Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Joint Committee of CCGs

Thursday 11th January 2018

13:00 – 15:00

Venue: Tanhouse Community Enterprise, Ennerdale, Tanhouse, Skelmersdale, WN8 6AN

Agenda

Agenda Item	Timings	Item	Owner	Action	Format
Standing Items					
1.	5 mins	Welcome and Introductions	Phil Watson	Information	Verbal
		Apologies	Phil Watson	Information	Verbal
		Declarations of Interest	Phil Watson	Information	Verbal
2.	5 mins	Minutes from the last meeting held on 2nd November 2017	Phil Watson	Information	Paper
		Action Matrix Review	Phil Watson	Information	Paper
3.	5 mins	Any other business declared	Phil Watson	Information	Verbal
For Discussion/Recommendations					
4.1	40 mins	A New Commissioning Framework For Lancashire & South Cumbria	Andrew Bennett	For Approval	Paper
4.2		Mental Health Commissioning Development Mobilisation and Next Steps *(There are a number of related technical papers supporting both these reports running to nearly 450 pages. Should any Committee member wish to receive copies, please contact the office on 01253 951630)*	Debbie Nixon	For Approval	Paper
5.	20 mins	Specialist Neuro Rehabilitation *Implementing a New Model of Care*	Carl Ashworth	For Approval	Paper
6.	20 mins	Commissioning Policies: • Complementary and Alternative Therapies • Facial Nerve Rehab	Hilary Fordham	For Approval	Paper
7.	5 mins	Any Other Business	Phil Watson		Verbal
Formal meeting closed – continue with Questions from the Public					

8.	10 mins	Questions and Answers	All	Discussion	Verbal
For information only					
9.	The next JCCCG Meeting will be held on:- Thursday 1st March 2018 Venue to be confirmed		Phil Watson	Information	Information

Apologies should be sent to Susan Hesketh susan.hesketh1@nhs.net or dial 01253 951490

Details of Venue – Directions and parking attached

By Road

Tanhouse Community Centre is at the far end of Ennerdale, a turning off Tanhouse Road, Skelmersdale.

The car park in front of the centre is for centre users and is free.

Our post code for your satnav is WN8 6AN

Accessibility

We are a single storey building with double doors at the entrance and into the main hall. The entrance is up a very slight slope from the car park but is step-free. We have a disabled toilet.

Public Transport

Preston Bus 3A travels along Tanhouse Road and stops near the other end of Ennerdale. It runs approximately hourly Mondays to Saturdays, Burscough - Parbold - Newburgh - Skelmersdale - Upholland - Appley Bridge. Timetable at www.prestonbus.co.uk

Other more frequent buses to/from Wigan, Ormskirk and Southport stop at the Upholland Labour Club approximately a 5-minute walk away. Timetable from Arriva

Rail: Wigan Northwestern and Wallgate stations are approximately 15 minutes away by taxi. Direct trains to/from Southport, Manchester, Preston, Warrington, Liverpool, St Helens

Lancashire & South Cumbria Change Programme Declaration of Interests – 1 April 2017 to 31 March 2018

Declaration of Interests form for Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members regarding financial and other interests.

This form is required to be completed in accordance The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations

Notes:

All members of Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members are required to register their financial and other interests on an annual basis on a Declaration of Interest form.

The form must be completed whether you have a declaration of interest to make or not, and should clearly state if there is no declaration of interest.

Any changes to interests declared, or new interests, must be registered within 28 days of the relevant event by completing and submitting a new Declaration of Interest form.

A signed, hard copy of the Declaration of Interest form should be delivered to the PA to Healthier Lancashire.

If in doubt as to whether a conflict or potential conflict of interest could arise, a declaration of the interest(s) should be made.

If any assistance is required in order to complete this form, then the member or employee should contact the Lancashire & South Cumbria Change Programme Director.

A Register of Interests will be made accessible to members of the public on request.

Lancashire & South Cumbria Change Programme Board members, Joint Committee and Workstream group members completing this Declaration of Interest form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest that the person has and the circumstances in which a conflict of interest with the business or running of Healthier Lancashire might arise.

Interests that must be declared:

1. Roles and responsibilities held within member practices;
2. Directorships, including non-executive directorships, held in private companies or PLCs;
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with Lancashire & South Cumbria Change Programme;
4. Shareholdings (more than 5%) of companies in the field of health and social care;
5. Positions of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care;
6. Any connection with a voluntary or other organisation contracting for NHS services;
7. Research funding/grants that may be received by the individual or any organisation they have an interest or role in; and
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within Lancashire & South Cumbria Change Programme whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual.

Declaration of Interests – 1 April 2017 to 31 March 2018

Name:				
Position:	**Band 1-7**		**8 or Above**	
	Please tick appropriate Band (or Equivalent)			

Type of Interest	**Details: Self**	**Details: Family Member, Close Friend or Other Acquaintance**
1. Roles and responsibilities held within member practices		
2. Directorships, including non-executive directorships, held in private companies or PLCs		
3. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with Lancashire & South Cumbria Change Programme		
4. Shareholdings (more than 5%) of companies in the field of health and social care		
5. Positions of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care		
6. Any connection with a voluntary or other organisation contracting for NHS services		
7. Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
8. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within Lancashire & South Cumbria Change Programme		

Signatory to the Declaration of Interests

☐ **I have no interests to declare**

OR

☐ **I have interests to declare as above**

I have read and understood my obligations as outlined in the Standards of Business Conduct. I am signing to confirm that the information provided on this form is true and correct to the best of my knowledge.

I consent to the disclosure of this information to the Local Counter Fraud Specialist and/or NHS Protect for verification purposes and for the prevention or detection of crime.

I acknowledge that if any changes to the above declaration occur it is my responsibility to inform Lancashire & South Cumbria Change Programme at the earliest opportunity, and within 28 days of the relevant event.

Further to this; I will not engage (directly or indirectly via a third party) in any discussion or decision where my private or external interests may affect my ability to act in an open and transparent way; as required by the Standards of Business Conduct (both National and Local).

Signed: …….

Print Name: ……..……..…….

Date: ……..……..…….

Lancashire & South Cumbria Change Programme Response to Declaration of Interest

To be completed by the Programme Director

☐ **I accept the Declaration of Interest as per Section A below**

OR

☐ **I do not accept the Declaration of Interest and have provided reasons in Section B below**

I accept the Declaration of Interest:

A) Lancashire & South Cumbria Change Programme acknowledges the above declaration and confirms that it is appropriate and conforms with the Standards of Business Conduct Policy. This declaration will now be included in the Register of Interests. This declaration will remain on the Register of Interests until the signatory to the declaration informs Lancashire & South Cumbria Change Programme that this has changed. The signatory to the declaration will be excluded from any discussions or decision-making where it is perceived that the above declarations may adversely influence their ability to act in an open and transparent manner in line with the Standards of Business Conduct (National and Local).

I do not accept the Declaration of Interest:

B) Lancashire & South Cumbria Change Programme acknowledges the above declaration, however it is not considered appropriate in line with the Standards of Business Conduct Policy for the following reasons:

[Enter details here]

A record has been included in the Register of Interests, however this will be discussed at the next formally minuted Executive meeting to ensure that this perceived conflict is dealt with and managed in the most appropriate way. The signatory to the declaration will be excluded from any discussions or decision making where the above declaration is deemed to adversely influence their ability to act in an open and transparent manner in line with the Standards of Business Conduct (National and Local).

Authorised By: ……

Programme Director

Date: ……..

Healthier Lancashire & South Cumbria

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

Minutes of the Joint Committee of the Clinical Commissioning Groups
held on Thursday 2nd November 2017, 1pm – 3pm
at Moor Lane Mills, Lecture Theatre, Lancaster

Chair	Phil Watson (PW)	Independent Chair	JCCCGs	Attended
Voting Members **(One vote per CCG)**	Alex Gaw	Chair	Morecambe Bay CCG	Attended
	Andrew Bennett	Chief Officer	Morecambe Bay CCG	Apologies
	Penny Morris	Chief Clinical Officer	Blackburn with Darwen CCG	Apologies
	Sumantra Mukerji	Chair	Greater Preston CCG	Apologies
	Doug Soper	Lay Member	West Lancashire CCG	Apologies
	Susan Fairhead	GP Member	Blackpool CCG	Attended
	Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Apologies
	Gora Bangi	Chair	Chorley South Ribble CCG	Apologies
	Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
	Mark Youlton	Chief Officer	East Lancashire CCG	Attended
	Tony Naughton	Chief Clinical Officer	Fylde and Wyre CCG	Attended
	Mary Dowling	Chair	Fylde and Wyre CCG	Attended
	Paul Kingan	Chief Finance Officer	West Lancashire CCG	Attended
	Phil Huxley	Chair	East Lancashire CCG	Attended
	Debbie Corcoran	Lay Member for Patient & Public Involvement	Greater Preston CCG	Apologies
	Roy Fisher	Chair	Blackpool CCG	Attended
	Roger Parr	Chief Finance Officer	Blackburn with Darwen CCG	Attended
	Denis Gizzi	Chief Officer	Greater Preston and Chorley and South Ribble CCG	Attended
In attendance	Dr Amanda Doyle	STP Lead	Healthier Lancs & South Cumbria	Apologies
	Andrew Bibby	Director for Specialised Services	NHS England	Attended
	Andy Curran	Medical Director	Healthier Lancs & South Cumbria	Apologies
	Carl Ashworth	Service Director	Healthier Lancs & South Cumbria	Apologies
	Gary Hall	Chief Executive Officer	Chorley Council	Apologies
	Gary Raphael	Finance Director	Healthier Lancs & South Cumbria	Attended
	Jane Cass	Acting Director of Operations	NHS England	Attended
	Lawrence Conway	Chief Executive Officer	South Lakeland District Council	Attended
	Sir Bill Taylor	Chair	Healthwatch	Attended
	Neil Greaves	Communications and Engagement Manager	Healthier Lancs & South Cumbria	Attended
	Clive Unitt	Lay Member	Morecambe Bay CCG	Apologies
	Dave Tillary	Representative	West Lancashire Borough Council	Attended
	Dean Langton	Representative	Pendle Borough Council	Apologies
	Debbie Nixon	SRO Mental Health	Healthier Lancs & South Cumbria	Attended
	Neil Jack	Chief Executive	Blackpool Council	Apologies
	Sakthi Karunanithi	Director of Public Health	Lancashire County Council	Apologies
	Katherine Fairclough	Chief Executive Officer	Cumbria County Council	Attended
	David Bonson	Chief Operating Officer	Blackpool CCG	Attended
	Harry Catherall	Chief Executive Officer	Blackburn with Darwen Council	Attended
	Steve Thompson	Director of Resources	Blackpool Council	Attended
	Vanessa Wilson	Divisional Manager	East Lancs Hospital Trust	Attended
	Charmaine McElroy	Business Manager to Amanda Doyle	Healthier Lancs & South Cumbria	Attended
	Lucy Atkinson	Communications and Engagement Officer	Healthier Lancs & South Cumbria	Attended

