Healthier Lancashire & South Cumbria

Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs)

Thursday 07 March 2019, 13:00-15:00,

South Ribble Borough Council (Shield Room), Civic Centre,

West Paddock, Leyland, Lancashire, PR25 1DH

Agenda

Time	Item	Description	Owner	Action	Format
Standing Items					
13:00	1.	Welcome and apologies	Chair	Information	Verbal
	2.	Declarations of interests	Chair	Information	Attached
	3.	Notes of the meeting held on 01 November 2018	Chair	Approval	Attached
	4.	Items for any other business	Chair	Information	Verbal
Improving Population Health					
13:15	5.	NHS Long Term Plan	A Doyle	Information	Attached
13:45	6.	Commissioning policies: • Sterilisation Reversal in Males and Females • Policy for Chalazia Removal • Policy for Haemorrhoid Surgery • Policy for Dupuytren's Contracture Release in Adults • Policy for Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea • Policy for the Excision of Ganglia and Mucoid Cysts • Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the Management of Pure Subacromial Shoulder Impingement	E Johnstone R Higgs	Approval	Attached
Any Other Business					
14:30	7.	Stroke Programme Update	G Stanion	Paper	Attached
14:50	8.	Any other business	Chair	Information	Verbal

Members of the public are asked to note that the Chair and Executive Lead for Commissioning will be available for a 30-minute pre-meeting (Wheel Room) at 12:30 to raise any questions about the agenda for the JCCCGs meeting.

Date and time of next meeting:
Thursday 02 May 2019, 13:00-15:00, Main Lecture Theatre, Morecambe Bay CCG, Moor Lane Mills, Moor Lane, Lancaster, LA1 1QD

Dates of future meeting held in public:
04 July 2019
05 September 2019
07 November 2019
02 January 2020
05 March 2020

Please send apologies to dawn.walker21@nhs.net

Declaration of Interests for members of the Joint Committee of CCGs

Introduction

Managing conflicts of interest appropriately is essential for protecting the integrity of the NHS commissioning system and to protect NHS England, Clinical Commissioning Groups, GP practices together with other providers from any perceptions of wrongdoing.

It is therefore essential that declarations of interest and actions arising from declarations are recorded formally in the minutes of the Joint Committee

Process

At the beginning of each meeting, the Independent Chair will ask colleagues to indicate if they have any interests to declare.

Members are asked to indicate the type of interest they wish to declare, making reference to the table below:

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a 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 (or similar owner 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; • 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

Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a 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, BMA or a medical defense organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE);
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
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 decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend;

After a declaration of interest is made, the Chair will make a determination as to how the individual members should continue to participate in the meeting. This will be on a case by case basis and the decision will be explained to the committee.

There are a number of options for actions that the Chair may take depending upon the particular interest identified:

- Member leaves the room for that agenda item
- Members stays in the room, can participate in the discussion and make comments but cannot vote on any decision
- Member stays in the room, can participate in discussion and can vote on the decision
- Item is deferred –agenda amended to reflect this

If the Chair is conflicted, the Deputy Chair will take the Chair's role for discussions and decision-making of the relevant part of the meeting and may use the above options for action.

The following information will be recorded in the minutes of the meeting:

- Individual declaring the interest
- At what point the interest was declared
- The nature of the interest
- The Chair's decision and resulting action taken.

In addition, any individuals retiring from and returning to meetings should be formally recorded in the minutes.

Notes of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 01 November 2018 13:00-16:00
NHS Morecambe Bay CCG (Lecture Theatre), Moor Lane Mills, Lancaster, LA1 1QD

Phil Watson	Independent Chair	JCCCGs	Attended
Voting Members (one vote per CCG)			
Penny Morris	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
Roy Fisher	Chair	Blackpool CCG	Attended
Dr Richard Robinson	Chair	East Lancashire CCG	Attended
Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
Mark Youlton	Chief Officer	East Lancashire CCG	Attended
Mary Dowling	Chair	Fylde and Wyre CCG	Attended
Denis Gizzi	Chief Officer	Chorley and South Ribble and Greater Preston CCG	Attended
Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG	Attended
Peter Tinson	Chief Operating Officer	Fylde and Wyre CCG	Attended
Anthony Gardner	Director of Planning and Performance	Morecambe Bay CCG	Attended
Doug Soper	Lay Member	West Lancashire CCG	Attended
In attendance			
Andrew Bennett	Executive Lead Commissioning	Healthier Lancashire and South Cumbria Integrated Care System (ICS)	Attended
Elaine Johnstone	Chair, Commissioning Policy Development and Implementation Group (CPDIG)	Midlands and Lancashire Commissioning Support Unit (M&L CSU)	Attended
Rebecca Higgs	Individual Funding Request (IFR) Policy Development Manager	Midlands and Lancashire Commissioning Support Unit	Attended
Prof. Dominic Harrison	Director of Public Health and Wellbeing	Blackburn with Darwen Borough Council	Attended
Amanda Doyle	Chief Officer	Healthier Lancashire and South Cumbria ICS	Attended
Andy Curran	Medical Director	Healthier Lancashire and South Cumbria ICS	Attended
Carl Ashworth	Strategy and Policy Director	Healthier Lancashire and South Cumbria ICS	Attended
Jane Cass	Locality Director	Healthier Lancashire and South Cumbria ICS	Attended
Gary Raphael	Executive Lead Finance	Healthier Lancashire and South Cumbria ICS	Attended
Sue Stevenson	Chief Operating Officer	Healthwatch Cumbria	Attended
Neil Greaves	Communications and Engagement Lead	Healthier Lancashire and South Cumbria ICS	Attended
Gemma Stanion	Programme Director	Healthier Lancashire and South Cumbria ICS	Attended
Claire Kindness-Cartwright	Senior Programme Manager	Healthier Lancashire and South Cumbria ICS	Attended
Gaynor Jones	Executive Assistant	Healthier Lancashire and South Cumbria ICS	Attended
Apologies			
Harry Catherall	Chief Executive	Blackburn with Darwen Borough Council ICS	
Dr Gora Bangi	Chair	Chorley South Ribble CCG	
David Bonson	Chief Operating Officer	Blackpool CCG	
Debbie Corcoran	Lay Member	Greater Preston CCG	
Sumantra Mukerji	Chair	Greater Preston CCG	
Katherine Fairclough	Chief Executive	Cumbria County Council	
Sakthi Karunanithi	Director of Public Health	Lancashire County Council	
Angie Ridgwell	Chief Executive	Lancashire County Council	
Dawn Roberts	Director of Governance	Cumbria County Council	
Louise Taylor	Executive Director of	Lancashire County Council	

