	Business Manager	NoE SCG (Y&H)
Anthony Prudhoe	Assistant Director of Contracting & Performance	NoE SCG (Y&H)
Kim Fell	Cancer Director	North Trent Cancer Network (item 38/11)
Louise Davies	Senior Commissioning Manager	Specialised Services Commissioning Team Y&H SCG (item 36/11 & 37/11)

SCOG 32/11 Apologies

Steve Hackett, Director of Finance, NHS South Yorkshire & Bassetlaw
Neil Hales, Assistant Director of Contracting & Performance, NoE SCG (Y&H)

SCOG 33/11 Declarations of Interest

There were no declarations of interest.

SCOG 34/11 Minutes of the Yorkshire & the Humber SCOG meeting held on the 27 January 2012

It was agreed:

that the minutes of the Yorkshire & the Humber SCOG meeting held on the 27 January 2012 be approved as a true and accurate record. **Paul Crompton**

SCOG 35/11 **Matters Arising**

There were no matters arising from the minutes.

SCOG 36/11 **Women's Low Secure Services in York**

A report in respect of women's low secure services in York was presented to the meeting.

The outline business case submitted by NHS North Yorkshire & York for the development of a new women's low secure service had been approved by NHS Yorkshire and the Humber in April 2011. The scheme comprised a capital payment of £9.4m and the subsequent service provision.

The SCT had been asked by NHS North of England to seek legal advice on the potential for any future challenges from alternative service providers to the Co-operation and Competition Panel.

A copy of the outline business case and the legal opinion provided, were presented as part of the report. The legal opinion indicated that the capital build process could proceed without risk of legal challenge, but there were potential risks in relation to the provision of services.

There were no risks relating to the delivery of the current service as this was provided through out of district spot purchases.

A discussion followed and it was felt that the roles of NHS North Yorkshire & York, and NHS Barnsley as the specialised commissioning host needed to be reviewed in terms of current and future commissioning arrangements. A conversation was also required with the SHA with regard to long-term issues for the NHSCB. There was also a view that the legal advice would need to be checked to ensure it was based on all the facts relating to the actions previously taken to advertise the opportunity to provide the service.

Ultimately clarification would also be required on the status and ownership details of the property in York and who would be providing the service.

It was agreed:-

(a) that the contents of the report in respect of women's low secure services in York be noted;

(b) that further discussions be held with NHS North Yorkshire & York, NHS Barnsley and NHS North of England regarding current and future risk and any other issues requiring clarification;

(c) that the legal opinion be re-checked; and

(d) a further report be made to the Yorkshire & Humber SCOG **Ged McCann/ Cathy Edwards**

SCOG 37/11 **Mental Health Case Management**

A report in respect of mental health case management was presented to the meeting, which set out an update from the Yorkshire & Humber SCG meeting in December 2011.

At that meeting the Y&H SCG had supported the need for additional case management capacity (1.5 wte), as part of the delivery of commissioning mental health 'minimum take' services from April 2012. Three PCTs currently had case managers (North Yorkshire & York, Bradford and Hull) and discussions to date indicated that these PCTs wished their staff be retained locally, rather than transferred to specialised commissioning.

A discussion followed, which confirmed that the mental health 'minimum take,' placed the responsibility for commissioning these services on the SCG. The issue therefore related to the need to transfer appropriate resources to reflect the transfer of commissioning responsibility.

It was recognised that the proposed interim structure would need to be handled very carefully, however, SCOG needed assurance that satisfactory arrangements for case management would be in place from April 2012 onwards.

It was agreed:-

(a) that further discussion would take place with NHS North Yorkshire & York, NHS Airedale & Bradford and NHS Hull regarding staffing issues;

(b) that the matter be referred to the Chief Executives' meeting, if required; and

(c) that a further report be made to the SCOG in respect of the assurances regarding the proposals for mental health case management from April 2012 onwards. **Cathy Edwards/ Ged McCann**

SCOG 38/11 Radiotherapy Services in Yorkshire and the Humber

A report was presented to the meeting in respect of radiotherapy services in Yorkshire and the Humber. The report provided an update from that reported at the January Y&H SCOG meeting.

A discussion followed, which was structured around the five recommendations in the report.

It was confirmed that the leadership and governance arrangements in relation to this matter rested with the Y&H SCOG on behalf of the North of England SCG. Cancer Networks would be a source of clinical advice to the Y&H SCOG. The work being undertaken by the North Trent Cancer Director was being undertaken on behalf of the Director of Specialised Commissioning. Radiotherapy services were part of the 'minimum take' to be commissioned by all SCGs from April 2012.

The next stage would be to determine the service model. Progress had been undertaken on mapping work for the Yorkshire & Humber area based on the national advice that services should be based on a dispersed model. More work was required on this and a further report would be made to the Y&H SCOG.

Once the service model was agreed, procurement options could be considered.

There would be a need for discussion with the SHA with regard to possible

procurement issues and/or capital development issues.

The commissioning policy for stereotactic body radiotherapy was discussed, including the capacity and case numbers associated with this; further understanding of the impacts was required.

It was noted that there was a new mandated national currency for radiotherapy from April 2012, and that these should be used in preparation for the implementation of the new national tariff.

It was agreed:-

(a) that leadership and governance in respect of commissioning radiotherapy, including the expansion plan, rested with the Y&H SCOG on behalf of the North of England SCG;

(b) that further work be undertaken on developing the service model based upon national guidance taking into account value for money principles;

(c) that procurement would follow existing processes and be based on the agreed service model;

(d) that clarification be sought in respect of the capacity and case numbers relating to stereotactic body radiotherapy;

(e) that contracts include the new mandated national currencies from April 2012; and

(f) a further report be made to the Y&H SCOG in respect of the service model. **Kim Fell**

SCOG 39/11 **Implementation of the Neonatal Services Recommendations**

An update report was presented to the meeting in respect of the implementation of the Neonatal Toolkit recommendations.

The report summarised the proposed integration of neonatal surgery at Sheffield Teaching Hospitals and Sheffield Children's Hospital which had been agreed at the Y&H SCG meeting on the 28 November 2011. The meeting was advised that Sheffield Teaching Hospitals had now formally written to the Director of Specialised Commissioning to say that there were some outstanding issues. Discussion had taken place and a way forward had been agreed. A meeting would take place at Sheffield Children's Hospital to clarify any issues relating to the current service and future service requirements.

In terms of the below 27 week threshold, both Chesterfield Royal Hospital FT and Airedale Hospital Trust had accepted the threshold.

A meeting had been held with Calderdale and Huddersfield NHS Foundation Trust (CHT) on 9 February. Further work was required before discussions could be concluded on the location of NIC services within the western part of the YNN.

A further meeting would take place on 13 March.

One of the issues raised at the February meeting was around the SCGs direction of travel i.e. whether below 27 weeks was part of a stepped change to a below 28 week threshold or the agreed final threshold.
A discussion followed and it was confirmed that the current intention was to commission to the 27 week threshold, however no assurance could be given for future intentions of the NHS Commissioning Board.

The meeting was advised that neonatal services would be part of the national specialised services work programme which would result in ensuring compliance with the Toolkit and to achieve more convergence in standards.

The report highlighted issues raised by providers in respect of pricing and income shortfall and the impact in meeting the Toolkit recommendations.