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		ACTION
1	**Welcome and Introductions** The Chair welcomed the members of the Committee to the formal meeting. He explained the status of the meeting and that the Committee had invited members of the public to a drop-in session prior to the meeting commencing, in order to give them the opportunity to ask questions in advance. He added that there would still be an option to ask questions after the meeting had finished. The Chair welcomed Denis Gizzi, Chief Officer for Greater Preston and Chorley and South Ribble CCG to the meeting.	**Information**
2	**Apologies and Quoracy** Apologies were received from: Dr Amanda Doyle, Debbie Corcoran, Geoffrey O'Donoghue, Gora Bangi, Sumantra Mukerji, Sakthi Karunanithi, Dean Langton, Gary Hall, Andy Curran and Neil Jack. The Chair approved Denis Gizzi as the formal representative from Greater Preston and Chorley and South Ribble CCG to make the meeting quorate. ***RESOLVED: The Chair noted the apologies and declared the meeting quorate***	**Information**
3	**Declarations of Interest** The Chair requested that the members declare any interests relating to items on the agenda. The Chair reminded those present that if, during the course of the discussion, a conflict of interest subsequently became apparent, it should be declared at that point. ***RESOLVED: No declarations of interests declared***	**Information**
4	**Minutes from previous meetings for ratification** The Chair explained that the outstanding issues with the minutes from 6th July 2017 and 2nd March 2017 had now been rectified. The Chair thanked Mary Dowling for her contribution in resolving the outstanding issues. • 7th September 2017 – Minutes approved with no amendments • 6th July 2017 - Minutes approved with no amendments • 2nd March 2017 – Minutes approved with no amendments **Revised Joint Committee of CCGs Terms of Reference** The Chair explained that the Terms of Reference had been refreshed to bring them in line with the current environment, with the outstanding comments provided by Phil Huxley and Mary Dowling incorporated. The Chair reminded members that the Terms of Reference will be reviewed again towards the end of the financial year and following the outcome of the STP Gateway Review, the roles and Terms of Reference for other associated groups will also be reviewed. The Chair commented that he is hoping that we can now use the revised Joint Committee Terms of Reference as a springboard for the Joint Committee to move forward. Mary Dowling commented that the revised Terms of Reference are as good as they can be at this stage and she paid tribute to Charmaine McElroy and other colleagues for their work on them. ***ACTION: The revised Terms of Reference were agreed***	**Agreement**

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5	**Action Matrix Review** The Chair explained that we had undertaken a refresh of the action matrix and the following points were discussed: • Evaluation and Hurdle Criteria – This has been removed from the matrix as an action for the Joint Committee and work is progressing on this via the Care Professionals Board. • Integrated Diagnostics – This has also been removed from the action matrix, as the work around this is being picked up via the Provider Group, as part of the work around the Carter Review. Mary Dowling queried whether there will be any commissioning issues in relation to this that would still require intervention from the Joint Committee. Gary Raphael responded to clarify that this work will have significant links with primary care and the intention is for the Provider Group to lead on developing the work, then when a decision will be required from commissioners, this will come back to the Joint Committee at the appropriate time. • Mental Health – The Chair explained that work is ongoing on this, linked to the commissioning development work. This will be brought back to the Joint Committee at the appropriate time. Harry Catherall commented that it is critical that we involve broader agencies such as the police in our work on mental health service development. Members of the Committee agreed with this.	**Information**
6	**Any Other Business Declared:** The Chair asked the members of the Committee if they had any other business they wished to declare for discussion at the end of the meeting. ***RESOLVED: No other business was declared*** The Chair added that there would also be an opportunity for the public to ask questions at the end of the formal meeting.	**Information**
7	**Local Maternity Services (LMS) Plan** The Chair invited Vanessa Wilson, Divisional Manager at East Lancashire Hospitals Trust, to commence her presentation. Vanessa Wilson explained that the purpose of the presentation today is to apprise the Joint Committee of CCGs of the ongoing work across Lancashire and South Cumbria (L&SC), with regards to Maternity Services, in line with national strategy and expectations. She explained that she is seeking support from the Committee today on the high level plan, which is summarised within the slides presented today. In 2015, Simon Stevens commissioned Better Births, a Five Year Forward View for Maternity Care. The key task is to deliver the expectations within Better Births across L&SC by the end of 2020/2021. The key elements are to improve maternity services in the following areas: • Improving choice and personalisation • Improving safety of services • NHS Personal Maternity Care Budget • Continuity of Care • Working with Strategic Clinical Networks	**Support**

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	• Development of Maternity Voices • Partnerships Vanessa Wilson explained that the demographics are challenging and there are significant workforce challenges around this agenda, with complex interdependencies that need to be considered that affect the flow of patients between hospitals. An LMS Board has been created, which is coterminous with STP geography. This is a key requirement outlined within Better Births. She explained that the governance structure surrounding LMS is complex and there are significant links with other areas of health and social care services that need to be considered. The LMS plan had been submitted to regional colleagues on 22nd October 2017, in line with national timescales. Vanessa Wilson indicated that there will not be national feedback on this; the regional teams will provide assurance to national colleagues on the robustness of the plan. Vanessa Wilson explained that she has not shared the detailed plan with members today, as it is in excel format with a significant number of lines of tasks. However, she indicated that she is happy to share this with members if felt necessary. She went on to explain that the plan does not sign us up to a way of changing services radically, it is a vehicle to implement the requirements outlined within Better Births and reduce variation and inequalities going forward. A Project Manager and Communications and Engagement Officer will be appointed to support the workstream. Workstream Chairs are already in place from constituent organisations and they are undertaking these roles in addition to their day job. The Chair thanked Vanessa Wilson for her presentation and invited questions from members. Graham Burgess asked regarding the timescales of the project. Vanessa Wilson explained that over the next 6 months, by the end of March 2018, baseline mapping will be undertaken and completed. Vanessa Wilson also offered to produce a condensed version of the plan, indicating the key tasks and timescales and agreed to share with members. Phil Huxley commented on the governance structure for the project and asked how patients are involved. Vanessa Wilson confirmed that there are patient voices on the LMS Board and other opportunities for engagement. It was acknowledged that we need to connect with people rather than just services. Harry Catherall went on to say that in Blackburn with Darwen he was surprised by how many young new families in the area do not really know about the support services out there. It was acknowledged that we need to ensure that we connect to our communities. Vanessa Wilson stated that there are plans to address this by establishing community hubs focused on local communities. Mary Dowling asked whether the workforce elements of the programme will be worked through on a L&SC basis, or whether it will be influenced nationally. Vanessa Wilson responded to say that there is a workforce planning tool that is	**Vanessa Wilson**

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	used for maternity workforce modelling, which is quite limited and does not take account of the broader pregnancy journey, where other services from different parts of the system can add value. She acknowledged that there are opportunities to bring together the relevant sections of the woman's care pathway, to improve the whole journey. Sir Bill Taylor reflected on a personal experience and asked what mechanisms there are in place for patients to feedback on their experience and suggest improvements. Vanessa indicated that there are opportunities for patients to talk about and review their experiences and the service welcomes this as part of continuous learning. Paul Kingan asked whether there are any specific issues for West Lancashire to be aware of in relation to this work. Vanessa Wilson agreed to link-in with Paul Kingan outside of the meeting to discuss further. ***ACTION: The Joint Committee agreed to support this plan.***	
8	**Transforming Care** The Chair invited Debbie Nixon to commence her presentation. Debbie Nixon stated that it is important to note that the boundary changed in April 2017 when the Morecambe Bay footprint changed. She explained that the Transforming Care Programme is aimed at moving away from hospital care, to more community orientated provision and we will be working with the lead commissioner as the programme progresses. We have a legacy agreement in place and we were charged with being ambitious in reviewing the model for L&SC, to develop a strategic plan and establish a Task and Finish Group to work up the model of care and develop options for public consultation by March 2020, when the legacy agreement will end and the new model of care will be in place. Paul Kingan queried the groups of people that are on the Operational Delivery Network. Debbie Nixon explained that the governance around the programme is very complex, but national guidance is prescriptive and the governance is in line with this. She added that Lancashire Care Foundation Trust is in a position to lead the Operational Delivery Network, which will bring together the providers in the North West, not just providers of Learning Disabilities services, including primary care and mental health. Debbie Nixon stated that this does not mean that we lose a grip on this on a L&SC basis. It is an opportunity for greater collaboration, to enable some of the workforce challenges and other complex areas to be effectively managed and worked through. Harry Catherall commented that Blackburn with Darwen Council provide a number of services to people with Learning Disabilities. He stated that it is critical that we properly understand the financial assumptions around Calderstones, as it will be difficult to facilitate faster discharges when the funding arrangements are not clear. He stressed the importance of urgently reviewing this issue. Graham Burgess welcomed sight on the timeline for delivery and felt this was really useful for the Committee. He queried the Lancashire housing providers and local pools, asking why the commissioning functions where listed in phase 2 rather than phase 1. Debbie Nixon explained that there are colleagues that are leading on the housing strategy elements, in terms of the full financial	**Decision**

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	arrangements. She went on to explain that the first iteration of the strategic plan aspired to having a single STP pooled budget, but this was not supported locally and so an alternative way forward was suggested by the national team. The recommendation from national colleagues was that we have to get our pools in place, or we will not get the funding flows right. The initial thoughts are that pooling in unitary areas would make most sense, as this has been most successful in other areas. Debbie Nixon explained that this will be the starting point and work will progress on assessing the benefits of this, to enable additional pools to be formulated. She went on to explain that a wider strategic case for change needs to be developed and this will require the support of the Joint Committee at the appropriate time. Mary Dowling raised a query regarding the timeline for the signoff of the plan. The timeline within the paper states November 2017 and she asked for clarity around this. Debbie Nixon apologised for the confusion and clarified that this should read that November 2017, the Joint Committee receives this update and not the actual plan. She agreed that she would amend this timeline and recirculate the paper to members. Roy Fisher also raised a query regarding the timeline around the technical appraisal of the clinical model. He asked that when the initial outcomes from the technical appraisal are collated, whether this should be brought back to the Joint Committee for discussion. Debbie Nixon explained that both the Mental Health and Learning Disabilities commissioning cases for change are being developed as part of the ongoing work around commissioning development and this will be brought back to the Joint Committee at the appropriate time. ***ACTION: Subject to amendments to the timeline within the paper, the Joint Committee agreed to support this proposal***	**Debbie Nixon**
9	**Urgent and Emergency Care/Core 24** The Chair invited David Bonson to commence this item. David Bonson explained that A+ E departments across Lancashire and South Cumbria are seeing a high number of mental health patients in crisis, which is not the best place for them to be treated for their mental health needs. He explained that there are two funding streams available to improve services for mental health patients in crisis, by putting provision in place as an alternative to A+E. L&SC had been successful in a recent bid submitted to secure Core 24 services, which is 24 hours a day/7 days a week support for mental health patients in crisis situations. He stated that an application was made to access the funding earlier this year to implement this service now, to ensure that mental health patients are seen in the right place at the right time in the most appropriate setting according to their needs. Plans are already in place to put services into A+ E departments, so that mental health patients presenting in crisis will be seen by the appropriate service to meet their needs. David Bonson stated that there will be specialist mental health triage and support in place within A+E departments and an access line which will be manned by mental health professionals, so that patients can access quick advice and support. The access line will be operational from 5th December 2017.	**Support**