	Transformation		
Lawrence Conway	Chief Executive	South Lakeland District Council	
Gary Hall	Chief Executive	Chorley Borough Council	
Dean Langton	Chief Executive	Pendle Borough Council	
Sir Bill Taylor	Chair	Healthwatch Blackburn with Darwen	
Clive Unitt	Lay Member	Morecambe Bay CCG	
Jerry Hawker	Chief Officer	Morecambe Bay CCG	
Paul Kingan	Chief Finance Officer	West Lancashire CCG	
Neil Jack	Chief Executive	Blackpool Council	
Dr Adam Janjua	GP and Vice Chair	Fylde and Wyre CCG	

A.	**Standing items**
1.	**Welcome and Introductions** The Chair welcomed members to the regular business meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) held in public and informed members that the business today was being live-streamed on YouTube. It was reported that in line with a previous meeting held in Leyland, members of the public were invited to raise any questions relating to items on the agenda prior to the start of the main meeting and there would be a further opportunity at the end of the meeting for further questions.
2.	**Apologies** Apologies were noted and listed above.
3.	**Declaration of Interest** None reported. The Chair reminded members that if during the course of the meeting a conflict of interest subsequently became apparent it should be declared at that point. D Soper asked for the minutes going forward to indicate the specific item a declaration of interest refers to and how it was resolved at the meeting.
4.	**Minutes of the meeting held on 04 October 2018** The minutes were agreed as an accurate record.
5.	**Action matrix** Action no. 002, *Policy for commissioning spinal injections and radio frequency denervation for low back pain.* The policy has been brought back to the Committee for further scrutiny and ratification (Item 7a). This action was closed.
6.	**Items for Any Other Business** Professor D Harrison informed the Chair that he would like to raise '*Reducing Obesity on the current Weight Management Services model'*. The Chair accepted this request subject to timing.
B.	**Health**
7.	**Commissioning Policies** E Johnstone, Chair of the Commissioning Policy Development and Implementation Group (CPDIG) presented this item and explained the context for the work of the CPDIG that had been in existence since April 2017. CPDIG was established to enable the eight CCGs across Lancashire and South Cumbria (L&SC) to address areas where commissioning policies were required to ensure that the most evidence-based and effective use of NHS resource were made equitably across the whole of L&SC and to bring clinical practices in line Lancashire-wide. E Johnstone went on to explain the process to develop the policies, as set out in Section 2 of the paper. Once the current clinical evidence base had been reviewed by a public health colleague, the policy group would then identify the criteria on how we commission. Draft policies are then taken through a clinical and public engagement process, the nature of which varies according to how much change is being proposed to the policy, varying from a short four

weeks largely web-based consultation process where there is minimal change, to a much more extensive 12-week programme to involve focus groups. Clinical oversight and assurance is also taken from the Care Professional Board (CPB). The Committee was informed that the CPB was supportive of the policy and happy to recommend its further consideration.

The following two policies had been through this process:

a) ***Policy for spinal injections and radio frequency denervation for low back pain***
E Johnstone explained that this policy had been through extensive clinical engagement and a number of changes were made as a result of that engagement.

The Committee was informed that the core eligibility criterion within the policy is unchanged from the existing Pennine Lancashire policy. The net impact of this policy is to bring clinical practice across L&SC in line with the prevailing national guidance. It was reported that only two CCGs had a policy in place previously. For three CCGs (Chorley and South Ribble, Greater Preston and West Lancashire) this is an entirely new policy. For two CCGs (Fylde and Wyre CCG and Morecambe Bay CCG) this is a wider policy in scope than was previously in place. Blackpool CCG's policy was not aligned to NICE guidance and had been updated and brought in line. For the two Pennine CCGs (East Lancashire and Blackburn with Darwen) the policy is essentially unchanged.

E Johnstone informed the Committee that due to the different histories in various CCGs, the introduction of this policy is expected to save resources in the region of £300k per annum.

Both public engagement and the equality impact assessment process had not identified any necessary changes and the policy is now ready for the Committee to endorse.

The Chair asked the Committee if there were any questions or comments relating to the policy.

G Jolliffe requested clarity on the transition of existing patients through the system.
E Johnstone informed the Committee that the generally agreed principle across L&SC for all policies where changes are introduced is that any patient who is already in the treatment pathway carries on with the pathway and the policy in place at the point of referral. The change will be for new patients.

M Youlton requested clarity on the process for communicating the information to providers once agreed. He also asked if providers are required to agree and sign a contract variation. E Johnstone responded to the question and informed the Committee that the standard NHS Contract has provision for contract variations if there is a level of potential change to provider income. There are clauses in the contract regarding the amount of notice and there is a degree of variation across L&SC about what has been negotiated with individual providers.

R Higgs answered the question regarding onward communication to providers and this varied depending on the nature of the policy being introduced. In general it is communicated by a contract variation to providers. The Committee was informed that providers had been involved in consultations throughout the development of this policy and are aware that the policy is due to be implemented in-year, so there is an expectation that the policy will be implemented by CCGs. Contract teams issue formal contract variations and process these through Trusts. Work was ongoing to understand the least bureaucratic way for CCGs to vary "commissioner/provider" approach.