An effective transport service was essential for neonates requiring critical care to be cared for in the most appropriate setting and for capacity to operate efficiently. The impact of the proposed changes to gestational threshold had been included in the ongoing assessment of the activity demands on the Embrace service.

It was agreed:-

(a) that the contents of the update report in respect of implementing the Neonatal Toolkit recommendations be noted;

(b) that the situation in respect of Sheffield Teaching Hospitals, Sheffield Children's Hospital and neonatal surgery services be noted;

(c) that the current position of Y&H SCOG was that they wished to commission on the basis of a below 27 week threshold;

(d) that further discussion take place with Calderdale and Huddersfield Trusts with regard to the situation in the western area of the Yorkshire Neonatal Network, and that a further report be made;

(e) that the work being undertaken to compare price and quality across Neonatal units be noted and that a further report be made on the matter; and

(f) that the proposal to strengthen the Embrace service be supported. **Lisa Marriott**

SCOG 40/11 **North of England SCG**

A verbal update was provided to the meeting in respect of the North of England SCG meeting held on 16 February 2012.

The meeting had agreed some 'contract principles' which had been useful in highlighting some areas that needed to be progressed.

A checking process was underway to ensure that all PCTs had agreed to the North of England SCG Establishment Agreement.

A 'Cluster Development Plan' had been presented to the meeting and this would be brought to a future Y&H SCOG meeting for information.

The proposals in respect of Major Trauma in the Yorkshire & Humber area

had been approved.

It was agreed:-

that the verbal update in respect of the North of England SCG meeting held on the 16 February 2012 be noted. **Cathy Edwards**

SCOG 41/11 **Transition General Update**

A verbal update was provided to the meeting in respect of 'Transition'. The over-riding issue was the concern which was being expressed by a wide range of individuals and organisations with regard to how specialised commissioning would feature in the NHSCB operating model. It was noted that the North of England SCG would be performance managed against the 'Cluster Development Plan'.

It was agreed:-

Cathy Edwards

that the verbal update in respect of 'Transition' be noted.

SCOG 42/11 **Contract Portfolio Update**

A report was presented to the meeting in respect of contract portfolios which provided an update using RAG ratings of the likelihood or otherwise of providers meeting the contract sign off deadline date set for the 15 March 2012.

The meeting was advised that the information in respect of mental health contracts needed updating as there had been changes since the report was written. A more detailed report would be presented to the Y&H SCOG meeting in March 2012.

There was a discussion about possible risks and it was felt to be important that the SCG and PCT returns were in conformity in their risk assessment.

The discussion that had taken place at the North of England SCG was reported in terms of what action could be taken if contracts were not signed by the 15 March 2012.

It was agreed:-

that the contents of the report on contract portfolios be noted. **Anthony Prudhoe**

SCOG 43/11 **SCG Acute CQUIN Scheme 2012-13**

A report was presented to the meeting in respect of the SCG acute CQUIN scheme 2012-13.

The report set out the progress that had been made at the Clinical Standards Sub Group meeting on the 9 February 2012.

It was noted that in Table 2, York should be denoted as both NIC and Renal CQUIN.

The CQUIN summary menu or national pick-list had been used as the basis

to form an outline scheme which proposed quality incentive indicators to be adopted for all providers. It was proposed that for Yorkshire and the Humber providers the indicators for 2012/13 would be distributed over the following areas:-

- 1 x Cancer
- 2 x Cardiac
- 2 x NIC
- 2 x PIC
- 2 x Renal
- 1 x Spinal (SCI)

1.5% or 60% of the total 2.5% available to providers under CQUIN in 2012/13 would be apportioned to the above specialty specific areas.

0.5% or 20% would be allocated to Quality Dashboards which were mandated for adoption in all SCG contracts for 2012/13.

The CSSG had suggested the maximum permissible amount of 20% (minimum 10%) be allocated to the production of Quality Dashboards as this looked to present a significant additional data collection burden for many providers. A higher level than the minimum 10% had further been suggested due to concerns providers may not engage in the process, and thus represented a risk in future migration to the NHS Commissioning Board, if the minimum % had been allocated.

0.5% or 20% remaining would be allocated to the following DH mandated schemes:

- VTE risk reduction
- Improving patient experience
- Improving diagnosis of dementia in hospitals
- Use of Safety Thermometer

The CSSG had thus produced an outline scheme for the Y&H contract team to negotiate with providers into 2012/13 contracts for specialised services.

There was a high level of clinical and managerial engagement in the CQUIN development process however further work was required to develop schemes in some areas in which the national CQUIN picklist were not deemed robust enough for Yorkshire & Humber providers.

CQUINs were to be further developed in:

- NIC
- PIC
- Renal

A final Yorkshire and the Humber CQUIN scheme for 2012/13 would be presented to SCOG for adoption at its March meeting.

It was agreed:-

(a) that the CQUIN apportionment of 0.50% DH mandated schemes, 0.50% quality dashboard and 1.50% individual schemes be approved;

(b) that the recommendations of the Clinical Standards Sub Group in respect of the composition of the 2012-13 scheme be noted; and

(c) that the final proposals be presented to the Y&H SCOG meeting in March. **Kevin Smith/ Neil Hales**

SCOG 44/11 Financial Plan

A report on the Financial Plan 2012-13 was presented to the meeting.

The current version was based on month 8 and adjustments to forecast-outturn had been renewed. The QIPP schemes had been updated to reflect the latest position. The Financial Plan formed the basis of the contract negotiations taking place. It was noted that the data for the additional services in the 'minimum take' was still being validated. In terms of mental health, work was still underway.

The value of the current financial plan was £694.063m which included some collaborative work. Taking all factors into account the actual increase from 2011-12 was 3.76%.

A discussion followed and it was noted that there was a risk to the Financial Plan as the figures may not be correct due to the validity of the data for contract splitting.

It was felt that the QIPP data should be detailed by PCT.

It was essential that there continued to be close working between the Y&H Specialised Commissioning Teamand PCTs to ensure a smooth 'close down'. It was noted that NHS Sheffield had issues relating to the CAMHs T4 service.

It was agreed:-

(a) that the current version of the Financial Plan 2012-13 be agreed as the basis for negotiating 2012/13 contracts.

(b) that PCTs and the SCT work together to finalise 2012/13 contract values. **Frances Carey**

SCOG 45/11 Financial Risk Share 2012-13

A report was presented to the meeting in respect of financial risk sharing in 2012-13.

The Y&H SCOG Board had agreed in principle to the proposal at the meeting held on the 28 November 2011. This was subject to the impact of the 'minimum take' being modelled through. Unfortunately, this information was still not available.

A draft of the risk share proposal had been presented to the PMSG meeting on the 8 February 2012. This provided two options:-

(a) a full risk share; or

(b) a risk share by individual contract group.

The PMSG supported, in principle, the latter proposal.

As at month 8 for 2011/2012 the forecast out-turn showed variances of between plus and minus £2m across different PCTs. A risk share would mitigate against this and give greater certainty in financial planning in 2012/2013.

There was concern raised about low secure due to the disaggregation of the risk share for 2011/2012. If baselines were set as they would normally be then this this should not bring about the issues raised previously around low secure contributions versus local services in place.