	David Bonson explained that there is some urgent care funding for developing services at Furness General Hospital. He went on to explain that there will be a gap in funding next year and CCGs will need to pick this up earlier than expected to ensure that the service developments are maintained. This is expected to come from CCG allocations. Denis Gizzi queried the purpose of reducing unnecessary admissions to A+ E departments and asked whether we should be striving for zero waits. Debbie Nixon explained that the ideal state is that we have far fewer attendances at A+E, by deflecting patients to an appropriate alternative, however patients are still turning up at A+E departments and we are doing our best to deter people and deflect, but mental health patients are a complex cohort of people who have both mental and physical problems and we cannot aspire to zero waits, but we can do everything we can to reduce them by ensuring appropriate alternative provision. Phil Huxley stated that careful thought and planning would need to be undertaken regarding the workforce to support redirecting people to other services, in that they need to be appropriately skilled and robust enough to cope with demand. He also asked why CCGs should draw down funds to support this, rather than using it elsewhere. Debbie Nixon responded to reiterate that we are required to deliver a very prescriptive Mental Health Five Year Forward View. We do not have a choice in this and the draw down of funding to support this work will enable us to deliver improvements in this area much quicker and this is not a choice locally. She went on to explain that Consultant Psychiatrists will be appointed and in addition to Core 24 delivery they will have a wider role. Alex Gaw raised concerns over funding for Morecambe Bay. Debbie Nixon confirmed that Morecambe Bay is not expected to draw down the money for South Cumbria as it was based on the footprint before the boundary change. This issue has been signalled to the national team regarding the boundary change. Mark Youlton asked whether we are responding to the immediate funding available for this, or whether are we trying to transform care to seek improvements in this area. Gary Raphael responded to reiterate that within the Five Year Forward View there are a number of priorities and must do's that we need to achieve and that we do not have a choice about the model of care that we need to deliver. He went on to clarify that national colleagues have agreed to provide non-recurring money to deliver this in a certain number of health economies. We have to do this anyway, but we have the opportunity to do this faster with support from the centre around this. Gary Raphael stated that he is doing some wider work on CCG allocations and other funding sources, working with Chief Finance Officers, to help colleagues understand all of the different funding elements and streams. Debbie Nixon responded stating that she was concerned that Core 24 is being considered by some Committee members as something that we may not want. She explained that this has been evaluated nationally and has had significant impact in other areas and it is considered as something that needs to be implemented faster to see the greatest impact. Mark Youlton stated that he understands all of this, but we also need to tackle mental health at source, such as in schools, social media etc. Gary Raphael stated he agreed with this and explained that we are taking all opportunities available regarding national funding to accelerate service developments, but it was acknowledged that there are some more significant strategic issues such as	

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	this that need to be progressed as a priority. The Chair explained that as a system we have not yet got into a position where we can avoid dealing with the urgent issues now, but we do need to look at long term solutions and tackle things at source. We are being told that we have to get on with this and do it next year, so we are taking every opportunity in terms of funding available, to accelerate this work. Debbie Nixon explained that she and Sakthi Karunanithi are doing a lot of work around prevention. It was suggested that it would be worthwhile for Sakthi Karunanithi to do a presentation to the Joint Committee at an appropriate future date, to talk about the ongoing prevention work. ***ACTION: The Joint Committee agreed to support this proposal.***	**Sakthi Karunanithi/ Debbie Nixon**
10	**Capital and estates pipeline** The Chair invited Gary Raphael to commence this item. Gary Raphael explained that the purpose of this report and update today to the Joint Committee is to ensure that members are aware that the L&SC Sustainability and Transformation Partnership (STP) is developing an estates and capital strategy, in line with national expectations and requirements, to enable us to access national capital funding streams. Gary Raphael stated that without a clear and robust strategy in place, we cannot progress in this area and money will not come down to the Partnership. He stated that the ask of the Joint Committee today is to ensure members are apprised of the issues around this and he is seeking support from the Committee to progress. He added that the timescales are tight for developing and submitting this strategy, the deadline is the end of November 2017. He went on to explain that the STP will need to agree to relevant schemes and plans, which will be in line with the overall L&SC strategy, in order to allocate funds appropriately. He stated that there is a L&SC Capital and Estates Workshop taking place on 3rd November 2017, to progress development around this. Harry Catherall commented that he strongly supports this initiative, but added that the One Public Estate Programme needs to be considered in this process, as they will be able to offer valuable resource and support to strengthen the strategy. Gary Raphael acknowledged this. Sir Bill Taylor asked whether lease vehicles have been considered as part of this work. Gary Raphael responded to say that currently this area has not been considered, but this may be one of the issues raised at the workshop tomorrow. Mary Dowling asked Gary Raphael what he requires from members of the Committee to help produce this strategy within the required timescale. He responded to say that the workshop tomorrow will be a critical stage in its development and that he requires the Joint Committee to support the proposal to develop this. Phil Huxley asked whether IT will be included within the strategy. Gary Raphael confirmed it will be and that we need a clear picture on the assets we have got across the system, to enable us to determine what we need to improve going forward. Mark Youlton stated that he strongly supports this. He commented that it is also	**Support**

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	worth having a discussion with Lancashire County Council around buildings, we need a consistent approach in the use of buildings. ***ACTION: The Joint Committee agreed to support this proposal*.**	
The next JCCCG Meeting will be held on: 11th January 2018, 1.00pm – 3.00pm – venue to be confirmed		
The Chair thanked the Committee members and members of the public for their attendance and closed the meeting prior to taking questions from members of the public.		

Topics discussed through the Public Questions:

Core 24 – recruitment of staff
Public consultation/co-production – when this will happen
Transforming Care – longer term funding for such services. Clarity on this.
Engagement with business community crime services

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Healthier Lancashire and South Cumbria Joint Committee of the Clinical Commissioning Groups Meeting Action Matrix

Ref	Subject	Owner	Update	Status	Complete
1	Mental Health Presentation	DN/AB	To receive a detailed proposal for a revised operating model for the commissioning of mental health services. This aims to implement the national mental health and wellbeing strategy.		
2	LMS Plan	VW	Vanessa Wilson agreed to provide members of the Committee with a condensed version of the full LMS Plan, so that members are sighted on key activities and timescales.		
3	Transforming Care	DN	Debbie Nixon agreed to make the suggested amendments to the timeline within the Transforming Care paper and re-circulate the paper to Committee members.		
4	Mental health - prevention	DN/SK	It was agreed that it would be beneficial for the Committee to receive an update on the work around mental health prevention at an appropriate time in the future.		

Joint Committee of Clinical Commissioning Groups

Title of Paper	A New Commissioning Framework for Lancashire and South Cumbria		
Date of Meeting	11th January 2018	Agenda Item	4.1

Lead Author	Andrew Bennett	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	x
Executive Summary	This paper outlines the process that local commissioners have taken to develop a new Commissioning Framework for Lancashire and South Cumbria. The Framework describes a set of design principles, expected benefits, a model of commissioning for the future centred around a place based approach and the next steps required for mobilisation.	
Recommendations	• The JCCCG is asked to endorse the framework for the development of the commissioning system in Lancashire and South Cumbria. • The JCCG is asked to agree that more detailed mobilisation plans are developed. • The JCCCG is asked to support further discussions and development of this framework with all partners.	
Equality Impact & Risk Assessment Completed	An Equality, Impact and Risk Assessment will be worked through as part of the Mobilisation Plan.	
Patient and Public Engagement Completed	Patient and the public engagement will be worked through as part of the Mobilisation Plan.	
Financial Implications	Currently being considered by CCG Chief Finance Officers as part of enabler work.	
Risk Identified	Risks will be worked through as part of the mobilisation plan.	
If Yes: Risk	As above	
Report Authorised by:	Andrew Bennett, Senior Responsible Officer for Commissioning Development	

A New Commissioning Framework for Lancashire and South Cumbria

Introduction

This report summarises the work undertaken by local commissioners to develop a new commissioning framework for Lancashire and South Cumbria. It describes the process of development and the outputs achieved.

The decision to develop a new approach to commissioning in Lancashire and South Cumbria was taken based on the clear understanding that the NHS 5 Year Forward View (5YFV) is driving fundamental changes in the commissioning system. The 5YFV set a strategic direction for population health improvement, service integration and improved finance and quality outcomes which challenges our current configuration of organisations and systems. It requires that we take much more decisive action on prevention and population health; we invest in new, more integrated, more efficient and more locally applicable models of care; we work much more closely with social care, primary care and specialist services, and over time we see a greater emphasis on efficiency coming from wider system improvements.

To achieve the changes required, the current commissioning, provider and local government organisations in Lancashire and South Cumbria are working together as members of the STP to find new, locally relevant ways of organising our health and care system. The development of a new Commissioning Framework aims to enable local commissioning organisations to successfully align their priorities and capacity in order to achieve their ambitions for improved health and well-being, population outcomes, financial performance and system efficiencies.

This report provides an outline of the key elements of commissioning development work including:

- The approach taken to develop the Framework,
- The outputs from the design and development work,
- The recommendations being made to the JCCCG.

1. Scope of Work

1.0 The agreement to develop a new approach to commissioning in Lancashire and South Cumbria was made by senior leaders from across the Lancashire and South Cumbria system, including Clinical Commissioning Groups, NHS England, Specialised Commissioning (North) and the Lancashire and Midlands Commissioning Support Unit (CSU), at a workshop on 30th August 2017.

1.1 A broad scope of work was agreed as follows:

- Define a truly place-based approach to commissioning with a clear understanding of what services will be commissioned at which level/place, to achieve the best possible health and well-being outcomes for the population.

- Define the LDP and neighbourhood level commissioning functions which can deliver improvements through local, integrated care models and

neighbourhood working. (Describe a clear set of statements about the process for local commissioning functions being undertaken in different and more creative ways, with a pipeline for implementation and the safeguards that will be in place to ensure good governance and clear accountability).

- Define the ACS level commissioning functions which can deliver efficiency through scale and improvements via consistency and standardisation. (Describe the process to shift to collective commissioning functions with a pipeline for implementation, a process for early adoption where appropriate and a plan for future development over time).

- Define how we will work with patients, Local Authorities and partners (NHSE/I, Providers, Primary Care etc.) and how we will sustain clinical leadership in commissioning, to enable us to make the necessary changes in our system.