A Doyle felt that the discussion was reverting to purist commissioners and went on to say that the whole point of developing an integrated approach to care is to look at how we prioritise the use of the total resource and agree what are the clinically appropriate things to do for the community. She added that implementation has to be around engaging the clinicians in the pathways that we have in L&SC. It was concluded that the bigger discussion is about clinical practice and how we communicate to patients and how we communicate to our clinicians on how they are expected to change their practice.

P Morris built on A Doyle's point by saying that one of the keys to success in Pennine Lancashire is educating clinicians on equality, safety and effectiveness of the policy and if we are signing up to the policy we, as commissioners, are also signing up to a programme to educate our clinicians.

E Johnstone agreed with the comments made and reiterated the need to achieve best value from the available financial resources. She reminded the Committee that the remit of the CPDIG is mainly development and implementation and the CPDIG go to great lengths to engage as many clinicians as possible at policy development stage and following policy approval. It is then over to the local health economy to follow-up conversations.

The Committee was informed that CPDIG is working with colleagues in business intelligence teams to get appropriate detailed information at procedure level across providers and CCGs. The CPDIG October 2018 meeting had reviewed activity information for the policies ratified by the JCCCGs in March 2018: tonsillectomy, hip and knee arthroscopy. An action is to follow this up by sending the information to the Finance Investment Group (FIG) of the ICS for oversight and visibility. The Committee was informed that there is a subtlety on how monitoring takes place but the fundamental point of how we communicate it and how we use ICS structures to manage implementation is being heard.

A Gardner recognised the concerns raised but wanted to ensure it is not just an ICS conversation. He informed the Committee that Morecambe Bay CCG is sharing policies with the local Trust for feedback as they are drafted. He agreed with the other points made regarding making sure this is backed up into contracts, but first and foremost there should be a clinical discussion across the ICS and locally to progress.

D Soper echoed the points made and that the Committee should agree a form of wording on how this is implemented in all contracts to clarify expectations in 2019/20. A Doyle informed the Committee that the CCGs are good at engaging with our local communities and our clinicians to make sure people understand and the onus is on the Committee to make this clear.

RESOLVED: that the Committee approved the policy.

b) Policy for assisted conception services.

E Johnstone informed the Committee that all L&SC CCGs had previously had polices for assisted conception services in place, some of which were inherited from legacy Primary Care Trusts (PCTs). The trigger for review at this stage was that the legacy policies had reached their review dates. When the work was taken on the CPDIG was clear on the following:

- To ensure the policy was aligned as much as possible with current evidence of best practice
- To harmonise eligibility criteria across the whole footprint due to significant variation in individual CCG policies
- To ensure the policy was comprehensive to cover all envisaged scenarios by someone who may approach the NHS for assisted conception
- The provision of the service to remain affordable to CCGs and contribute to the effective use of NHS resources

The policy had been through the process as previously discussed. It was important to note that of all the policies reviewed so far, this policy led to the biggest response at public engagement stage. The evidence base was reviewed for equity as some questions were raised on equality and equity issues and on a number of areas legal advice was taken. The CPB had reviewed the draft of the policy on several occasions and was supportive of the changes and rational for them. The CPB was supportive of the changes and rationale for them.

E Johnstone briefly outlined the changes in the policy: CPDIG has adopted the extant clinical NICE guidelines in defining a treatment cycle. This review has uncovered variations in cost

and charging method which has now been recognised nationally - as a result there is a National Working Group established to look at developing a set of benchmark prices for assisted conception technologies. The current expectation is this will come out in time for it to be incorporated in the 2019/20 contracting year. The impact of the policy on each CCG will be different. It was reiterated that the concept and proposal is for one treatment unit.

E Johnstone reported the key changes:

- **Age Limits:** NICE guidance has increased the upper age limit for women accessing this treatment and this had been applied to the proposed policy. Only two CCGs had already applied that in their existing policy (Blackpool CCG and Morecambe Bay CCG). For the remaining CCGs there will be additional patients eligible for treatment within the age criteria. Four L&SC CCGs had previously had a lower age limit for access to treatment in their policy (23yrs) from previous existing NICE guidance; the current NICE guidance does not include a lower age limited for access to treatment. Legal advice was sought to define a reasonable lower age limit and it was settled that 18yrs was the legal definition of adulthood.
- **Provision of treatment where living children exist from a couple who wish to access this service:** two CCGs had previously allowed access treatment where either individual within a couple already had a child from a previous relationship. It is now proposed to adopt the policy of the other six CCGs where if there is an existing living child there would not be access to services.
- **Couples in same sex relationships and single women:** there were inconsistencies in the legacy policies. The impact of the proposed policy leads to increased access in three CCGs (Blackburn with Darwen, East Lancashire and Fylde and Wyre). Patients in three areas will experience a higher threshold for access (Chorley and South Ribble, Greater Preston and West Lancashire). There is no change for the residents of Blackpool CCG and Morecambe Bay CCG
- **Criteria and eligibility:** the policy includes access criteria and storage for gamete cryopreservation. This is not embryo storage that may be for patients that are to undergo cancer therapy or any other kind of treatment to render them clinically infertile because of the treatment they have to have for another condition. The NHS will fund gamete preservation for that purpose within the policy and patients in all eight CCGs will now have access
- **Clear definition of one treatment unit:** regardless of which CCG or which provider the patient accessing treatment should receive the same opportunity of intervention across the whole L&SC area.

A Doyle understood there was an outstanding High Court challenge on one of the aspects of gamete preservation for patients about to undergo transgender reassignment processes. The Committee recognised that this challenge is ongoing and should the outcome of the legal case be different to the proposed policy it was proposed to amend the policy without further ratification. The Committee agreed.

G Jolliffe raised a question on contravention of human rights. R Higgs informed the Committee that this policy had been through an assessment on the equality and inclusion on human rights with no concerns being raised as the definition of “family life” was widespread.

E Johnstone explained the financial impact of the policy. The current estimate of expenditure on assisted conception services was circa £2.5m per annum. The potential savings incurred by moving to one treatment unit are estimated to give sufficient headroom to cope with additional cost pressures relating to additional access created in the policy. It was reported that CPDIG will continue to monitor national benchmark pricing.