A particular issue has also been raised by NHS Sheffield around where a tertiary centre also undertakes activity that could be classed as DGH work but is difficult to split out from specialist activity due to issues around counting and definitions. Other associates to the contract would not have this activity within the SCG contract but would pick up the activity in other contracts. Whilst this was a valid point it was not considered to be a material impact on the overall % of risk share application.

A discussion followed on the advantages of a risk share and the problems and concerns raised by NHS Sheffield and relating to low secure services. It was noted that the matter needed to be resolved by the March meeting of the Y&H SCOG. It was felt that further discussions should take place to try and address the areas of outstanding concern.

It was agreed:-

Frances Carey

a final report on the risk share for 2012-13 be presented to the March meeting of the Y&H SCOG.

SCOG 46/11 **Management Budget 2012-13**

A report in respect of the management budget 2012-13 was presented to the meeting.

A report in March 2011 to the Y&H SCOG Board had set out the recurrent and non-recurrent baselines for SCG management budgets which included staff and non-pay budgets.

The proposed budget for 2012-13 included a number of assumptions detailed in the report. These included:-

- Funding for CSAS at £2,400 per PCT had been assumed following agreement at the January 2012 SCOG;

- Additional funding for national clinical databases of a maximum of £75,000 had been assumed following a national review;

- Any additional costs as a result of incremental increases would be met from existing funding; and

- Any support to the arrangements for the North of England SCG would be absorbed within the current funding envelope. This did however mean that there was little flexibility left within the funding available.

A forecast under-spend of £133,000 had been projected and this may increase to £200,000. The actual value would need to take into account any implications in terms of the outcome of the South Yorkshire & Bassetlaw voluntary redundancy scheme.

A discussion followed and it was felt that PCTs should be refunded a figure of £133,000 for 2011-12.

It was agreed:-

(a) that the constituent PCTs be refunded £133,000 in respect of Y&H management costs for 2011-12; and

(b) that PCT Finance Directors be advised of any changes. **Frances Carey**

SCOG 47/11 Neuromuscular Services

A report in respect of neuromuscular services was presented to the meeting.

The December meeting of the Y&H SCG Board had considered a recommendation from the Neuromuscular Expert Panel at its meeting on the 16 December 2011. It was agreed that there should be further discussions on the possible future commissioning of specialist staff to co-ordinate and enhance local services.

The report highlighted that further discussions had taken place with Steve Wainwright, Matt Neligan and Bill Redlin the conclusion was that there was broad agreement that there was a health need to be met.

A discussion followed and it was noted that PCTs needed to determine how to take this matter forward in the context of the clinical, media and political criteria to be considered. It was noted that there was a health need and the associated costs of the proposals were minimal.

NHS Sheffield raised a number of points and it was felt that further discussions should take place particularly and specifically about implementation and the need to integrate with local services.

It was proposed that implementation be managed via the sub-regional arrangements.

It was agreed:-

(a) that the recommendations of the Neuromuscular Disease Expert Panel be agreed in principle, subject to further discussion on the implementation;

(b) that the specialised commissioners develop the work further in terms of implementation;

(c) that implementation be taken forward co-ordinated through NEYCOM, WYCOM and NORCOM. **Kim Cox/ Steve Wainwright/ Matt Neligan/ Bill Redlin**

SCOG 48/11 Major Trauma in Yorkshire and the Humber

An update report in respect of major trauma in the Yorkshire and the Humber

was presented to the meeting.

The North of England SCG at its meeting on the 16 February 2012 had approved the proposals which had been agreed by the Y&H SCOG meeting on the 27 January 2012.

The report summarised the key points and the proposed contractual arrangements in 2012-13.

The proposed contractual arrangements had been circulated to all PCT contract leads. No activity adjustments would be made to the initial contract baselines. The Best Practice Tariff would be paid via the SCG on the basis of TARN data. NHS North Yorkshire and York reiterated their concerns in the discussion, about various criteria, including the Best Practice Tariff payments. The meeting felt that there was a significant risk associated with the proposed changes and there would need to be close and continuous monitoring of activity changes as the implementation progressed.

It was agreed:-

(a) that the decision of the North of England SCG Board in respect of the major trauma services for Yorkshire and the Humber be noted; and

(b) that the proposed contractual arrangements for the major trauma service in the Yorkshire & Humber area for 2012-13 be endorsed. **Sarah Halstead/ Cathy Edwards**

SCOG 49/11 Cardiac QIPP Implementation – Update

A report in respect of the Cardiac QIPP implementation was presented to the meeting, and this summarised the progress since November 2011.

It was agreed:-
that the contents of the report in respect of the Cardiac QIPP Implementation update be noted. **Lisa Marriott**

SCOG 50/11 Policy Recommendations from the Regional Policy Sub Group

A report in respect of the policy recommendation from the Regional Policy Sub Group was presented to the meeting.

It was requested and agreed that the proposed policy in respect of Tobramycin drug powder inhaler be withdrawn further to developments on price from the manufacturer.

The report made the following recommendations for policies:

A policy for Botulinum toxin (brand name Botox) for the prevention of migraine in adults had been first developed as part of the Evidence Based Commissioning project. This policy had now been reviewed following approval of marketing authorisation for use of Botox in this indication and publication of a number of appraisals, all of which had not supported such use. A NICE Technology appraisal of Botulinum toxin for the prevention of migraine in adults was anticipated in June 2012; in its Appraisal Consultation Draft published on 16 February, the NICE Appraisal Committee was “minded not to recommend” Botulinum toxin for this indication.

The Regional Policy Sub-Group heard from a number of clinicians and commissioners who were asked to comment on the policy and concluded

that, despite clinical support for this intervention, there was no compelling evidence to change the current “not routinely funded” policy ahead of publication of the NICE Technology Appraisal.

However, it should be noted that this was not a specialised service and this policy had been developed as a collaborative piece of work. At least one PCT had agreed to fund the use of Botulinum toxin in the management of migraine in patients meeting certain criteria, with another PCT also considering approval of funding.

Lanreotide for the treatment of pancreatic fistula and other complications following pancreatic surgery; this intervention was funded by PCTs across the region either routinely or following individual funding request. The aim of developing this policy was to provide a consistent and explicit approach to funding without the need for further funding requests. There was no impact on expenditure or clinical pathways anticipated through approval of this policy.

Defibrotide for veno-occlusive disease. Defibrotide was used rarely in the treatment of veno-occlusive disease associated with stem-cell transplant. All individual funding applications made to PCTs had been funded. The aim of this policy was to provide consistent and explicit funding criteria without the need for further requests. There was no impact on expenditure or clinical pathways anticipated through approval of this policy.

Stereotactic radiosurgery/radiotherapy and stereotactic radiosurgery for the treatment of cerebral metastases. These policies aimed to provide a baseline for commissioning of services in the region based on existing arrangements and funding. They described current evidence for interventions and summarised national developments in this area. There was no impact on expenditure or clinical pathways anticipated through approval of these policies.

A discussion followed and there were two important factors to consider. First, how policy development in the Yorkshire & Humber area fitted into the national process and second, what were the correct procedural arrangements for the approval and implementation of Yorkshire & Humber policy recommendations within the North of England SCG arrangements.

In addressing the first criteria it was important to focus on the formalization of current working arrangements into a policy and in terms of the latter it would be necessary to submit a report to PCT Boards to clarify the situation, as the only way forward may be through individual PCTs agreeing the policies.