- Define the shifts that will support effective system assurance (e.g. in relation to quality, safety, workforce and financial controls) as the relationship between the STP and regulators also evolves.

2. Commissioning Development Group (CDG)

2.0 The development work has been managed through a Commissioning Development Group (CDG) task and finish group which has reported to the Collaborative Commissioning Board Pre Meet Group. Regular progress reports have been provided to the CCB Pre Meet Group throughout the undertaking of this work. Additional updates have also been provided to the Joint Committee of Clinical Commissioning Groups (JCCCG), the STP Board, CCGs and partner organisations.

The CDG has overseen the:

- Development of the Framework through a co-production approach which has involved colleagues from across the STP

- Development of a proposition (test case) for mental health to be a potential early adopter of the new approach.

- Initiation of enabler work to support the on-going development of the framework.

2.1 Membership of the CDG has included Chief Officers from Lancashire and South Cumbria CCGs, representatives from the CSU and the Assistant Regional Director of Specialised Commissioning (North) at NHS England.

3. The Approach Taken to Develop the Framework

3.0 The Commissioning Framework has been developed through a co-production process. At least 60 individuals have been involved in the development of the Framework, contributing subject matter expertise and organisational representation. A number of key partners have also informed the development of the Framework,

including colleagues from Greater Manchester, NHS England, Local Authorities, Provider Trusts and Commissioning Support.

3.1 The Framework was developed in 'blocks' based on four key elements of design:

- Vision and Principles
- Commissioning Model and Decisions
- Case Examples and Application (mental health test case)
- Recommendations and Next Steps

3.2 Content for each block of the Framework has been shared with identified stakeholders at key steps in the design journey and a process of 'continuous evolution' has been adopted to respond to comments and inputs.

3.3 A workshop offering leaders a chance to hear a detailed presentation of the Framework was held on November 22nd 2017 with small working groups comprised of commissioning stakeholders, convened to look at themed topics. A further iteration of the Framework was subsequently produced using the feedback provided from that workshop. This version of the framework was circulated to commissioning organisations and partners for wider comment during December 2017. Helpful comments were received back organisational representatives from across Lancashire and South Cumbria. Each comment was assigned to a category relevant to the on-going development of the Framework. The categories are described below:

1. Not material – noted but no change to the Commissioning Framework required (10 comments)
2. Material – amendments made to the Framework as a result of the comment (8 comments)
3. Relevant to mobilisation – comment assigned to an enabler group for onward progression (34 comments)

3.4 Changes to the Framework have now been made based on comments understood to be material to accuracy or content (category 2). Those comments relevant to the future mobilisation of the Framework are being considered by the CDG in the context of the on-going enabler work.

4. The Output from the Design and Development Work

4.0 The outcome of the design work has been the production of a Commissioning Framework that sets out a model of 'place based commissioning', i.e. commissioners organising themselves so that they collaborate together to address the challenges and improve the health of any defined population.

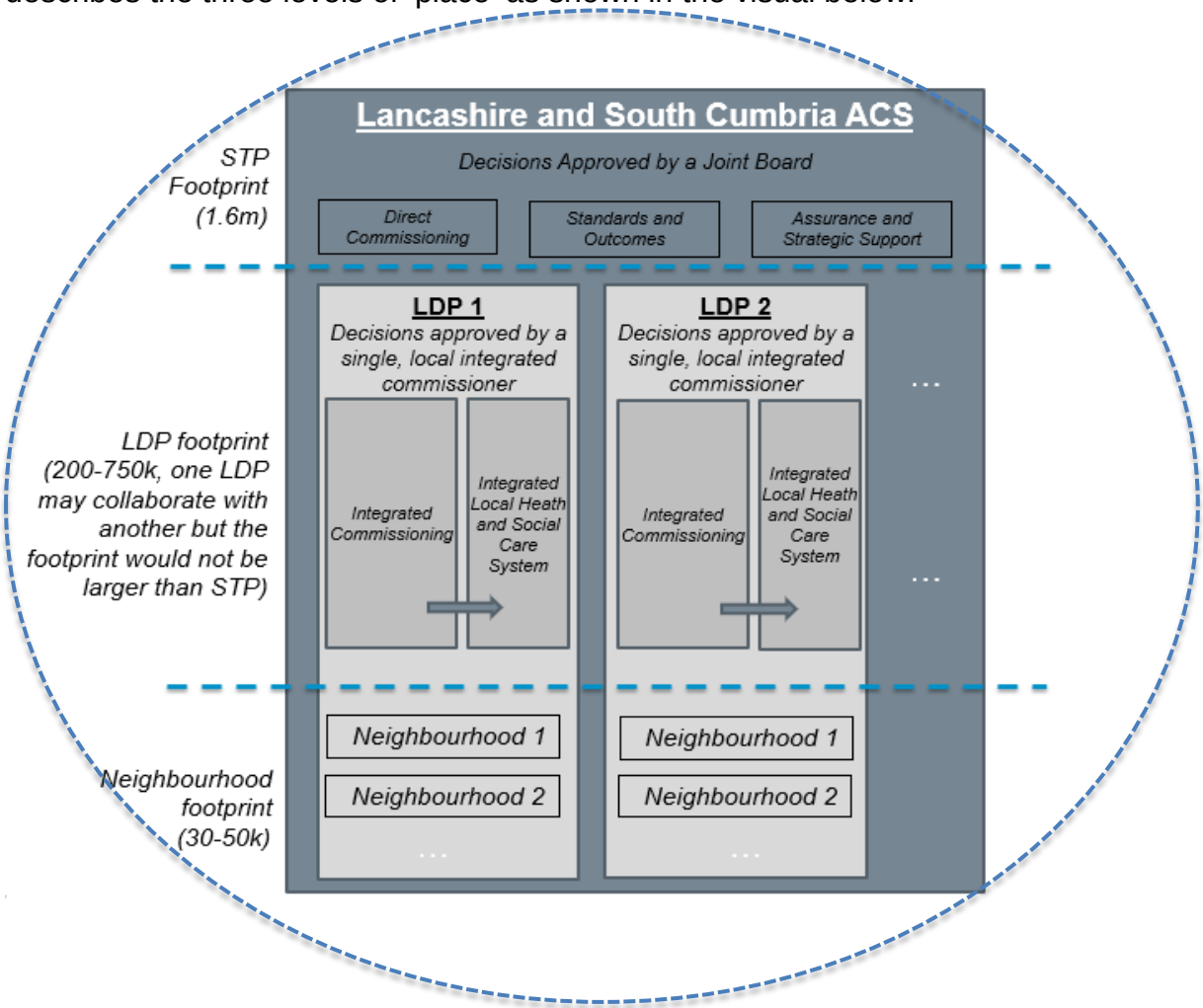
4.1 Three levels of 'place' are proposed in the framework:

- the Accountable Care System level (i.e. Lancashire and South Cumbria)
- the Local Delivery Plan/Accountable Care Partnership level (i.e. Fylde Coast, Pennine, West Lancashire, Central Lancashire and Morecambe Bay)
- the local Neighbourhood (sometimes called locality) level (e.g. Fleetwood, Kendal, Blackburn East)

4.2 In order to properly develop the 'place based' model, the commissioning of mental health services was selected as a 'test case' to consider the potential operation of the Framework in more detail. Mental Health stakeholders worked with the CDG to develop a mental health proposition using decision making criteria and a decision-making tool set alongside the design principles and the commissioning model outlined in the Framework. This report should therefore be read in conjunction with the report titled '*Mental Health Commissioning Development: Mobilisation and Next Steps'*, also submitted for this meeting.

4.3 The Commissioning Framework, in its current final version is embedded in Appendix 1 of this report. In summary it outlines a vision for our future system that is based on the development of a more coordinated and more integrated public sector, organised around 'place'.

4.4 The Framework includes a model for 'place based commissioning' which describes the three levels of 'place' as shown in the visual below:



4.5 The Framework also outlines potential mechanisms for overseeing the new system and for ensuring the right capability and leadership in its onward implementation.

5. Mobilising the Framework

5.0 It is of note that the Framework has been widely supported and no comments received back at any stage of development have disputed the vision, principles, model or recommendations outlined to date. Next steps will therefore concentrate on moving the Framework forward with on-going development and mobilisation. A Mobilisation plan will be required, if the JCCCG endorse the Framework and work is beginning on this. A number of enabler workstreams have been initiated to start the process which include:

- Human Resources/Organisational Development
- Finance
- Comms and Engagement
- Service priorities

6. Next Steps

6.0 Over the next weeks and months, the CDG aims to ensure that continued progress is being made in the development of the framework and the associated enablers. A high-level summary of work expected to be undertaken (subject to endorsement of the Framework) between now and April 2018 is provided below:

Enabler Workstream	Tasks Being Undertaken	Deadline
HR/OD	• Scope out the HR requirements to implement the Framework • Understand the work taking place at regional level on the development of an HR Framework and align the local approach	Jan 2018
Finance	• Develop a set of common financial principles that can underpin changes in commissioning arrangements	Apr 2018
Comms and Engagement	• Develop an approach for keeping staff updated about the commissioning development work • Oversee the production and dissemination of staff briefings	Feb 2018
Service priorities	• Identify the pipeline of other commissioning agendas that will co-produce plans to move to place based commissioning	Feb 2018

6.1 The Joint Committee can expect to receive more detailed briefings on mobilisation work as the workstreams develop and a Mobilisation Plan produced.

7. Recommendations

The JCCG is asked to:

- The JCCCG is asked to endorse the framework for the development of the commissioning system in Lancashire and South Cumbria.
- The JCCG is asked to agree that more detailed mobilisation plans are developed.
- The JCCCG is asked to support further discussions and development of this framework with all partners.