The Chair thanked E Johnstone and R Higgs for the work carried out.

R Fisher commented on the policy and the appeals around assisted conception and highlighted the advantages of providing a standardised handout, comparable to Blackpool CCG’s, to send to practices and GPs explaining the policies and the reasons for the decisions, as this would assist GPs in supporting individual patients with concerns and to assist GPs with a difficult and

	complex issue. E Johnstone responded that the CPDIG has been working with communications colleagues on an easy read policy and a user-friendly patient leaflet to explain assisted conception is ready to be distributed. M Dowling recalled at the last meeting an explanation on the standardised review process for all policies and requested confirmation on this particular policy and what trigger events might mean an earlier review. M Dowling went on to say how hugely impressed she was with the development of the robust processes in place now and for the future and in relation to this policy that has been particularly complex as all questions and issues raised had been answered during the course of the policy development. M Dowling extended her thanks to E Johnstone, R Higgs and the wider team. A Doyle answered the question relating to the standardised review process. The trigger for review in this and other policies was clinical evidence and information that might lead to a change to criteria. One of the reasons for this policy is that we have got to prioritise NHS funding as the NHS does not have unlimited resources. G Burgess explained he was uncomfortable to vote and agree an open-ended commitment to the new policy with limited financial effectiveness. As the financial information was not available to make a projection of cost there needed to be some assurance if the new policy is costing in excess of £2.5m. E Johnstone informed the Committee that cost can be tracked and there was a possibility the national benchmark may increase the cost of every treatment cycle. The Committee was informed that the CPDIG will continue to monitor the cost impact and the Finance Investment Group (FIG) will be kept informed on datasets to trigger a review. **Action: E Johnstone** G Raphael informed the Committee that this would be closely monitored. **RESOLVED**: that the Committee ratified the policy.
8	**Stroke update** A Bennett introduced G Stanion and C Kindness-Cartwright who are leading the programme for stroke services improvement across L&SC. The Committee was informed that the purpose of the paper was to bring colleagues up-to-date on the work and to point the way on the future choices that commissioners will need to make as the programme comes to a critical stage. C Kindness-Cartwright provided a high-level overview on progress across each phase of the stroke pathway. Excellent clinical engagement had taken place in terms of developing an alternative ambulatory model of care and hospital-based rapid assessment and diagnosis of patients. Clinical and patient engagement on this work is continuing. It was reported that the Chair of the Stroke Programme Board (D Lowe) is the national lead for "Getting It Right First Time" (GIRFT). D Lowe is a clinical director and consultant at Arrowe Park Hospital who is advising the programme. Also included in the paper was a direction of travel for L&SC aligned with an understanding of the National Stroke Plan. G Stanion reassured the Committee that the focus is on continuous improvement from each Acute Trust and sharing what is working well across L&SC. G Stanion went on to say that work was on-going to address areas where there are gaps in the service and variations in outcomes. The Chair thanked G Stanion and C Kindness-Cartwright and reminded the Committee that the report was for information only. The Committee was asked to endorse the programme and the work going forward. G Jolliffe questioned the absence of smoking in the prevention priority and also wanted reassurance that his area (Barrow in Furness) would not be disadvantaged by not having an acute hyper stroke unit. After a question raised by P Tinson, G Raphael informed the Committee that a seminar of senior finance colleagues was to take place that would include consideration around stroke. Discussions should take a wider view of how one assesses the financial impact not only of the

	benefits of people being treated effectively and having less disability but the costs incurred for longer-term care. It is possible this could cost the NHS more in some aspects but may have bigger benefits within the local authority sector. Meetings were due to take place seeking input from local authority colleagues to gain fully rounded views on the costs and benefits of this particular programme. G Stanion informed the Committee of the challenges from a clinical acute perspective/hyper acute implemented from a staffing and workforce perspective. In terms of Cumbria it was reported that a meeting took place with commissioning and provider representatives from Morecambe Bay to discuss how to make it very clear for residents in that part of the patch what we are doing to ensure they have the best possible outcomes of the pathway. A Bennett informed the Committee that this was a detailed stocktake predicated on helping to understand where commissioning needs to come together to secure certain outcomes and to share the same with provider leaders. A Bennett asked that the Committee endorsed the collective action being taken by providers to address gaps in the current services. G Stanion agreed to convey the message, including the omission of smoking. **RESOLVED**: that the Committee noted the content of the report and endorsed the programme and work going forward.
9	**Special Educational Needs and Disabilities (SEND)** M Youlton provided a formal update on the latest position of the services across the county of Lancashire. Following a review of the service in November 2017 where the outcome was far from good, a process was put in place to submit a written statement of action to improve the services. Two reviews by the regulators had taken place in 2018. It was reported that a number of patients and carers are members of the Board overseeing this improvement plan. A service around autism spectrum disorder (ASD) has been put in place in North Lancashire with 135 children and young people moving off the waiting list within a few months. Engagement had taken place in schools with school heads, patients and carers and one event resulted in 44 carers who want to be actively involved in this programme in Lancashire. A Power Group made up of mainly young people had produced great videos and powerful stories about people with these disabilities and this is something the group will continue to develop, along with the development of the 'local offer' website for Lancashire families to access messages of support and for that support to be consistent to lead them through the challenges they face. Actions to date: • Engagement workstream developing a new website • 16 regional events attended by 190 parents and carers on what the service can offer • 129 practitioners involved and 600 patient carers • 368 children and young people completed surveys with 285 educators attending events across the county and this will continue through the process Further work was ongoing following an assessment of engagement at the beginning of October 2018. Work was also ongoing with the appointment of designated clinical officers who will have a key role in assessing the quality in health and education care plans in existence for people to ensure they are of a consistent quality across the county. A final scrutiny visit is due in December 2018. Professor D Harrison commended on the piece of work as one of "the best pieces of work we have done all year to reduce inequalities." From a public health perspective this is one of the areas probably most critical in the health and wellbeing of vulnerable young people. He went on to say that the criminal justice system has between 40-60% of young people with an undiagnosed learning difficulty or ASD and this service will make a big different to the risk of that cohort going into the criminal justice system. S Stevenson informed the Committee that Healthwatch, across L&SC, will support this