It was agreed:-

(a) that the policy recommendations of the Regional Policy Sub Group in respect of:-

Botulinum toxin for migraine
Lanreotide for paediatric fistula
Defibrotide for veno-occlusive disease
Stereotactic radiosurgery/radiotherapy to cerebral metastases

be noted.

(b) that a report be prepared for PCT Cluster Boards to enable consideration and approval of the policies; and

(c) that the policies are implemented and maintained and that they are made available to the public in accordance with directions of the Secretary of State. **Paul McManus**

SCOG 51/11 Exception Performance Report to 30 November 2011

The exception performance report to the 30 November 2011 was presented to the meeting.

The report provided a sensitivity analysis with a range of forecast outturns. The overall position ranged from an overspend of £690k to £2,752k. The significant variables were; Sheffield Teaching Hospitals £721k to £1,221k underspend; Hull and East Yorkshire Hospitals £1,604k to £2,504k overspend; Bradford Teaching Hospital £647k to £995k overspend; Sheffield Children's Hospital £23k to £823k overspend; Mid Yorkshire Hospitals £699k to £1,226k overspend; National Contracts £1,891k to £2,541k overspend; Mental Health £0 to £1,475k underspend.

The Board were asked to note the current overspend shown on SCG contracts as at month 8 and the forecast outturn positions. The current year to date overspend translated into a forecast outturn overspend of £2,752m. The Board's attention was drawn to the sensitivity analysis highlighting the difficulty in providing an accurate year end forecast due to a variety of large value variables. The sensitivity analysis suggested an overspend of £690k was more likely.

In line with previous reports the key significant financial pressures were with Mid Yorkshire Hospitals and in national contracts.

It was agreed:-

That the contents of the exception performance report to 30 November 2012 be noted. **Neil Hales**

SCOG 52/11 SCT Acute CQUIN Scheme 2011-12 – Quarter 3

A report in respect of the SCG Acute CQUIN Scheme 2011-12 – Quarter 3 performance was presented to the meeting. The Clinical Standards Sub Group meeting on the 9 February 2012 had reviewed performance and made recommendations.

The report recommended that all providers be awarded in full for the Quarter 3 performance.

The Clinical Standards Sub Group also recommended that in respect of indicator 6a haemophilia, a systematic recording of bleeds, that the final trajectory for Q4 should be 75% or maximum of 2 patients not recorded whichever was the greater.

It was agreed:-

(a) that all Providers be paid for the Quarter 3 CQUIN performance; and

(b) that the Quarter 4 trajectory for indicator 6a be 75% or maximum of 2 patients not recorded, whichever was the greater. **Kevin Smith Neil Hales**

SCOG 53/11 **Y&H SCOG Terms of Reference**

The proposed terms of reference for the Y&H SCOG were presented to the meeting.

The North of England SCG Board at its meeting on the 16 February 2012 had agreed a core template for the terms of reference.

It was proposed that the Y&H SCOG terms of reference should have two extra paragraphs relating to non-specialised services and commissioning policy.

A discussion followed which highlighted the problems of double-delegation and how PCT Cluster Boards would be aware of the outputs from the Y&H SCOG.

It was agreed:

(a) that further discussion take place with the North of England SCG Chief Operating Officer re the terms of reference for the Y&H SCOG; and

(b) that a further version of the terms of reference be submitted to the March 2012 Y&H SCOG meeting. **Cathy Edwards**

SCOG 54/11 **Publication of Y&H SCOG minutes and agendas**

A verbal request was made that the Y&H SCOG agree to the minutes and agendas for the meetings being published on the website.

It was agreed:

that the minutes and agendas for the Y&H SCOG meetings be placed on the website. **Paul Crompton**

SCOG 55/11 **Minutes of the Performance Monitoring Sub Group meeting held on the 11 January 2012**

It was agreed: that the minutes of the Performance Monitoring Sub Group held on the 11 January 2012 be received. **Frances Carey/ Neil Hales**

SCOG 56/11 **Minutes of the Clinical Standards Sub Group meeting held on the 18 January 2012**

It was agreed: that the minutes of the Clinical Standards Sub Group held on the 18 January 2012 be received. **Kevin Smith**

SCOG 57/11 **Any Other Business**

There were no items of other business.

SCOG 58/11 **Date of the Y&H Specialised Commissioning Operational Group**

The next meeting of the Y&H SCOG would be held on Friday, 23 March 2012 at 9.00am at Sandal Rugby Club, Wakefield.

Enclosure: A

YORKSHIRE AND THE HUMBER SPECIALISED COMMISSIONING OPERATIONAL GROUP

Meeting held on Friday, 23 March 2012
At Sandal Rugby Club, Wakefield

Decision Summary for PCT Boards

1 STRATEGY & DIRECTION

SCOG 66/11 SCG Acute CQUIN Scheme 2012-13 – Final Version

It was agreed:

(a) that the final version of the SCG Acute CQUIN scheme 2012-13 be approved; and

(b) that a further update report be made to the April meeting of the Y&H SCOG. **Kevin Smith/ Neil Hales**

SCOG 71/11 Financial Plan 2012-13

It was agreed:

(a) to note the changes to the mental health 'minimum take';

(b) to note the situation in respect of the acute contract minimum take; and

(c) that a further report be made to the Yorkshire & Humber SCOG meeting in April 2012. **Frances Carey**

2 POLICY

SCOG 63/11 North of England SCG Meeting, 15 March 2012 – Cystic Fibrosis Drugs – National Policy

It was agreed:

that the policy documentation for cystic fibrosis drugs be circulated to PCTs. **Cathy Edwards**

SCOG 76/11 Cancer Drug Fund – Priority Medicines List

It was agreed:

that the recommendations of the CDF Cancer Medicines Panel be noted. **Paul McManus**

3 GOVERNANCE

SCOG 79/11 Yorkshire & the Humber SCOG – Terms of Reference

It was agreed:

(a) that the Y&H SCOG terms of reference be recommended to the NoE SCG for approval;

(b) that the NoE SCG Executive Team be requested to prepare and circulate example 'decision-trees; and

(c) that the Y&H SCOG minutes continue to be presented to PCT Cluster Boards for adoption.

YORKSHIRE AND THE HUMBER SPECIALISED COMMISSIONING OPERATIONAL GROUP

Meeting held on Friday, 23 March 2012
Sandal Rugby Club, Wakefield

Present:

Matt Neligan	Director of Commissioning Development – Chair	NHS Airedale, Bradford & Leeds
Tim Furness	Associate Director Business Planning and Partnerships	NHS Sheffield also representing NHS Barnsley, Doncaster & Rotherham (deputising for Ian Atkinson)
Ann Ballarini	Executive Director of Commissioning and Service Development	NHS Calderdale, Kirklees & Wakefield
Caroline Briggs	Director of Strategy & Joint Commissioning	NHS The Humber

In Attendance:

Cathy Edwards	Director	NoE SCG (Y&H)
Kevin Smith	Medical Advisor	NoE SCG (Y&H)
Lisa Marriott	Assistant Director of Commissioning	NoE SCG (Y&H)
Ged McCann	Associate Director, Secure & Specialist Mental Health	NoE SCG (Y&H) (item 4a and 4b)
Simon Kaye	Assistant Director of Finance	NoE SCG (Y&H)
Paul Crompton	Business Manager	NoE SCG (Y&H)
Neil Hales	Assistant Director of Contracting & Performance	NoE SCG (Y&H)
Sarah Halstead	Project Manager	Y&H SHA (for item 7)

SCOG 59/11 Apologies

Andy Buck, Chief Executive, NHS South Yorkshire & Bassetlaw Cluster
Steve Hackett, Director of Finance, NHS South Yorkshire & Bassetlaw Cluster
Steve Wainwright, Chief Operating Officer, NHS Barnsley
Ian Atkinson, Chief Operating Officer, NHS Sheffield
Jayne Brown, Chief Executive NHS North Yorkshire & York Cluster
Frances Carey, Deputy Director of Finance, NoE SCG (Y&H)
Anthony Prudhoe, Assistant Director of Contracting & Performance, NoE SCG (Y&H)

SCOG 60/11 Declarations of Interest

There were no declarations of interest.