Andrew Bennett
Chief Officer NHS Morecambe Bay CCG and Lancashire and South Cumbria SRO Commissioning Development
3.1.18

Appendix 1

System Version
Final JCCCG 3.1.18.p

Appendix 2: Glossary of Terms

- **Accountable Care System (ACS)** – the whole system that we are seeking to create across Lancashire and South Cumbria (commissioners, providers and regulators)
- **Local Delivery Plan areas (LDP), becoming known as Accountable Care Partnerships (ACP)** – sub Lancashire and South Cumbria level systems i.e. Pennine, Fylde Coast, West Lancashire, Morecambe Bay, Central Lancashire (commissioners and providers)
- **Neighbourhood** – sub LDP area level systems e.g. Fleetwood, Millom etc, (which may or may not align to local authority districts, depending on local arrangements)
- **Place based commissioning** – commissioners organising themselves so that they collaborate together to address the challenges and improve the health of any defined population
- **Collective Commissioning** – commissioning collaboratively across the whole geography of Lancashire and South Cumbria
- **Sustainability and Transformation Partnership (STP)** – the partnership of NHS and other organisations working to deliver our 5 year **Sustainability and Transformation Plan** for Lancashire and South Cumbria that describes how we will improve quality, develop new models of care; improve health and wellbeing; and improve efficiency of services
- **Accountable Care Organisations** – a single provider or an alliance of providers that work under one budget and one contract to deliver services to a population*

Joint Committee of Clinical Commissioning Groups

Title of Paper	Mental Health Commissioning Development: Mobilisation and Next Steps		
Date of Meeting	11/01/2018	Agenda Item	4.2

Lead Author	Debbie Nixon, Senior Responsible Officer for Mental Health; and Andrew Bibby, Director of Specialised Commissioning.	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	This paper builds upon a Case for Change that was presented to JCCCG in September 2017. The paper presents the next steps in terms of the required mobilisation of the new commissioning model for Mental Health.	
Recommendations	• To endorse the levels of Mental Health commissioning, as per the Commissioning Development Framework • To agree the mobilisation plan, including the requirement for more focussed engagement with the Local Authorities and Providers • To note the timescales of the mobilisation plan and enabling workstreams as set out in the paper	
Equality Impact & Risk Assessment Completed	This will be worked through as part of the mobilisation plan.	
Patient and Public Engagement Completed	This is an ongoing as part of the Mental Health programme.	
Financial Implications	These will be worked through as part of the mobilisation plan.	
Risk Identified	Yes	
If Yes : Risk	Risks have been set out in the Case for Change and the paper seeks to address	

	and mitigate these risks as part of the recommendations and next steps.
Report Authorised by:	Andrew Bennett, Senior Responsible Officer for Commissioning Development

Mental Health Commissioning Development: Mobilisation and Next Steps

Contents

1.0 Executive Summary

This paper builds upon a Case for Change for a collective commissioning model for Mental Health services across the Lancashire and South Cumbria (L&SC) Accountable Care System (ACS), which was presented to the Joint Committee of Clinical Commissioning Groups (JCCCG) in September 2017. Subsequently Mental Health has been used to 'road test' the development of a Commissioning Development Framework, with the approach and methodology set out in the paper below. The paper presents the next steps in terms of the required mobilisation of the new commissioning model for Mental Health and the recommendations are as follows:

- To endorse the levels of Mental Health commissioning, as per the Commissioning Development Framework
- To agree the mobilisation plan, including the requirement for more focussed engagement with the Local Authorities and Providers
- To note the timescales of the mobilisation plan and enabling workstreams as set out below

2.0 Introduction

The Five Year Forward View (FYFV) sets out a direction of travel whereby Sustainable Transformational Partnerships (STPs) evolve into ACSs. These are systems in which the NHS and Upper Tier Local Authorities (LAs), both commissioners and providers, take clear and collective leadership and action to address whole population needs.

The development of an ACS requires a radical review of both commissioning and provider roles and is likely to increasingly blur the boundaries between the two. The development of an ACS requires collective commissioning at different levels, including Neighbourhoods, Accountable Care Partnerships (ACPs) and ACSs. A Senior Responsible Officer (SRO) has been appointed to lead a programme of Commissioning Development work on behalf of the L&SC ACS. This work has been reported to JCCCG and has used Mental Health to 'road test' the new approach and proposed Commissioning Framework.

3.0 Implementing the Five Year Forward View

Mental Health is one of the headline clinical priority areas set out in the FYFV, and a subsequent Mental Health Delivery Plan (MHDP) was published by NHS England in July 2017. This ambitious programme scales up over the next 4 years, investing £1 billion to deliver evidence based care to one million more people by 2020/21. The FYFV for Mental Health sets out 12 key deliverables. The benefits include:

- Improving patient and carer experience
- Reducing the number of Emergency Department attendances
- Reducing admissions and length of stay in Acute and Specialist Mental Health hospital Trusts
- Reducing self-harm and suicide
- Delivering care in the least restrictive setting
- Reducing ambulance dispatch and conveyance
- Achieving zero out of area placements and reduce unnecessary placements into complex and often expensive packages of care
- Reducing the number/waiting times in delayed transfers of care in Mental Health and Acute Hospital admissions
- Reducing the life expectancy gap with people experiencing Mental Health illness
- Improving levels of patients in recovery managed in primary care or Improved Access to Psychological Therapies (IAPT) services

The delivery requirements are significant and challenging, with a key focus upon clinical fidelity to national prescribed care models and increased access to a range of evidence based interventions. Significant investment is required in a number of service areas and settings, predominantly in workforce as outlined in "Stepping Forward to 2020/21: The Mental Health workforce plan for England" (2017), to achieve the national targets, timescales and standards. In addition, there is a requirement to increase Mental Health investment in line with nationally agreed levels, however this additional investment in Mental Health should have the effect of alleviating demand in the wider health system where patients are currently presenting in unplanned ways (e.g. Accident and Emergency (A&E) attendances; in settings where Mental Health co-morbidities either prolong length of stay or generate higher levels of acuity as a result of sub-optimal management of physical health conditions).

The MHDP refreshes and amends current system accountability and delivery mechanisms regionally and nationally, driving implementation to best deliver the FYFV MH, and deliver performance management through a single lens. The MHDP allocates responsibility for local delivery principally to the ACS, working in an increasingly integrated fashion with NHS England, NHS Improvement and the Strategic Clinical Networks. Achievement of the plan will be tracked via an ACS Mental Health dashboard and will be performance managed by the newly emerging ACS Board.

There has already been significant progress made in some areas, particularly in securing national funding to develop Early Intervention in Psychosis (EIP) and IAPT services for people with long term conditions, Core 24 Acute Mental Health Liaison, and a Mother and Baby Unit. However, if we are not to fall behind in this complex task, it is imperative to move quickly to a more collective commissioning and delivery arrangement.

4.0 The Case for Change for Mental Health Commissioning within the Lancashire & South Cumbria ACS

At present within the ACS footprint there are eight Clinical Commissioning Groups (CCGs), Four Upper Tier Local Authorities (LAs) and NHS England (Specialised Commissioning) with responsibility for commissioning aspects of Mental Health services for their respective populations. Traditionally a lead CCG and contracting approach has been undertaken across Lancashire for some aspects of Mental Health care (provided by Lancashire Care NHS Foundation Trust) by Blackburn with Darwen CCG. This has included responsibility for all aspects of contracting, quality and performance management. It has also included lead commissioning responsibility for inpatient Mental Health services and the specialist Community Mental Health Teams as these are explicitly linked to the Mental Health Acute Reconfiguration, which is due to complete in 2018/19. The local CCGs have been responsible for commissioning services such as IAPT and Memory Assessment Services (MAS) amongst others.

This has enabled some level of coordination within the system regarding inpatient and some specialist Mental Health services, however patient pathways remain fragmented and there is no single set of commissioning intentions or a Lancashire wide strategic context. Since April 2017 the boundary change for Morecambe Bay has meant that Cumbria Mental Health services are now monitored as part of the L&SC ACS and we are working closely with both commissioners and the provider to ensure that we have integrated provision. It relies, however on influence and relationships, which means decision making is complex with significant variation and duplication in the system. Such an informal approach is not adequate for the task of delivering accountability and responsibility for a programme as complex as that envisaged by the FYFV.

There are no formal integrated commissioning arrangements with Local Authorities (LA) on the ACS footprint although there has been much effort to work together to align priorities. These include work through the Children and Young People's (CYP) Programme Board, Mental Health Steering Group, the Crisis Care Concordat Group and the Suicide Prevention Oversight Group. The interface between health and local authority commissioning is complex and there are significant challenges within the system. In addition, Adult and Children's Mental Health services, and Learning Disability services have been planned and commissioned separately from each other which has led to overlap, duplication and pathway fragmentation at the important point of transition between services.

Since the introduction by NHS England of consistent national service specifications for Specialised Services in 2013, pathways for locally commissioned service do not always align with downstream Specialised Services. This has often led to patients falling between the gaps in services, that have not changed to reflect greater clarity in commissioning responsibility since the 2012 Act. An example of this relates to the Child and Adolescent Mental Health Services (CAMHS) pathway.

In addition, the following sub-sections outline a compelling local context for change.

4.1 Prevalence and Demand

L&SC has above the national England average for socio-economic deprivation, including four areas in the 2015 English Indices of Deprivation's top 20 most deprived local authority districts in England (Burnley, Blackburn, Blackpool and Pendle). The link between deprivation and Mental Health is well established, leading to L&SC having above national average prevalence for a range of Mental Health conditions, including severe mental illness (SMI), Mental Health and Conduct Disorders in CYP, dementia, self-harm, suicide and common Mental Health problems such as anxiety and depression. Some of these rank within the top quartile of prevalence nationally, including SMI and depression (further information around Mental Health prevalence in L&SC can be found in Appendix 1). A recent publication commissioned by the national Mental Health programme team titled "Making the Case for Integrating Mental and Physical Healthcare" (Midlands and

Lancashire Commissioning Support Unit Strategy Unit, 2017) has developed an ACS data pack, which has highlighted the following areas of need (the full report is attached in full as Appendix 2):

- There is a current life expectancy gap for people with a diagnosed mental health condition of around 18 years for men and 15 years for women
- The difference is more marked in older Mental Health service users – those aged 65 are likely to only have half the remaining life expectancy of the population not in contact with Mental Health services
- Mental Health service users are around 2-4 times more likely to die of cancer, circulatory or respiratory disease
- Mental Health service users attend A&E more than twice as often as the rest of the population
- Compared to England the ACS overall has higher activity for the following activity subgroups: patients conveyed by ambulance to A&E but discharged following no investigation and no treatment; patients who leave A&E before being seen; ambulatory care sensitive admissions; medicines related admissions; smoking related admissions; obesity related admissions; patients admitted for self-harm; and admissions of those attending A&E with a primary diagnosis of Mental Health

4.2 Workforce Challenges

Following publication of the national workforce strategy document "Stepping Forward to 2020/21: The Mental Health workforce plan for England" (2017), analysis has been undertaken by Health Education England (HEE) with modelling suggesting that to deliver the FYFV for Mental Health L&SC must create an additional 602 posts in the initial seven growth areas. This is likely to be an under-estimate in additional workforce requirements however as it does not account for current vacancies, natural attrition within the workforce (such as retirements, early leavers or career changes), the move towards 7-day services, historical demographic movements, population forecasting, or supply and demand forecasting (i.e. reduced supply of Registered Mental Health Nurses and Psychiatrists). HEE are working with commissioners and providers to validate the current workforce position and map the true workforce gap required to meet Stepping Forward.

Meeting the future workforce requirements will be especially challenging in L&SC given a number of exacerbating factors; such as: its proximity to several major conurbations; significant areas of rurality; and a reduction in overseas workforce supply as a result of European Union staff exiting the workforce and the introduction of new language tests by the General Medical and the Nursing and Midwifery Councils. Mental Health therefore is working in close partnership with the Lancashire Workforce Action Board (LWAB) to develop an action plan that addresses these various and complex challenges in order deliver the national workforce strategy outlined in Stepping Forward.