	programme to an even greater degree than the other programmes mentioned due to its importance. A Doyle was sure the programme would welcome the offer. **RESOLVED:** that the Committee accepted the report.
10	**Commissioning development** A Bennett provided a brief overview on the ongoing approach to commissioning development in light of the agreement to proceed with a placed-based approach reached in June 2018. He informed the Committee that there was now a formal Commissioning Oversight Group (COG) overseeing the work. Work was ongoing across a number of workstreams and host organisations to create mechanisms on how we bring together commissioning teams. The work also involved reviewing the work at a neighbourhood level. The Committee was informed that Adult Mental Health (AMH) and Out of Hospital (OOH) workstream portfolios would be presented to the Committee at its workshop in December for endorsement. **RESOLVED:** that the Committee noted the update.
11	**Any other business** Professor D Harrison provided the Committee with information on *Reducing Obesity on the current Weight Management Services model.* He raised the example of a Department of Public Health (DPH) colleague in Sheffield regarding the analysis of how long it will take Sheffield to get to 'zero prevalence' for overweight and obesity using the current weight management 'services model' (similar to those of Cumbria and Lancashire). He went on to say that this analysis suggests, 'it will take 240 years to get population prevalence to zero'. The consensus drawn from this work is that several of our medical model interventions are unlikely to deliver continued health improvements. Reports of this nature underline the need for the L&SC system to rapidly develop a robust and transformational 'population health system' if we are to seriously meet the collective social aspirations of improving health outcomes, as well as reducing health care system demand and costs. It was reported that Dr S Karunanithi, Director of Public Health, Lancashire County Council, had facilitated an excellent meeting with NHS England colleagues to discuss the prospects of Cumbria and Lancashire establishing a model 'population health system' across the NHS and Local Authorities and partners at both an ICS and ICP level once the NHS ten-year plan is published. The reference document for this work can be found at: https://gregfellpublichealth.wordpress.com/2018/10/30/population-impact-of-weight-management-services/ **RESOLVED**: that the Committee noted the information.
	Questions from the public From a question raised by a member of the public on the governance of the ICS and how this relates to the Committee, A Bennett agreed to provide further information outside the meeting.
Date and time of next meeting: Thursday 10 January 2019, 13:00-15:00 (Brunswick Room) Blackpool Central Library, Queen Street, Blackpool, FY1 1PX.	

Agenda item no. 5

Joint Committee of CCGs

Title of Paper	NHS Long Term Plan		
Date of Meeting	7th March 2019	Agenda Item	5

Lead Author	Amanda Doyle	
Contributors	Andrew Bennett	
Purpose of the Report	Please tick as appropriate	
	For Information	X
	For Discussion	X
	For Decision	
Executive Summary	The NHS Long Term Plan was published in January 2019. The Plan sets clear priorities for the NHS working with patients, citizens, staff and partners, supported by an additional investment of £20 billion over the next 5 years. An on line link to the Long Term Plan can be found at: https://www.longtermplan.nhs.uk/online-version/ The partner organisations in Healthier Lancashire and South Cumbria are now expected to explain and engage with communities how we will implement the Long Term plan in our neighbourhoods, local organisations and across the whole ICS. The Chief Officer of Healthier Lancashire and South Cumbria will provide an overview presentation of the Long Term Plan and invite members of the Joint Committee to express their views.	
Recommendations	Members of the Joint Committee are invited to share their perspectives on the Long Term Plan.	
Next Steps	Senior leaders across Healthier Lancashire and South Cumbria are drafting a strategic document in response to the Long Term Plan which will enable further engagement with patients, citizens and partners. This process is being overseen by the ICS Board.	

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Joint Committee of CCGs

Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		
If Yes : Risk	The Long Term Plan is intended to address a number of the most obvious risks facing communities, patients and the NHS. There are also inevitable risks to delivery of the Plan.		
Report Authorised by:	Andrew Bennett		

Joint Committee of Clinical Commissioning Groups

Title of Paper	Development of Lancashire and South Cumbria clinical commissioning policies, Decision paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	07.03.2019	Agenda Item	6
Lead Author	Rebecca Higgs, Policy Development Manager, NHS Midlands and Lancashire CSU		
Purpose of the Report	For Discussion		
	For Information		
	For Approval	X	
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed a review of seven intervention specific commissioning policies. Revised and updated policies have been prepared for adoption across Lancashire and South Cumbria.		
Recommendations	That the JCCCGs ratify Lancashire and South Cumbria policies on the following interventions: - *sterilisation reversal* - *chalazia removal* - *haemorrhoid surgery* - *Dupuytren's contracture release* - *adult snoring surgery in the absence of obstructive sleep apnoea* - *ganglia and mucoid cyst excision* - *arthroscopic shoulder decompression surgery for the management of pure subacromial shoulder impingement*		
Equality Impact & Risk Assessment Completed	Yes		
Patient and Public Engagement Completed	Yes		
Financial Implications	No		
Risk Identified	No		

If Yes : Risk	
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Healthier Lancashire and South Cumbria ICS

NHS
Midlands and Lancashire
Commissioning Support Unit

Development of Lancashire and South Cumbria clinical commissioning policies

A decision paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)

1. Introduction

1.1 The purpose of this paper is to apprise the JCCCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to develop commissioning policies on the following interventions:

- *sterilisation reversal*
- *chalazia removal*
- *haemorrhoid surgery*
- *Dupuytren's contracture release*
- *adult snoring surgery in the absence of obstructive sleep apnoea*
- *ganglia and mucoid cyst excision*
- *arthroscopic shoulder decompression surgery for the management of pure subacromial shoulder impingement*

2. Development process

2.1 The development of the *Policy for Sterilisation Reversal in Males and Females* has been completed in accordance with the process approved by the CPDIG, which has been shared with the JCCCGs previously. That process included the following key steps:

i. an evidence review by an allocated policy lead;
ii. clinical stakeholder engagement;
iii. public and patient engagement;
iv. notification of local Health, Overview and Scrutiny Committees;
v. consideration of any financial implications
vi. an Equality Impact Risk (EIA) Assessment;
vii. consultation with Healthier Lancashire and South Cumbria Care Professionals Board (the CPB) for clinical assurance purposes.