SCOG 61/11 Minutes of the Yorkshire & the Humber SCOG meeting held on the 24 February 2012

It was agreed:

that the minutes of the Yorkshire & the Humber SCOG meeting held on the 24 February 2012 be approved as a true and accurate record.

SCOG 62/11 **Matters Arising**

(a) Women's Low Secure Services in York

A report in respect of women's low secure services in York was presented to the meeting, the report provided an update of developments since the last SCOG meeting on the 24 February 2012.

Since the last meeting of the SCOG, NYYPCT had sought further advice from Hempsons who also managed the legal processes relating to the business transfer. This further advice indicated that the procurement process had enabled a full market test of the proposed service as part of the invitation to Tender and as such, the balance of probability of any future procurement challenge was in the PCT's favour.

The Yorkshire & Humber Office were awaiting a letter of confirmation from the Chief Executive of NHS North Yorkshire & York, together with a copy of this latest legal advice.

The North of England SHA required a formal view of matters from the Y&H SCOG. It was felt that a letter of assurance could be forwarded from the Chair of the Y&H SCOG subject to receipt of the written legal advice.

It was agreed:-

(a) that the update report in respect of women's low secure services in York be noted; and

(b) that a letter from the Chair be forwarded to the North of England SHA providing the assurance requested, subject to the receipt of the revised written legal advice from Hempsons. **Ged McCann/ Andy Buck**

(b) Mental Health Case Management

A report in respect of mental health case management was presented to the meeting. The report provided an update of developments since the last SCOG meeting on the 24 February 2012.

Since the last meeting a formal view had been requested from the four PCTs involved in relation to the three case managers who currently case manage low secure pathways. A response had been provided by NHS Hull and NHS North Yorkshire & York and the view was that the staff had been aligned to the Commissioning Support Unit function. It was also not clear where the case management function would be located in future structures.

A discussion followed and it was noted that there wasn't an opportunity to make decisions in the absence of any national guidance and direction. It was felt that for 2012-13 there would have to be an interim solution that reflected the current situation.

In terms of the additional work load generated through the minimum take, it had been calculated that an extra 1.5wte would be required. Interim arrangements with existing case managers had been agreed for the period April to August 2012. Beyond this date it was hoped to have temporary secondments from provider organisation staff. This would enable costs to be contained within existing budgets.
Attached to the report were six draft Access and Egress Protocols relating to:

- Forensic/Secure Mental Health Services
- Tier 4 CAMHS
- Specialist Services for Eating Disorders
- Perinatal Mental Health Services (Mother & Baby Unit only)
- Gender Dysphoria Services
- Specialised Mental Health Services for the Deaf

Any final comments on these were to be forwarded to Ged McCann by the end of March 2012.

It was agreed:

(a) that the proposed interim case management arrangements be supported; and

(b) that the draft Access and Egress Protocols be approved subject to any final comments. **Ged McCann**

(c) Neonatal Services

A verbal update report in respect of neonatal services was provided to the meeting.

With regard to neonatal surgery in the south of the patch a meeting had been held with Sheffield Children's Hospital and a meeting with Sheffield Teaching Hospital was planned.

Further active discussions had taken place with Calderdale Trust re the levels of services and a number of issues had been addressed. The issue of what the larger DGHs do, had sparked a more strategic debate about the situation in West Yorkshire. It was noted that Bradford Trust was proceeding with their new capital project.

In South Yorkshire the 27 week target would be fully implemented, the only outstanding issue was neonatal surgery. Liaison was now taking place with the tertiary centre and DGH units to effect the change.

It was felt that a further report should be submitted to the Y&H SCOG meeting in June to set out progress made and with particular reference to the issues in West Yorkshire (Calderdale and Bradford).

It was agreed:

(a) that the verbal update report in respect of neonatal services be noted; and

(b) that a further detailed report be made to the Y&H SCOG in June **Cathy**

2012. **Edwards**

(d) Neuromuscular Services

A verbal update report in respect of neuromuscular services was provided to the meeting. Work had now started with the Expert Panel in setting out the implementation of the proposals, this included producing a vision document, job descriptions and an implementation time-line.

Unplanned admissions were also being looked at. It was noted that these services would be commissioned by the CCGs/PCTs.

A discussion followed and it was reiterated that the proposed model had been agreed and that the implementation was now being progressed with integration with the local services.

It was agreed:

that the verbal update report in respect of neuromuscular services be noted. **Kim Cox**

SCOG 63/11 **North of England SCG Meeting, 15 March 2012**

A verbal briefing in relation to the NoE SCG meeting on the 15 March 2012 was provided to the meeting. The following matters had been discussed.

- Transition – John Lawlor was now assisting Ian Dalton in respect of developing the Operating Model for the NHSCB including the arrangements for specialised services.
- Children's Heart Surgery
- North of England SCG Branding
- Contracts, in particular the agreement and signing of new contracts for 2012/13
- QIPP delivery
- Cystic Fibrosis Drugs – the proposed national policy had been agreed. Although this was a national policy, Yorkshire & Humber had taken the lead role in development.
- Establishment Agreement – sign off

It was agreed:

(a) that the verbal briefing on the NoE SCG meeting on the 15 March 2012 be noted; and

(b) that the policy documentation for cystic fibrosis drugs be circulated to PCTs. **Cathy Edwards**

SCOG 64/11 **Transition**

A verbal update was provided in respect of transition. The structures and number of offices had not yet been finalised. Further information on the future Operating Model was expected imminently. It was felt important that transition remain as a standing item on the agenda.

It was agreed:

that the verbal update on transition be noted. **Cathy Edwards**

SCOG 65/11 **Contract Update**

A summary document setting out the position with regard to contracts for 2012-13 was tabled at the meeting.

Only one acute contract, that with HEY had not been agreed, there had been a number of delays consolidating specialised services activity. It was hoped that agreement would be reached later in the day on the 23 March 2012.

All mental health contracts had been signed off.

It was agreed:

that the report in respect of contract completions for 2012-13 be noted. **Neil Hales**

SCOG 66/11 **SCG Acute CQUIN Scheme 2012-13 – Final Version**

A report together with the indicator templates in respect of the SCG acute CQUIN scheme for 2012-13 was presented to the meeting.