4.3 Provider Development

In L&SC we have two specialist Mental Health providers (Lancashire Care NHS Foundation Trust (LCFT) and Cumbria Partnerships Foundation Trust). There are also two Acute Trusts who provide Child and Adolescent Mental Health services, as well as some elements of Adult Mental Health services (Blackpool Teaching Hospitals NHS Foundation Trust and East Lancashire Hospitals NHS Trust).

This provision is based on historical demand and organisational configurations. Our Mental Health services experience significant demand. For example, based on most recent NHS Benchmarking data, LCFT receives the highest level of referrals for Community Mental Health Teams in England at 2.7 times the national average and 31% above the national average for Crisis and Home Treatment contacts per 100,000 registered population.

There are clear examples where patients could be managed in a more appropriate and less restrictive part of the system. For example:

- Locked Rehabilitation – in a national report the Care Quality Committee has recently questioned the appropriateness and number of patients who are detained in locked rehabilitation placements for extended periods of time. In L&SC we currently spend approximately £16m on complex rehabilitation packages both in and outside of the L&SC area
- Tier 4 CAMHS – L&SC have amongst the highest utilisation rates for Tier 4 CAMHS admissions and significant inappropriate referral rates for these services. In addition, within L&SC there is significant variation in need for Tier 4 CAMHS services indicative of variation in quality of community based services for CYP

5.0 Commissioning Development in the ACSs

The decision to develop a new approach to commissioning in L&SC was driven by the clear understanding that the 5YFV is driving changes in the commissioning system. The development of a new approach aimed at enabling local commissioning organisations to successfully align their priorities and capacity to achieve their ambitions for improved health and well-being, population outcomes, financial performance and system efficiencies; both at the local system level and at the L&SC level.

On the 30th August 2017, Accountable Officers and key partners agreed to develop a new Commissioning Framework for L&SC and to test the framework using the Mental Health commissioning agenda. The scope of the framework was agreed as follows:

- To define a truly place-based approach to commissioning with a clear understanding of what services will be commissioned at which level/place, to achieve the best possible health and well-being outcomes for the population
- To define the ACP and neighbourhood level commissioning functions which can deliver improvements through local, integrated care models and neighbourhood working (describe a clear set of statements about the process for local commissioning functions being undertaken in different and more creative ways, with a pipeline for implementation and the safeguards that will be in place to ensure good governance and clear accountability)
- To define the ACS level commissioning functions which can deliver efficiency through scale and improvements via consistency and standardisation (describe the process to shift to collective commissioning functions with a pipeline for implementation, a process for early adoption where appropriate and a plan for future development over time)
- Define how we will work with patients, Local Authorities and partners (NHS England, NHS Improvement, Providers, Primary Care etc.) and how we will sustain clinical leadership in commissioning, to enable us to make the necessary changes in our system
- Define the shifts that will support effective system assurance (e.g. in relation to quality, safety, workforce and financial controls) as the relationship between the ACS and our regulators also evolves

In response to this a Commissioning Framework (based on work undertaken in Greater Manchester) was developed and it was agreed that this would be tested using the Mental Health commissioning work-stream. The Commissioning Framework looked at three levels of commissioning: ACS, ACP and neighbourhoods.

5.1 How this was applied to Mental Health

A series of workshops were held with Mental Health commissioners and clinicians to determine the application of the framework. It was decided that this work would be undertaken in the context of a locally developed stepped care model which had previously been devised as part of the early Healthier Lancashire Change Programme. This stratified the expected prevalence of Mental Health conditions across the three commissioning levels (this is attached as Appendix 3 – The Lancashire 'Cone').

Consensus was achieved around the majority of areas, however there were a number of areas where it was agreed that further work was required to determine the most appropriate 'place' to commission these services (please see Appendix 4 for more information). These areas included Community Mental Health Teams, Increasing Access to Psychological Therapies (IAPT) and Eating Disorders. As Mental Health was the test case it was felt that these services needed to be tested against a more robust set of criteria. A set of criteria was then developed under the broad categories of: population, integration, finance, clinical outcomes, and system resilience. Following this initial work, engagement with the Acute and Specialised work-stream identified that an equivalent set of criteria, along with a decision-making tool, had already been developed and tested. Work was then undertaken to adapt the tool used in the Acute and Specialised work-stream to align the series of questions used within the tool to the set of criteria developed by Mental Health commissioners.

Two Mental Health Commissioning Development workshops were then held on the 14th and 19th of December 2017 to test the tool using six services that had been previously identified as requiring further analysis: Community Eating Disorders; IAPT; Community Mental Health Teams; Core 24/Mental Health Liaison Teams; Memory Assessment Services (MAS); and the broader Crisis pathway (the completed tools from these sessions have been attached as Appendix 5). Strong consensus and confidence was achieved around the methodology developed.

6.0 Proposed future commissioning approach and expected key benefits

The consensus building work on commissioning levels undertaken as described above has resulted in the following recommendation for future planning geographies for individual aspects of Mental Health service delivery as follows (please note this is an indicative table that reflects the current position. Further work is pending on the services marked with an asterisk. This will be undertaken as we work through the mobilisation plan, as set out in Section 8, alongside further work to include CYP):

- **Scale greater than L&SC** - services will continue to be commissioned by NHS England, however with greater involvement of North West ACSs
- **ACS** - services will be commissioned collectively at a L&SC level, however may be delivered in multiple settings. These services will be commissioned via the JCCCG, with some NHS England Specialised Services included in this level of commissioning
- **ACP and ACS** - services will be commissioned locally but to service specifications, standards and outcomes that have been commonly developed
- **ACP and Neighbourhoods** - services will be embedded in local ACP arrangements and determined for local population and patient need

Table 1:

Locally Determined to Meet Local Patients'/Population Needs		**Collective Commissioning** *(ACS –setting standards and outcomes ACP –implementation and review)*	**Collective Commissioning** *(direct commissioning of the whole commissioning cycle)*	**Specialised Commissioning/NHS England** *(includes population planning, securing services, implementation and review)*
Neighbourhoods	ACP	ACP and ACS	ACS	Scale greater than L&SC
• Health and Wellbeing Services • Inclusion Services	• Primary Care Mental Health Workers • Screening Programmes (e.g. SMI Checks)	• Adult and Older Adult Crisis Pathway (e.g. Richmond Fellowship, Mind, Vulnerable Adult Liaison etc)* • Community Mental Health Teams • Core 24/Mental Health Liaison Teams • Increasing Access to Psychological Therapies • Memory Assessment Services	• Attention Deficit Hyperactivity Disorder Services • Community Eating Disorders • Crisis Resolution/Acute Home Treatment (Adult and Older Adult)* • Early Intervention Psychosis • Inpatient beds • Intensive Community Services • Out of Area Placements • Perinatal (Inpatient and Community • Personality Disorders • Rehabilitation Services/Complex Packages* • Services interdependent with Learning Disability/Autism Services	• Criminal Justice • Gender Identity Surgical Services • Low, Medium and High Secure Adult Mental Health Services • Prisons • Specialised Eating Disorders (inpatient and community) • Specialised Mental Health Services for the Deaf

6.1 Proposed Future State for Mental Health Commissioning

It is proposed that there will be a collective commissioning function for Mental Health working on behalf of the ACS and the ACPs which is capable of integrating the different levels of commissioning for mental and physical health. This will operate at the levels set out above. Further work will be undertaken as part of the mobilisation plan to determine the required capacity and workforce. This work will need to be aligned to the broader Commissioning Development programme which is being mobilised across the ACS.

6.2 Expected Benefits

- Having a shared vision of what good looks like for Mental Health services for our population and the ability to describe this both for our residents and our provider community
- Deliver the ambitions of the 5YFV (as articulated in Section 3) and maximise the health outcomes of our population
- Reduce unwarranted variation and inequalities, achieving consistency and fidelity of local Mental Health services
- Delivering the required transformation while managing the financial risks at an ACS level rather than at a single organisational level
- Agree a consistent approach to performance management and delivery
- Mitigate risks in relation to workforce, resilience and sustainability, and consider innovative delivery models for the future
- Delivering the commissioning agenda in the context of a significant reduction in CCG running costs
- Minimising transactional costs between system partners to maximise investment in frontline services

7.0 The Critical Path to Mobilisation

Local commissioners have agreed to develop a new Commissioning Framework and Mental Health is the test case for this process, as set out in this paper. This section of the paper describes the critical path to mobilisation.

7.1 Determining the appropriate Planning Geography

Significant work has already been undertaken to determine what the appropriate planning population and therefore the level of commissioning in L&SC for each Mental Health service will be. This has included a number of consensus building workshops and the adaptation of an objective tool (used by the Acute and Specialised work-stream) to determine the appropriate level. The next step is for JCCCG to endorse the outcomes of this work which will then form the foundation of our service strategy. Further work will then be required to consider the number and distribution of settings of delivery once the appropriate planning populations have been determined.

7.2 Service Strategy and Design

Utilising the foundations of the planning geography work above, and subject to agreement of JCCCG, the adoption of the national ‘core offer’ as described in the 5YFV, a workstream will develop these into an integrated service strategy which sets out to deliver the aims and benefits described earlier in this document (e.g. reduce the life expectancy gap; ensure that patients are treated in the least restrictive setting to meet their need; and that we maximise health utility by investing appropriately in service pathways), with detailed service specifications to include access and egress criteria, outcomes, performance metrics. This will be tested and refined at a clinical summit in the summer of 2018, which will inform the development of Commissioning Intentions for 2019/20 onwards.

7.3 Finance

The FYFV sets out a clear programme of investment for CCGs, which is contained in CCG baselines. A summary of the new FYFV investment is attached at Appendix 6. This is deemed to be the national core offer for Mental Health. This new investment will however need to align with current Mental Health investment in L&SC and take account of our overall ACS position in relation to delivering the required Mental Health outcomes and priorities. ACPs for example may wish to invest in other areas of the Mental Health programme but this will need to be prioritised after the national core offer has been met. A set of financial principles are being developed by Chief Finance Officers as part of the Commissioning Development programme and will be applied to Mental Health as part of the mobilisation plan. The ACS will need to agree its approach to funding transformation and ensuring that Mental Health delivers the required benefits both within Mental Health and across the interdependent programmes, including Urgent Care, Primary Care, Acute and Specialised.

Stepping Forward – the national workforce strategy makes a clear commitment to funding additional front-line staff and early analysis in L&SC suggests approximately an additional 602 staff are required. This will need to be factored in to more detailed financial plans, which will include a consistent staffing model across the ACS and the need for all Trusts to meet the Carter reforms.

A more detailed national financial strategy for Mental Health will be published shortly emphasising the need for Mental Health investment to be prioritised against the national deliverables. In addition, it is focussing on a Mental Health currency which will include the current Care Clusters and look to develop mechanisms like the 'year of care' and national based tariffs for services such as Early Intervention Psychosis and IAPT.