2.2 The remaining policies have been produced in response to national guidance published by NHS England (NHSE) on 29 November 2018 under the title "Evidence Based Interventions: Guidance for CCGs." This forms part of a national programme of work being undertaken by NHSE to target the effective use of NHS resources and

is a parallel workstream to the medicines programme titled “Items which should not be routinely prescribed in primary care.”

2.3 The national guidance has been developed with the intention of reducing the number of inappropriate interventions provided on the NHS and outlines a minimum set of commissioning criteria that Clinical Commissioning Groups (CCGs) are required to adhere to for 17 procedures.

2.4 The 17 interventions were identified due to substantial variation in performance rates nationally that could not be explained by differences in population demand.

2.5 Where CCGs do not currently have commissioning policies in place for the 17 interventions covered by the guidance, they are expected to do so by 01 April 2019. A detailed review was undertaken to ensure compliance. This identified that harmonised Lancashire and South Cumbria commissioning policies were required for the remaining 6 interventions covered by this paper.

2.6 The evidence review and criteria setting *for Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the management of Pure Subacromial Shoulder Impingement* was undertaken by NHS Chorley and South Ribble and Greater Preston CCGs, who developed the policy locally prior to the publication of the Evidence Based Interventions programme. The remaining policies rely on the national evidence review that was undertaken by NHSE as part of their work programme. However, all 6 policies were then subject to the locally agreed development process set out above from point ii onwards.

2.7 In addition to the development of these six policies extensive work has been undertaken locally to identify any potential points of variation between existing local harmonised commissioning policies for the remaining 11 interventions covered by the guidance and the national recommendations. The CPDIG agreed at their meeting in February 2019 that changes were required to some of these of local policies to facilitate alignment. Once this work has been concluded these policies will be presented to the JCCCGs for ratification.

2.8 The final policies are available to view via the following links:

Policy for Sterilisation Reversal in Males and Females
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/ERaG9ww5d_9NqDxxBq17AAwBw9VD_nIZ9vmeYWiJx4CReA?e=DugoS4

Policy for Chalazia Removal
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EQdvOAU764ZEhO9M7_wXrQcBuP_N_gaB2GTL-OJ_my1wrQ?e=K4i7zc

Policy for Haemorrhoid Surgery
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EUmZ9GDPFlJDr5W0knpBpC4BLXHyo2Wys5R4PdMjlOpnOg?e=O5nDNo

Policy for Dupuytren’s Contracture Release in Adults

https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EXZa2a-DB55HsT6y8nP06xcBwI-1QdBnVCIIhsMUy8WiNw?e=VPzQVP

Policy for Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea (OSA)
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EWkSh6uYC_FDmEZyIJKp3V0B5nRgwMRZxlVAeLOhGg95hg?e=xeHfz1

Policy for the Excision of Ganglia and Mucoid Cysts
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EXPj7779BW5Lg5D1AE1yaSkB2AjTGVyUj1JTv261e1R01w?e=yWj0Jh

Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the Management of Pure Subacromial Shoulder Impingement
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/ERBSOgFfPKZMpiy9XMvqR-AB6s0FMzbW92m43tM8Gp_tRg?e=B4dVIs

3. Policy for Sterilisation Reversal in Males and Females

3.1 This policy has been developed as the existing CCG policies for this intervention have reached their review dates. The review intended to ensure the policy continued to reflect the existing evidence base and CCG commissioning intentions.

3.2 No changes were made to the policy criteria as a result of either the evidence review or clinical engagement, although the scope of the policy has been clarified to aid understanding, and clinicians were supportive of the policy. The CPB supported the development of the policy, pending the outcome of public engagement.

3.3 Neither the public engagement, nor the final stage two EIA[1] identified any changes required to the policy when they were presented to the CPDIG on 16 August 2018. As a result, the policy criteria remain unchanged and the group agreed the policy should proceed to ratification.

3.4 As no changes have been made to the policy, the CPDIG anticipate existing activity and expenditure levels will be unaffected by this policy.

4. Policies for Chalazia Removal, Haemorrhoid Surgery and Dupuytren's Contracture Release in Adults

4.1 These policies have been developed in response to NHSE's Evidence Based Interventions programme, as none of the CCGs in Lancashire and South Cumbria have existing commissioning policies covering these interventions. The resulting criteria-based policies are fully aligned with the national guidance and outline the specific clinical circumstances that must be present for the procedures to be commissioned.

4.2 In addition to the national stakeholder engagement undertaken by NHSE, work was carried out locally to inform stakeholders, including clinicians, patients and the public, of the CCGs' intention to implement policies that comply with the national guidance. No material changes were required to the policies following local stakeholder engagement.

4.3 The policies were also presented to the CPB, who supported their development.

4.4 These are new policies for all CCGs, with the exception of the section of the *Policy for Dupuytren's Contracture Release in Adults* relating to the use of collagenase clostridium histolyticum, which is subject to an existing mandatory NICE Technology Appraisal Guidance (TA459). They will ensure clinical practise is aligned with the prevailing national evidence-based guidance and reduce avoidable harm to patients by preventing unnecessary operations. Activity levels in Lancashire and South Cumbria for these interventions are therefore expected to reduce following local adoption.

4.5 However, NHSE have indicated that the intention of the guidance is not to achieve financial savings. Rather, the expectation is that local systems will re-deploy the capacity released by the changes towards more effective interventions or the adoption of new, proven innovation. The guidance therefore includes activity reduction goals based on all non-emergency spells (including day cases, inpatient activity and non-emergency non-elective admissions) from 2017/2018. These are shown at Healthier Lancashire and South Cumbria Sustainability and Transformation Plan (STP) level for each intervention in Table 1 below.