The proposed final scheme included indictors in 6 service areas. This represented more than 50% of the overall spend in the minimum take services. Since the February meeting the following changes had been agreed:

Cancer - one indicator covering IMRT
Cardiac - reduced to one indicator focusing on acute surgery
NIC - two new indicators had been developed based on national examples.
PIC - after further discussion with the network leads, an access target had been set
Renal - two new indicators had been developed based on national examples
Spinal - the single indicator, with three parts, had been incorporated into the scheme

1.5% or 60% of the total 2.5% available to providers under CQUIN in 2012/13 would be apportioned to the above specialty specific areas. The documentation for the final scheme was attached to the report.

0.5% or 20% would be allocated to quality dashboards which were mandated for adoption in all specialised services contracts for 2012/13.

0.5% or 20% remaining would be allocated to the following DH mandated schemes:

- VTE risk reduction

- Improving patient experience
- Improving diagnosis of dementia in hospitals
- Use of Safety Thermometer

It was noted that in respect of the DH mandated schemes, the SCG would make payment if the core scheme had been approved by the host PCT.

The approach to the 2012-13 CQUIN scheme would be as follows:
Q1 – Engagement
Q2 – Data collection and target setting for Q3 and Q4
Q3 – Q4 – Reporting and indicating what actions had been taken

The spinal indicators were still the subject of discussion with Sheffield and Mid Yorkshire providers.
It was agreed:

(a) that the final version of the SCG Acute CQUIN scheme 2012-13 be approved; and

(b) that a further update report be made to the April meeting of the Y&H SCOG. **Kevin Smith/ Neil Hales**

SCOG 67/11 **Major Trauma Network –Approach to Development**

The approach to the development of the Major Trauma Network in Yorkshire and the Humber had been approved by North of England SCG on 16 February 2012. The report confirmed the arrangements that would be in place from the 2 April 2012.

The key features of the new arrangements included:-

- All patients assessed at the roadside using a standard national approach
- Paramedic in the ambulance control room co-ordinating the decision making on admissions and transfers based on both the capacity at MTCs and clinical priority
- All secondary transfers from a trauma unit to an MTC to be achieved within 48 hours
- All transfers out of the MTC for repatriation/rehabilitation to be achieved within 48 hours
- Rehabilitation prescriptions to be completed for all major trauma patients
- Sub regional networks to be fully established with clear governance arrangements
- Robust TARN data will be submitted
- Data and information collection and reporting systems will be established to inform the future development of the network. This will include a major

trauma patient tracking system that will be managed by YAS.

There would be an initial review of development of the Y&H Major Trauma Network at the end of the first quarter in 2012/13 with recommendations made by Major Trauma Network Executive Group (MTNEG).

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There would be a further more detailed review and stock take in October 2012. This would inform planning and recommendation made to Y&H SCOG about major trauma care in 2013/14.

A discussion followed and it was noted that the situation in West Yorkshire was very complex and needed very careful monitoring and review.

It was agreed:

(a) that the arrangements for major trauma that would be put in place from 2 April 2012 be noted; and

(b) that the next steps for reporting progress, set out in the report be agreed. **Sarah Halstead**

SCOG 68/11 **Rehabilitation following Major Trauma**

A report in respect of rehabilitation following major trauma was presented to the meeting.

The report set out the recent national guidance.

The Payment by Results Draft Guidance 2012-13 states (para 289): "Within the criteria to attract Best Practice Tariff for major trauma is that every patient with an ISS of more than 8 has a rehabilitation prescription. The core components of the rehabilitation prescription will be recorded as part of the TARN minimum data set return."

The report set out the details of the key elements of the rehabilitation prescription. A five part recommended approach to this issue had been developed following discussion with a range of clinicians and managers.

- **The rehabilitation prescription would be implemented in line with national guidance:** this included providing patients with a completed copy of the form. In phase 1 the documentation would be labelled as 'Rehabilitation Advice Note' rather than rehabilitation prescription.

- **Submission of data to TARN:** as a minimum all units would submit the minimum TARN dataset from April 2012 with full submission to TARN as soon as possible. Progress would be reviewed after Q1 2012-13.

- **Capturing outcome information at discharge:** all providers to submit discharge data (as per national guidance) on TARN, potentially phasing introduction but working towards complete data quality submissions by the end of Q1 2012-13.

- **An audit process for 2012/13 that would address the 3 Qs in the DH guidance:** sub-regional groups would be asked to establish an audit process to address the three national guidance questions. Audit report to MT Network Executive Group who would make any appropriate recommendations to commissioners.

- **Assurance of rehabilitation / service improvement:** MTNEG would use the information gathered in 2012-13 to inform suggested service improvements in 2013-14. The first gap analysis would be undertaken in September 2012 after 6 months of network operation.

A discussion followed. It was felt that there was a need to look at the expressed need and from a commissioner's point to look at what needs to be provided or changed this could be undertaken as part of the assurance process in the gap analysis. It was felt that it would be appropriate to look at the data at the end of Q1. There would be three key activities to undertake:

- Mapping of current provision.

- Commissioning Task Group to review the data returns to identify the expressed need/demand.

Conduct a review of the gap at the end of Q1.

It was confirmed that the acute episode of major trauma rehabilitation was covered by tariff. The audit process should identify gaps between the acute episode and other parts of the pathway and this may lead to system re-design.

It was agreed: **Sarah Halstead**

that the recommended five point approach to the rehabilitation prescription set out in the report be approved subject to the first review taking place at the end of Q1.

SCOG 69/11 **Interim Designation of Major Trauma Centres and Trauma Units**

A report was presented to the meeting in respect of the interim designation of the major trauma centres and trauma units.

Interim Designation has been awarded to MTCs and TUs by SCG subject to the submission of a robust self-assessment against network standards and plans as to how they would achieve core standards to which they were not yet compliant. The process to award full designation would take place in 2013/14.

All MTCs and TUs had all submitted self-assessments. Each submission had been assessed in terms of the ability to achieve the standards and the quality of the submission had also been assessed.

A key point made by all MTCs was that whilst they may be able to achieve the standard for Phase 1 capacity achievement in phase 2 would require further service development planning.

The self-assessment further emphasised the need to focus on rehabilitation in

2012/13.

During the discussion it was confirmed that designation was for the 'Trust' rather than the Centres/Units. The process for full designation in 2013-14 would be finalised once it was clear what the standards would be.

It was felt that the Health Overview and Scrutiny Committees would need to be further engaged around October 2012 about the proposals for 2013-14.

It was agreed:

(a) that the next steps set out in the report be endorsed and in particular that each Trust be given feedback on their self-assessment, seeking further clarification about achieving specific standards which had not yet been met.

(b) that further meetings with Trusts be arranged to resolve outstanding issues, including any specific requirements to re-submit self-assessments.

(c) that all the Trusts receive interim designation conditional on further progress being made on action plans to achieve the required standards and;

(d) that Health Overview and Scrutiny Committees be engaged at the appropriate time in respect of the proposals for 2013-14. **Cathy Edwards/ Sarah Halstead**

SCOG 70/11 **Review of Children's Heart Services**

A verbal update was presented to the meeting in respect of the national review of children's heart services. The judicial appeal had been made during the week and it was anticipated that the decision would be made in April 2012.

The JCPCT was making contingency plans based on two scenarios:-:

- the decision would uphold the original consultation and in this scenario, there would be a meeting in public in June 2012 to announce the JCPCT decision.
- the decision would quash the consultation and a new consultation process would be required, which would possibly be based on a national series of 'exhibitions' to be held between June and September 2012.