Under the current legislative framework, the only vehicle for incentivising investment patterns shifting upstream away from tertiary services is via a formal pooling arrangement between NHS England and CCGs (such as S13v or S75). This is consistent with the policy direction of travel regarding place-based commissioning, establishing 'New Models of Care' approaches, and will increasingly be expected as a way of working.

It is proposed therefore that the ACS moves towards a collective commissioning function which has oversight of a pooled budget. Phase One will include pooling between Specialised Commissioning and the CCGs for services in the third column of Table 1 in section 5.1 on page 8 (ACS level services). Further engagement with Local Authorities may see the scope of collectively commissioned services expanded as part of a Phase Two.

7.4 Contracting/Commercial

Work is required to develop a commonly understood baseline of what is currently commissioned for the population of L&SC. Once we have a clearer idea of the emerging detail, work can then be undertaken to translate this into an appropriate contractual form which ensures that we are incentivising the right clinical and inter-provider behaviours that support rather than hinder the achievement of patient outcomes.

7.5 Provider Development – New Models of Care

This work-stream aims to ensure that providers of Mental Health services are fit for the future, both in terms what they deliver but also how they behave in a new NHS system architecture. A central tenet of the future will be around co-design and co-production and organisational development will be required to move providers into this space. As part of the paradigm shift towards Accountable Care, some commissioning functions for Mental Health may in future become operational business of providers or provider alliances as part of the move to this system architecture. As the service strategy develops, we may also identify areas of provision for which there is no incumbent provider and may need to stimulate the local provider landscape.

7.6 Commissioning Workforce

Work will be required, dovetailing with wider work in the ACS to determine the workforce requirements to support the effective commissioning of Mental Health services across L&SC. As part of this, we will establish a transitional arrangement for April 2018 for pan-ACS coordination of Mental Health commissioning. We anticipate that formal arrangements will be in place for December 2018.

7.7 Governance

In order to effectively achieve the aim supported by JCCCG of delivering a coherent and cohesive Mental Health programme for L&SC, delegation of decision making to the Joint Committee is required to ensure timely and consistent decision making. Furthermore, to enable pathway-wide commissioning arrangements including services under the purview of NHS England's Specialised Commissioning function, the only legal mechanisms to enable resources to be shifted from tertiary to upstream services to achieve better health utility is via pooled budget arrangements such as S75 or S13v. Work is required to develop robust and legal arrangements to facilitate this.

7.8 Patient and Public Voice

The Mental Health steering group has representatives from Mind, Help the Aged, Samaritans, and individual carers. There is an opportunity to embed patient, carer, public and Third Sector views into the new collective commissioning arrangements.

As part of the wider ACS engagement approach, this will help shape future Mental Health services, building upon the strong foundations of engagement to date, which have included three Mental Health public consultations, nationally recognised engagement work which included working collaboratively with the national clinical advisory team. This will need to build upon the existing work being undertaken and prioritised at an ACS level.

Table 2: Mobilisation Plan

Area of Work	Foundations for Transformation	Step 1 April 2018	Step 2 September 2018	Step 3 January 2019
Agreement of appropriate planning geography for each service	Agreement by JCCCG on the appropriate planning population and levels of commissioning for each service within the portfolio.	Consideration on 'settings of delivery' approach(es) for services identified as ACS level services.	Final Agreement by JCCCG on geographical distribution of services.	
Commissioning Strategy and Service Design	JCCCG Endorsement of the 'core offer' approach set out in the 5YFV as the foundation for future service design in L&SC.	High level needs assessment which defines health outcomes, priority interventions and best value. Clinical Summit including Public Health input and support.	Finalise Commissioning Intentions for 2019/20 onwards.	JCCCG sign-off of: 1) Core Offer for Mental Health 2) L&SC Service Specifications
Finance	1) As part of the Commissioning Development programme agree a set of financial principles which can be applied to Mental Health as part of mobilisation 2) Commitment by L&SC CCGs to create a pooled budget for the services identified to be commissioned at ACS level 3) Seek support from Specialised Commissioning Regional Leadership Group to support pooling of Specialised budgets in ACS	Establish a Finance Task & Finish Group who will: 1) Develop a Mental Health finance and investment strategy, based upon the agreed principles, to support and underpin the core offer for the ACS 2) Make recommendations around size, construction, and methodology for pooling arrangement, including what is in scope (e.g. Specialised, Acute and Complex Cases)	JCCCG to sign-off Mental Health Finance and Investment Strategy and arrangements for required pooled budgets.	Mobilisation of Pooled Budget arrangements for 2019/20 (CCGs and Specialised Commissioning as a minimum).
Contracting/Commercial	Undertake a baseline review of current commissioned services and contractual arrangements.	Consider options for future contractual/accountability arrangements for the spectrum of Mental Health services.	Serve Notice on current arrangements as signal of move to new service models.	Award new contracts/agreements describing new arrangements.
Provider Development	Ensure that we have a robust and integrated Provider market as part of the emerging ACS footprint.	1) Meet with providers to socialise our strategic vision and outline a move away from existing arrangements and system behaviours	1) Work with provider community to ensure that they are ready and able to respond to new service model; service specifications and new	

Area of Work	Foundations for Transformation	Step 1 April 2018	Step 2 September 2018	Step 3 January 2019
			ways of working 2) Consider any gaps in provision and, if necessary, stimulate market	
Commissioning Workforce	Use the emerging leadership model to help shape Mental Health commissioning workforce requirements.	Identify capacity and requirements for a future Mental Health commissioning workforce across L&SC (all three levels).	Consultation with staff and mobilisation.	
Governance	1) L&SC CCGs agree to delegate MH commissioning as described to the Joint Committee 2) JCCCG Endorsement of the establishment of a Mental Health Clinical/Provider Reference Development Group to co-design future service model, and JCCCG to develop detailed commissioning proposals	1) Shadow arrangements in place for system-wide decision making and monitoring of services 2) Undertake the necessary statutory processes, including consultation, to set up S13V or S75 arrangements enabling pooling of budgets between different organisations	1) Establish S13V or S75 arrangements ready for pooled budgets 2) Review JCCCG governance arrangements to ensure that decisions on S13V/S75 can be taken in this forum	Formal Joint decision making starts around new model of delivery.
Stakeholder and PPV	Develop a patient engagement strategy.	Engagement in Q2 2018/19.		

8.0 Recommendations

The recommendations of the paper as follows:

- To endorse the levels of Mental Health commissioning, as per the Commissioning Development Framework
- To agree the mobilisation plan, including the requirement for more focussed engagement with the Local Authorities and Providers
- To note the timescales of the mobilisation plan and enabling workstreams as set out below

Appendices

Appendix 1: L&SC Prevalence


L&SC MH JSNA Prevalence.png


CYP MHW Indentification of N

Appendix 2: Making the Case for Integrating Mental and Physical Healthcare


MHPH_Lancashire& SouthCumbriaSTP_F

Appendix 3: The Lancashire 'Cone'


MH Model Of Care_Draft_V5 0.pdf

Appendix 4: Commissioning Framework slides


Draft Commissioning Fran

Appendix 5: Population Tool Outputs from the 14th December 2017 Workshop


All-age Community Eating Disorders Co


IAPT Completed Tool 141217.xlsx


CMHT Completed Tool 141217.xlsx


Core 24 Completed Tool 141217.xlsx


All-age Crisis Pathway Completed


MAS Completed Tool 191217.xlsx

Appendix 6: FYFV Finance Baselines Summary


5YFV lancashire shares.xlsx

Joint Committee of Clinical Commissioning Group's

Title of Paper	Specialist Neuro-Rehabilitation – Implementing a New Model of Care		
Date of Meeting	11 January 2018	Agenda Item	5.

Lead Author	Carl Ashworth, Service Director, Midlands and Lancashire Commissioning Support Unit Janet Spallen Neurorehabilitation Manager, NHS England North West
Purpose of the Report	For Noting
Executive Summary	The work previously undertaken by the Strategic Clinical Network and supported by the Collaborative Commissioning Board (CCB) in July 2016 had already developed the vision for the new model of care for specialist rehabilitation. The model of care being developed by the Specialist Rehabilitation workstream seeks to support a person's rehabilitation needs being met within a community setting where appropriate, and ensure that inpatient beds are utilised only where there is no suitable alternative. The paper describes the key features which will enable this model of care to be achieved. It also provides an update to the JCCCG on progress in developing and implementing the model of care, identifying specific areas of work that will support pathway improvement; and challenges to be considered in order to continue to move forward effectively. It is recognised that the need to ensure that existing resources within the specialist rehabilitation pathway are used efficiently to support the new model of care. The next stages of the workstream will be to build up individual business cases to demonstrate how financial resources could be realigned to improve patient experience and outcomes. The primary focus at this stage is in highlighting the real opportunity this high cost specialty presents at STP level for redirecting financial flows to ensure greater efficiency and providing care at the right time in the right setting, and seeking support to proceed in this direction.
Recommendations	The JCCCG is asked to: • Note the content of this paper regarding progress in developing and progressing implementation of the model of care for specialist rehabilitation. • Support the CCB actions for providing commissioning leadership and financial principles for achieving the model of care through financial realignment of existing resources. • Support the CCB assertion that the JCCCGs should take joint decisions on support for future business cases for implementation of the model of care and the associated realignment of resource.

Equality Impact & Risk Assessment Completed	Not Applicable
Patient and Public Engagement Completed	Not Applicable
Financial Implications	To be confirmed
Risk Identified	No

JOINT COMMITTEE OF CCGS

SPECIALIST NEURO-REHABILITATION – IMPLEMENTING A NEW MODEL OF CARE

1. AIMS OF THIS PAPER

- To provide an update to the JCCCGs on progress in developing and implementing the model of care for specialist neuro-rehabilitation.
- To identify opportunities to redesign and transform service delivery through realignment of financial resources to ensure greater efficiency and patient and family experience.
- To highlight challenges to progressing the revised model of care.

2. CONTEXT OF WORK

Recommendations to improve neuro-rehabilitation services for adults with acute onset neurological injuries/disease were presented to the Lancashire & South Cumbria (L&SC) Collaborative Commissioning Board (CCB) in July 2016. This identified proposals for a new model for commissioning and providing neuro-rehabilitation services, improving patient outcomes and making better use of available resources across the wider footprint. The CCB recommended this work should be taken forward within the Healthier Lancashire and South Cumbria Programme, and the Specialist Rehabilitation workstream was established at the end of January 2017 under the auspices of the Acute and Specialised Services work.

In December 2017, Janet Spallen (NHS England Specialised Commissioning) and Dr David Shakespeare (Consultant in Rehabilitation at Lancashire Teaching Hospital Foundation Trust) presented an update on the outputs of the workstream to CCB, along with requests for ongoing commissioning leadership for the work. This paper summarises the update and the CCB agreement on future actions.