Table 1: Evidence Based Intervention Guidance nationally determined activity reduction goals for Healthier Lancashire and South Cumbria STP.

Procedure	2017/2018 intervention count (spells)	Estimated activity reduction opportunity (spells)
Chalazia Removal	246	189
Haemorrhoid Surgery	278	110
Dupuytren's Contracture Release	650	289

4.6 The anticipated activity reductions for all the policies outlined in this paper have been presented to Healthier Lancashire and South Cumbria's Finance Investment Group (FIG) for assurance purposes. The FIG supported the development of these policies.

4.7 In addition to STP level data the national programme has published activity reduction goals for all 17 procedures at individual CCG level and activity baseline measures at individual Provider level. These are available to view via the following link: https://www.england.nhs.uk/publication/evidence-based-interventions-programme-activity-and-estimated-activity-reduction-goals/

4.8 Stage two EIAs[2,3,4] have been undertaken locally to supplement the national work. They have not identified any equality risks associated with these policies. The EIAs were presented to the CPDIG, along with final versions of the policies on 21 February 2019, when the group agreed they should proceed to ratification.

5. Policy for Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea (OSA)

5.1 This policy has also been developed in response to NHSE's Evidence Based Interventions programme, as there is currently no single harmonised commissioning policy in Lancashire and South Cumbria covering this intervention. The policy indicates this procedure will no longer be routinely commissioned; this position is fully aligned with the national guidance.

5.2 In addition to the national stakeholder engagement undertaken by NHSE, work was carried out locally to inform stakeholders, including clinicians, patients and the public, of the CCGs' intention to implement policies that comply with the national guidance. No material changes were required to the policy following local stakeholder engagement.

5.3 The policy was also presented to the CPB, who supported its development.

5.4 This is a new policy for all CCGs, except for NHS Chorley and South Ribble and Greater Preston CCGs, who have an existing commissioning policy that is aligned with the proposed Lancashire and South Cumbria policy. The policy will ensure that clinical practise across the region is aligned with the prevailing national evidence-based guidance.

5.5 Activity for this intervention is expected to reduce to near zero, recognising the potential for a small number of procedures to be undertaken following successful Individual Funding Requests (IFRs). This is being supported by a variation to the National Tariff Payment System, that will introduce a £0 tariff for the procedure.

5.6 The Evidence Based Intervention guidance indicates the 2017/2018 activity levels for this intervention based on all non-emergency spells (including day cases, inpatient activity and non-emergency non-elective admissions) to provide an indication of the potential number of activity spells that may be avoided on this intervention following the introduction of this policy. These are shown at Healthier Lancashire and South Cumbria Sustainability and Transformation Plan (STP) level in Table 2 below.

Table 2: Evidence Based Intervention Guidance nationally determined activity reduction goals for Healthier Lancashire and South Cumbria STP.

Procedure	2017/2018 intervention count (spells)	Estimated activity reduction opportunity (spells)
Adult Snoring Surgery	68	68

5.7 A stage two EIA[5] has been undertaken locally to supplement the national work. This has not identified any equality risk associated with the policy. The EIA was presented to the CPDIG, along with the final version of the policy on 21 February 2019, when the group agreed it should proceed to ratification.

6. Policy for the Excision of Ganglia and Mucoid Cysts

6.1 This policy has again been developed in response to NHSE's Evidence Based Interventions programme, as there is currently no single harmonised commissioning policy in Lancashire and South Cumbria covering this intervention. The criteria-based policy is fully aligned with the national guidance and outlines the specific clinical circumstances that must be present for this procedure to be commissioned.

6.2 In addition to the national stakeholder engagement undertaken by NHSE, work was carried out locally to inform stakeholders, including clinicians, patients and the public, of the CCGs' intention to implement policies that comply with the national guidance. No material changes were required to the policy following local stakeholder engagement.

6.3 The policy was also presented to the CPB, who supported its development.

6.4 This is a new policy for all CCGs. For NHS Chorley and South Ribble and Greater Preston CCGs, this policy will supersede an existing commissioning policy for this intervention that is not fully aligned with the Evidence Based Intervention Guidance. The remaining CCGs do not have existing commissioning policies for ganglia excision.

6.5 The policy will ensure clinical practise is aligned with the prevailing national evidence-based guidance and reduce avoidable harm to patients by preventing unnecessary operations. Activity levels for this intervention in Lancashire and South Cumbria are therefore expected to reduce following local adoption.

6.6 The Evidence Based Interventions guidance includes activity reduction goals based on all non-emergency spells (including day cases, inpatient activity and non-emergency non-elective admissions) from 2017/2018. These are shown at Table 3 below.

Table 3: Evidence Based Intervention Guidance nationally determined activity reduction goals for Healthier Lancashire and South Cumbria STP.

Procedure	2017/2018 intervention count (spells)	Estimated activity reduction opportunity (spells)
Ganglia Excision	271	149

6.7 A stage two EIA[6] has been undertaken locally to supplement the national work. This has not identified any equality risk associated with the policy. The EIA was presented to the CPDIG, along with the final version of the policy on 21 February 2019, when the group agreed it should proceed to ratification.

7. Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the Management of Pure Subacromial Shoulder Impingement

7.1 This policy has also been developed in response to NHSE's Evidence Based Interventions programme as the CCGs in Lancashire and South Cumbria, with the exception of NHS Chorley and South Ribble and Greater Preston CCGs, do not have a commissioning policy for this intervention.

7.2 The criteria-based policy is based on the existing Central Lancashire policy, which is aligned with the intention of the national guidance. That guidance indicates the procedure should only be commissioned where patients remain symptomatic despite non-operative treatment. The local policy, although consistent with the national principle, contains specific criteria on the nature and length of conservative management that should be undertaken. The CPDIG were of the view that this would provide additional clarity to stakeholders on the commissioning position and ensure consistent application of the policy across the region.