It was agreed:

that the verbal update in respect of the Review of Children's Heart Services be noted. **Cathy Edwards**

SCOG 71/11 **Financial Plan 2012-13**

An update report in respect of the financial plan 2012-13 was presented to the

meeting.

The figures presented in relation to contract baselines, outcomes, horizon scanning and PbR had not changed.

The financial plan for 2012/2013 also included the impact of specialised services contracts moving to the definitions set out within the specialised services minimum take. The mental health minimum take had been revised since February for the final figures agreed with NHS Leeds and the latest figures for NYY services transferring to LYPFT (other PCTs remain unchanged). The acute contract minimum take figures had not yet been included because several contracts were currently being finalised and the minimum take was integral to those discussions. The acute minimum take would be disaggregated, summarised and reported to PCTs as soon as it was available.

In principle the starting point for the transfer of minimum take services into SCG contracts was on a and cost neutral basis. However it was understood that there may be cost implications of transferring these services between contracts and where known these discussions were taking place with the PCTs.

The premise of agreeing contracts however was that any financial impact on PCTs would be discussed and agreed with the relevant PCT prior to contract signature. The expectation was that a further report would then be presented to the April SCOG setting out the contract agreement compared with the financial plan envelopes.

A discussion followed and it was clarified that the total figure of £693m contained £650m of specialised and £43m of collaborative projects.

It was agreed:

(a) to note the changes to the mental health 'minimum take';

(b) to note the situation in respect of the acute contract minimum take; and

(c) that a further report be made to the Yorkshire & Humber SCOG meeting in April 2012. **Frances Carey**

SCOG 72/11 **Financial Risk Share Proposals 2012-13**

A verbal update was provided to the meeting in respect of the financial risk share proposals for 2012-13.

There were a number of outstanding concerns, including the inclusion of low secure and the inclusion of DGH work in the Sheffield Teaching Hospitals contract.

Discussions with NHS Sheffield had not yet taken place.

A discussion followed and it was felt that the main issue was whether or not there were compelling reasons to change for 2012-2013. It was felt that a concluding report needed to be made to the April Y&H SCOG meeting to set out the rationale, and that the Performance Monitoring Sub Group should consider the report at their meeting on the 11 April 2012.

It was agreed:

(a) that the verbal update in respect of the risk share proposals be noted;

(b) that the Performance Monitoring Sub Group meeting in April consider the final proposals; and

(c) that the final proposals be presented to the Yorkshire & the Humber SCOG meeting in April 2012. **Frances Carey**

SCOG 73/11 **Implementation of Improving Outcomes Guidance in Cancer Networks**

(a) Sarcoma

A report in respect of sarcoma services was presented to the meeting, setting out the current position in each Cancer Network and identifying the risks to Improving Outcomes Guidance (IOG) compliance. Peer Review visits regarding the IOG were programmed for 2012-13. The Yorkshire Cancer Network (YCN) and the North Trent Cancer Network (NTCN) had both made excellent progress in implementing the Sarcoma IOG, the services being based in Leeds and Sheffield.

The situation with the Humber and Yorkshire Coast Network (HYCCN) service based in Hull, was that the HEY Trust had accepted that the current situation was not sustainable. A clinical review was to be lead by the Trust and the North East Yorkshire & Humber Clinical Alliance. There was also a Cluster review of services following the acquisition of Scarborough Trust by York Hospitals FT.

There would be documents relating to specialised commissioning to be approved for submission as evidence to the peer review team. To ensure this happened in a timely manner it was proposed that the Chair of the Specialised Commissioning Operational Group (SCOG) and the Director of Specialised Commissioning, were given the remit to approve these documents.

It was agreed:

(a) to note the update for each Network in terms of IOG compliance. **Cathy Edwards/ Andy Buck**

(b) to note the proposed clinical review in Humber and Yorkshire Coast Cancer Network.

(c) that the Chair of the SCOG and the Director of Specialised Commissioning be authorised to approve any documents required for submission to the peer review process.

(b) Brain/CNS

A report was presented to the meeting providing a summary of the current

position in each Cancer Network and identifying the risks to IOG compliance. Peer Review visits re IOG compliance were programmed for 2012-13.

There were a number of areas in each Network where there were risks of compliance with the Peer Review measures as follows:-

- Yorkshire Cancer Network: level of engagement in some units; each unit would need to produce their own action plan. Work was in progress to improve the centre/unit interface. The future funding of the clinical nurse specialist posts needed to be resolved.

- North Trent Cancer Network: continued support was required to support data collection and management. Work ongoing to complete referral guidelines and timed pathways by May 2012. Network leading work to complete and embed rehabilitation and supportive care pathways.

- Humber & Yorkshire Coast Cancer Network: the main concern raised through the 2011 National Cancer Peer Review process related predominantly, both at Network and MDT level, to gaps in key clinical team membership – rehabilitation and neuropsychology. In addition the resignation of the neuro-pathologist had necessitated locum cover to deliver a bespoke service to ensure delivery of dual reporting. Links were now being made with Leeds that should benefit both teams and make compliance achievable in the future.

  At the time of publication of the IOG for Brain and CNS tumours in 2006 referral arrangements were in place between HEYHT and Sheffield Teaching Hospitals Trust for some complex skull based tumours. Implementation plans included a requirement to formalise and agree pathways and referral protocols for this group of patients.

It was agreed:

(a) to note the update for each Network in terms of IOG compliance; and

(b) that the Chair of the SCOG and Director of Specialised Commissioning be authorised to approve documentation required for submissions to the Peer Review process. **Andy Buck/ Cathy Edwards**

SCOG 74/11 NSCG Workplan 2012-13

A report was presented to the meeting setting out the NSCG workplan for 2012-13. The predominant focus was on major areas/issues where there needed to be a single national approach. Within the workplan the NoE SCG (Yorkshire & Humber Office) had the lead for cystic fibrosis.

It was agreed:

That the NSCG workplan for 2012-13 be received. **Cathy Edwards**

SCOG Burn Care Services – Telemedicine

75/11

A report in respect of Burn Care Services – Telemedicine was presented to the meeting.

The Northern Burn Care Network was keen to introduce and develop the use of telemedicine across the Network.

Building on both the procurement process and the implementation of telemedicine to support stroke services it was proposed to pilot the linking up of the 3 specialist burn care centres in Wakefield and Sheffield with A&E departments in Doncaster, Scarborough and Scunthorpe.

The report outlined the proposed phasing and associated costs for the pilot phase and the potential 3-5 year roll out.

There was close liaison with the SHA, who had lead on the stroke telemedicine procurement, around the commercial, procurement and legal issues associated with this development.

The funding source would be the national burn care funding allocated via the SHA bundle and would still available in 2012/13.

It was agreed:

(a) to note the work to date.

(b) to approve the implementation and funding of the pilot proposal to use telemedicine to support the links between the specialist centres and the selected emergency departments.

(c) to approve the use of the national burn care funding allocation to support the pilot.