7.3 The policy underwent clinical engagement with organisations including GP practices, Secondary Care Trusts and the Strategic Clinical Network. Changes were made to the policy in response to the feedback received to aid understanding, clarify the scope and ensure that the criterion related to the use of steroid injections was fully aligned with the evidence base.

7.4 The policy was also presented to the CPB, who supported its development.

7.5 This is a new policy for all CCGs, except for NHS Chorley and South Ribble and Greater Preston CCGs. The policy will ensure that clinical practise across the region is aligned with the prevailing national evidence-based guidance and that treatment provision is equitable. Activity levels for these interventions are therefore expected to reduce in the remaining CCG areas following local adoption.

7.6 The Evidence Based Interventions guidance includes activity reduction goals based on all non-emergency spells (including day cases, inpatient activity and non-emergency non-elective admissions) from 2017/2018. These are shown at Table 4 below.

Table 4: Evidence Based Intervention Guidance nationally determined activity reduction goals for Healthier Lancashire and South Cumbria STP.

Procedure	2017/2018 intervention count (spells)	Estimated activity reduction opportunity (spells)
Shoulder Decompression Surgery	423	184

7.7 Neither the public engagement, nor the final stage two EIA[7] identified any changes required to the policy when they were presented to the CPDIG on 21 February 2019. As a result, the group agreed the policy should proceed to ratification.

8. Conclusion

8.1 The JCCCG is asked to:

- Note the additional work being undertaken locally to ensure existing commissioning policies are aligned with the national "Evidence Based Interventions Guidance."
- Ratify the following collaborative commissioning policies, which will replace any existing CCG policies:
  - Policy for Sterilisation Reversal in Males and Females
  - Policy for Chalazia Removal
  - Policy for Haemorrhoid Surgery
  - Policy for Dupuytren's Contracture Release in Adults
  - Policy for Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea (OSA)
  - Policy for the Excision of Ganglia and Mucoid Cysts
  - Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the Management of Pure Subacromial Shoulder Impingement

Elaine Johnstone, Chair of the CPDIG
22 February 2019

References

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2. Equality Impact and Risk Assessment Stage 2 for Policies, Policy for Chalazia Removal, 08.02.2019
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EZtNknlSbd5Dixlw5pRIBQ8BbXSItnre8JBGYj7SVTU7xQ?e=Quqr6N

3. Equality Impact and Risk Assessment Stage 2 for Policies, Policy for Haemorrhoid Surgery, 08.02.2019
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5. Equality Impact and Risk Assessment Stage 2 for Policies, Policy for Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea (OSA), 08.02.2019
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7. Equality Impact and Risk Assessment Stage 2 for Policies, Policy for the commissioning of Arthroscopic Shoulder Decompression Surgery for the Management of Pure Subacromial Shoulder Impingement, 08.02.2019
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Joint Committee of CCGs
UPDATE REPORT

Work Programme: Stroke Programme	**Programme Director:** Gemma Stanion **Programme Team:** Elaine Day, Claire Kindness-Cartwright, Kate Turner **Clinical Lead:** Mark O'Donnell
PERIOD OF REPORT	March 2019

FOR INFORMATION

1. Introduction

This report follows on from the reports provided to the November 2018 (formal) and February 2019 (informal) Joint Committee of CCGs meetings. The paper provides a position statement in relation to the decision making underway within individual CCGs in relation to investment in Integrated Community Stroke Rehabilitation services. These actions are being taken by commissioners to secure a more effective end to end stroke pathway across Lancashire and South Cumbria.

This is an essential element of improving the stroke pathway for all patients, and is referred to as such in the NHS Long Term Plan. Currently stroke rehabilitation is provided in a variety of ways, including in some acute Stroke Units. This has led to unjustified variation in access, and potentially clinical outcomes, for patients, which could be improved.

The Joint Committee of CCGs is requested to:

- **Note the content of this update report**
- **Ask each CCG to include an agreed level of investment in community-based stroke rehabilitation services in CCG operational plans for 2019/20**

2. Position Statement – Investment Decisions

The NHS Long Term Plan published in January 2019 has highlighted the national commitment to more integrated and higher intensity rehabilitation in order to support improved outcomes for patients.

"Out of hospital, more integrated and higher intensity rehabilitation for people recovering from stroke, delivered in partnership with voluntary organisations including the Stroke Association, will support improved outcomes to six months and beyond." (NHS England 2019; The NHS Long Term Plan pg.64)

All CCGs have been actively engaged in the development of business cases over the past few months and at an ICS level we have worked with local commissioners to support work where this has been requested. These business cases are now in the process of being reviewed by CCGs.

The table below demonstrates the current position in relation to each CCG's business case.

ICP/CCG	Business Case Review Date	Outcome	Business Case Due for Decision
Pennine Lancashire ICP			
Blackburn with Darwen CCG East Lancashire CCG	05/03/19 Joint Operations Meeting	Not known at the time of writing	18/03/19 Committee of Commons
Central Lancashire ICP			
Chorley & South Ribble CCG Greater Preston CCG	12/02/19 Stroke Strategy Group w/c 04/03/19 Management Team Exec	Additional information requested Not known at the time of writing	27/03/19 & 28/03/19 Governing Body Meetings
Fylde Coast ICP			
Blackpool CCG Fylde & Wyre CCG	19/03/19 Senior Management Team	Not known at the time of writing	26/03/19 Finance & Performance Committee
Morecambe Bay ICP			
Morecambe Bay CCG	22/02/19 CCG Exec Meeting	Shortlisted for further consideration against other priorities	21/05/19 Governing Body
West Lancashire ICP			
West Lancashire CCG	April 2019 (date tbc) CCG Exec Meeting		21/05/19 Governing Body

The Joint Committee of CCGs is requested to:

- **Note the content of this update report**
- **Ask each CCG to include an agreed level of investment in community-based stroke rehabilitation services in CCG operational plans for 2019/20**