(d) to note the timescales and arrangements for evaluation and roll out. **Cathy Edwards**

SCOG 76/11 **Cancer Drug Fund – Priority Medicines List**

A report in respect of the CDF – Priority Medicines List was presented to the meeting. The report summarised recommendations of the Cancer Medicines Panel to the SHA CDF Panel in respect of the use of Dasatinib for the treatment of patients with chronic, accelerated or blast phase CML who were intolerant or resistant to imatinib and who could not take nilotinib (NB not for 3rd line use after nilotinib failure)

- Dasatinib has been routinely funded by PCTs in the region for this indication. However, publication of a negative NICE TA (TA 241) which recommended the use of nilotinib but not dasatinib meant that routine funding of dasatinib by the local NHS should not continue.
- 12 patients were estimated as being eligible for funding with a total drug cost of around £400,000.
- Since treatment for these was previously commissioned, this change to the CDF list is not expected to impact on PCT service costs.

- Under the NICE TA, nilotinib is recommended as an option for certain patients with CML who cannot take imatinib or who have not responded to imatinib. Such patients may have received dasatinib in the past. As the price of nilotinib has been reduced under a NICE approved patient-access scheme, the overall cost to PCTs of treating patients with CML is likely to fall.

An application for the addition of ofatumumab to the treatment of refractory CLL was rejected on the basis of inadequate evidence of benefit.

An application for the addition of rituximab to treat marginal zone lymphoma and other CD20 positive lymphomas was referred to the Regional Policy Group for consideration of a regional commissioning policy. Funding of rituximab in the region for such indications was patchy and would benefit from a better understanding of current arrangements before determining whether CDF funding was an option.

An application for FOLFIRNOX for pancreatic cancer was rejected as there was not a consensus in support of its inclusion in the Priority List across all 3 cancer networks. Clinicians will liaise with local commissioners to determine local arrangements.

It was agreed:

that the recommendations of the CDF Cancer Medicines Panel be noted. **Paul McManus**

SCOG 77/11 **IFR Arrangements for Specialised Services**

A report in respect of Individual Funding Request (IFR) arrangements for specialised services was presented to the meeting.

Since April 2009, Directions from the Secretary of State for Health have been in force requiring PCTs to have in place arrangements for adopting policies and for making determinations for individuals when the general policy was not to fund.

At the time the directions were first published, the SCG were advised that:

The key challenge in the Directions… was that where a PCT does not have a policy, this must first be addressed before the issue of exceptional treatment can be considered.
In essence, all of the guidance pointed to the conclusion that:

Individual Funding Requests relate to requests where
- a policy exists and
- the patient does not meet the criteria within the policy for funding

This leads to the subsequent conclusion that:
Exceptional means exception to the policy **not** an exceptional case

Following the introduction of the Directions, YHSCG had led a process to agree a common approach to IFR- endorsed by Y&H SCG Board in September 2009.

Since that time Y&H SCG has developed common commissioning policy at regional level in three programmes:

1. Regional commissioning policies for Specialised services commissioned by the SCG (eg BMT)
2. Regional commissioning policies for services not included in the list of Specialised services where PCTs had agreed to collaboratively commission (eg IVF)
3. Common policies offered for adoption by all PCTs following the work of the SHA led Evidence Based Commissioning process (Botox for Migraine- originally developed by Hull and NYY PCTs).

PCTs had continued to consider Individual Funding Requests (IFRs) on all services in local panels. For the most part, when the request related to a specialised service the SCT has been contacted for advice. The SCT had also tried to identify service areas of frequent requests as priorities for consideration by the Regional Policy Sub Group (RPSG).

In order to keep control of specialised services commissioning across Yorkshire and the Humber over the next year, it was vital that IFR panels be briefed on the portfolio of services, relevant contract documentation, commissioning policies and developments both in the current "minimum take" and in the full list of specialised services.

Over the coming weeks the NoE SCG (Yorkshire & Humber Office) Medical and Pharmacy Advisors will work with PCT Clusters to brief IFR Panels on the commissioning of specialised services.

For the avoidance of doubt:

- PCT IFR Panels would continue to receive requests relating to specialised services (acute but not mental health)
- Individual Funding Requests relating to specialised services should be discussed with the SCT in advance of any IFR panel meeting.
- IFRs for services not yet commissioned by SCG, but included in specialised services, will, where possible, be redirected to a service development route. Emergency treatment or clinical urgency may mean this was not possible.
- Results of IFRs that relate to specialised services should be notified to SCT to allow consideration of work to agree a Commissioning Policy at Regional, North of England or National level.
- As now, approval by a PCT IFR Panel would result in the PCT being invoiced for the additional activity.

It was agreed:

that the contents of the report in respect of IFR arrangements for specialised services be noted.

Kevin Smith/ Paul McManus

SCOG 78/11 **Exception Performance Report (to 31 December 2011)**

The Exception Performance Report to the 31 December 2011 was presented to the meeting.

The meeting was asked to note the current overspend shown on SCG contracts as at month 9 and the forecast outturn positions. The current year to date

overspend translated into a forecast outturn overspend of £2,303 taking into account the SCG strategic reserve of £1.8m.

In line with previous reports the key significant financial pressures were with Mid Yorkshire Hospitals and in national contracts.

SCOG 79/11 Yorkshire & the Humber SCOG – Terms of Reference

The proposed Terms of Reference for the Yorkshire & Humber SCOG were presented to the meeting. These were the 'core' Terms of Reference set out by the NoE SCG Board with the addition of the following:

"The Yorkshire & the Humber Specialised Operational Commissioning Group would also have responsibility for and oversight of specific non specialised services where members had agreed that there is collective benefit from carrying out the work on a collaborative basis. A specific register of those non specialised services would be maintained and reviewed on a quarterly basis.

NB: For the avoidance of doubt, commissioning policies recommended by the Yorkshire & the Humber Regional Policy Group would be agreed by the Operational Group but formal adoption would be achieved by members reporting on commissioning policies to PCT Cluster Boards."

A discussion followed and the general consensus was that it was still confusing, to understand the governance and decision making relationships between the NoE SCG, Y&H SCOG and the PCTs. It was suggested that the production of example 'decision trees' for various scenarios would be extremely useful. It was also felt to be very important that PCT Boards continued to take the Y&H SCOG minutes for adoption.

It was agreed:

(a) that the Y&H SCOG terms of reference be recommended to the NoE SCG for approval;

(b) that the NoE SCG Executive Team be requested to prepare and circulate example 'decision-trees; and

(c) that the Y&H SCOG minutes continue to be presented to PCT Cluster Boards for adoption.

SCOG 80/11 Draft Minutes of the Regional Policy Sub Group Meeting held on the 7 February 2012

It was agreed:

that the draft minutes of the Regional Policy Sub Group meeting held on the 7 February 2012 be received. **Paul McManus**

SCOG Minutes of the Performance Monitoring Sub Group meeting held on the

81/11 8 February 2012

It was agreed:

that the minutes of the Performance Monitoring Sub Group meeting held on the 8 February 2012 be received. **Neil Hales/ Frances Carey**

SCOG 82/11 Draft Minutes of the North Trent Neonatology Steering Group meeting held on the 3 February 2012

It was agreed:

that the draft minutes of the North Trent Neonatology Steering Group meeting held on the 3 February 2012 be received. **Joanne Poole**

SCOG 83/11 Draft minutes of the Yorkshire Neonatology Network meeting held on the 7 February 2012

It was agreed:

that the draft minutes of the Yorkshire Neonatology Network meeting held on the 7 February 2012 be received.

SCOG 84/11 Any Other Business

There were no items of other business.

SCOG 85/11 Date of Next Meeting

9.00am on Friday, 27 April 2012 at Sandal Rugby Club Wakefield