3. SPECIALIST REHABILITATION MODEL OF CARE

The model of care being developed by the STP Specialist Rehabilitation workstream seeks to support a person's rehabilitation needs being met within a community setting where appropriate, and to ensure that inpatient beds are utilised only where there is no suitable alternative. The following are key features enabling the model of care to be achieved:

- Agreement of inpatient bed model
- Comprehensive community specialist rehabilitation teams
- Management of the most complex pathways
- Workforce
- Realignment of financial resources

Progress has been made most significantly in the following areas:

- **Stakeholder engagement -** excellent engagement from providers across Lancashire and South Cumbria with real commitment to improving the specialist rehabilitation model of care.
- **Inpatient model of care -** review of present bed occupancy at Preston by patient complexity to provide an indication of approximate split between level 1 and 2 rehabilitation needs
- **Community specialist rehabilitation teams -** review of service specifications and inclusion criteria with a need for standardisation to ensure equity of access for those requiring specialist rehabilitation.

- **Management of complex pathways** – a respiratory pilot was supported in July by CCB to improve care of patients with tracheostomies in the community with opportunity for significant savings though reduced care arrangements required. Further work has been undertaken to review the present pathway for those with cognitive-behavioural needs.
- Where community teams have developed a **case manager** role, these have proved pivotal in supporting patient flow across care settings and co-ordinating patients with the most complex care arrangements.

4. CHALLENGES

- The inpatient model is an important area to review and agree the optimal bed base with clarity in commissioning responsibilities.
- Specialist rehabilitation spans many areas of commissioning - acute and community services, mental health, CHC care arrangements and significant individual patient activity.
- Taking forward the concept of realignment of resources is a major priority. A more informed position of how the initiatives will produce efficiency gains is being developed, but will require pump-priming in the first instance. The first example of this has been the respiratory pilot where savings were demonstrated through a small number of trial patients. Other initiatives (such as enhancing the function of community teams and developing case managers) need to be supported on an invest to save basis.

5. ALIGNMENT OF FUNDING

The need to ensure that the existing resources within the specialist rehabilitation pathway are used efficiently to support the new model of care is recognised. The next stage of the work will be to build up individual business cases to demonstrate how financial resources could be realigned to improve patient experience and outcomes.

The specialist rehabilitation model of care crosses many organisational boundaries, care settings and involves multiple stakeholders. The primary focus at this stage is in highlighting the real opportunity this high cost specialty presents at STP level for redirecting financial flows to ensure greater efficiency and providing care at the right time in the right setting.

6. OUTCOMES FROM COLLABORATIVE COMMISSIONING BOARD 12TH DECEMBER 2017

The detailed update paper was presented to CCB on the 12th December 2017. The following actions were agreed:

- Mark Youlton (ELCCG) and Claire Heneghan (WLCCG) were nominated as commissioning leads for the further development of the models of care and associated implementation plans
- Gary Raphael would confirm with the Finance and Investment Group that alignment of finances would be managed in line with agreed L&SC financial framework
- That the JCCCGs should be requested to make a joint decision on support for future business cases for implementation of the model of care and the associated realignment of resource.

7. RECOMMENDATIONS

The Joint Committee of CCGs is asked to:

- Note the content of this paper regarding progress in developing and progressing implementation of the model of care for specialist rehabilitation.
- Support the CCB actions for providing commissioning leadership and financial principles for achieving the model of care through financial realignment of existing resources.
- Support the CCB assertion that the JCCCGs should take joint decisions on support for future business cases for implementation of the model of care and the associated realignment of resource.

Joint Committee of Clinical Commissioning Group's

Title of Paper	Briefing on the review of clinical commissioning policies		
Date of Meeting	11.01.2017	Agenda Item	6.

Lead Author	Rebecca Higgs IFR Policy Development Manager	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	Following support through CCB, the Commissioning Policy Development & Implementation Working Group (CPDIG) has been established to consolidate system efforts to write, review, update and support the implementation of a suite of clinical commissioning policies on behalf of CCGs. As part of the CPDIG's work plan a review of the clinical policies on complementary and alternative therapies and rehabilitation after damage to the facial nerve has been completed. The JC CCG is asked to ratify the policies.	
Recommendations	1. The revised and updated Policy for Complementary and Alternative Therapies is ratified. 2. A new Policy for rehabilitation after damage to the facial nerve is ratified.	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	No	
Financial Implications	Yes	
Risk Identified	No	
If Yes : Risk		
Report Authorised by:		

Briefing for the Joint Committee of CCGs (JC CCG) on the review of clinical commissioning policies.

Introduction

1. This report is to appraise the JC CCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) of the review the existing Lancashire and South Cumbria commissioning policies on *complementary and alternative therapies* and to prepare a new, collaborative, commissioning policy for *rehabilitation after damage to the facial nerve*.

CPDIG review process

2. The review of the *Policy for Complementary and Alternative Therapies* was conducted to ensure the policy continues to reflect the current evidence base.

3. The new *Policy for Rehabilitation after Damage to the Facial Nerve* was created to manage the demand for facial nerve rehabilitation across the Lancashire and South Cumbria. The demand was identified due to the increasing number of requests for facial nerve rehabilitation received via the Individual Funding Request (IFR) route, as this service is not included in the existing pathway for the management of facial nerve palsy. As a result, patients with rehabilitative potential were not being managed in accordance with the available evidence base and the development of a policy was required to ensure appropriate management. This would support the reduction of inappropriate consultations and associated costs in primary care.

4. The development and review of the policies has been completed in accordance with the process approved by the CPDIG. A copy of the process is shown in **Appendix 1.** The JC CCG should be aware that this process, including the evidence review and setting of the initial criteria, commenced under the predecessor group; the Lancashire Commissioning Policies Group (CPG).

5. The following steps were undertaken during the review of the policies; an evidence review by an allocated policy lead, public engagement, notification of local Health, Overview and Scrutiny Committees of the review and engagement process. Stakeholders, including primary and secondary care clinicians, were given an opportunity to comment on the policies, Healthier Lancashire and South Cumbria's Care Professionals Board (CPB) was consulted. The financial implications were assessed and an Equality Impact and Risk (EIA) Assessment was undertaken. Amendments were made to both policies during the consultative process.

6. The policies were presented to the CPB on 27.10.2017. On that occasion the CPB provided their support for the policies to proceed to ratification, pending the completion of the public engagement process.

7. The CPDIG were presented with the outcome of the public engagement period on 16.11.2017. As a result of the feedback received it was agreed that a small change

was required to the wording of the criteria on the *Policy for Complementary and Alternative Therapies* to provide clarity. A copy of the survey results and feedback report are attached as **Appendices 2-4.**

8. Members then agreed that the policies were ready for ratification. A copy of the final version of the *Policy for Complementary and Alternative Therapies* is attached as **Appendix 5** and the *Policy for Rehabilitation after Damage to the Facial Nerve* is attached as **Appendix 6.**

9. A stage two Equality Impact and Risk Assessment (EIA) has been undertaken on each policy, and this did not highlight any areas of concern. A copy the EIAs are attached as **Appendices 7 and 8.**

Financial implications

10. The *Policy for Rehabilitation after Damage to the Facial Nerve* is a new policy for a treatment that has not previously been commissioned routinely within Lancashire and South Cumbria. As a result, there is an associated cost implication.

11. The Public Health policy leads from Lancashire County Council carried out an assessment of the potential cost to CCGs for provision of treatment in line with the draft policy, based on the number of Individual Funding Request's (IFR's) submitted and disease incidence.

12. Based on this information it is difficult to precisely forecast the potential uptake of treatment. If requests continue in line with existing IFR activity levels, around four requests per year, they advise the annual cost of introducing the policy would be approximately £6,800, or £850 per CCG. However, an assessment of the incidence and prevalence of facial nerve palsy determined that potentially approximately 69 patients per year would meet the policy requirements. The annual cost of provision to those patients would be in the region of £117,000, or £14,620 per CCG.

13. It is however anticipated that the actual costs incurred by CCGs would be somewhere within the middle of this range. If the proposed policy is ratified by CCGs activity monitoring will be undertaken to determine the actual cost at an appropriate time post implementation.

14. The revised *Policy for Complementary and Alternative Therapies* is not expected to have a financial implication for CCGs.

Conclusion

15. The JC CCG is asked to ratify the following policies on behalf of all eight CCGs:

    - The revised *Policy for Complementary and Alternative Therapies.*
    - The new *Policy for Rehabilitation after Damage to the Facial Nerve*.

16. Once the JC CCG has taken a decision on the recommendations within this paper arrangements will be made for the collaborative implementation of the policies.

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Midlands and Lancashire Commissioning Support Unit

Lancashire Clinical Commissioning Groups (CCGs), Commissioning Policy Development and Implementation Working Group (CPDIG)

Process for the Development of Clinical Commissioning Policies

Stage 1

Task:	Actioned By:
Review policy requirement	**Policy Development and Implementation Working Group**

This stage is completed by the Commissioning Policy Development and Implementation Working Group (CPDIG). An initial review will ascertain whether there is a need for a policy. The assessment will be supported by the Policy Development Team from MLCSU via the provision of information such as activity and spend analyses.

Where there is an existing policy under review, then primary and secondary care clinicians will be contacted in this stage to identify changes in best practice, potential areas of contention and other relevant factors to assist the CPDIG.

Stage 2

Task:	Actioned By:
Evidence review and establishment of policy criteria	**Policy Development Team**

The Policy Development Team in conjunction with Public Health representatives, will identify and collate any relevant guidance from organisations such as NICE, NHS England, Department of Health and any relevant Royal Colleges and will develop proposed policy criteria. An initial EIA will be carried out supported by EIA leads.

Stage 3

Task:	Actioned By:
Review of the proposed policy	**Clinical Forum/ IFR Team/ Lead Providers**

A review of the proposed policy will be carried out by the Clinical Forum, the IFR Team, Lead Providers and CCG GP Leads. Following the review, and any revision, comments will be sought from the Healthier Lancashire and South Cumbria Change Programme's Care Professionals Board.

Stage 4

Task:	Actioned By:
Decision on the requirement for engagement and legal advice taken	**Policy Development and Implementation Working Group**

The CPDIG is presented with the proposed policy and an overview of the work that has taken place.

The CPDIG will decide whether engagement/consultation is required and whether the policy can proceed to that stage.

The CPDIG will consider whether legal advice is required. If it is, then Stage 5 will be undertaken, if not the policy will proceed to Stage 6 immediately.

Stage 5

Task:	Actioned By:
Legal advice obtained and considered	**Policy Development and Implementation Working Group**

It is not anticipated that it will be necessary to seek expert legal advice on all proposed policies. The Policy Development Team will organise legal advice supported by CPDIG advice. The CPDIG will consider the legal advice and implement any necessary amendments to the policy and document the rationale for accepting or declining any advice.

Stage 6

Task:	Actioned By:
Engagement/ Consultation	**Communication and Engagement Team**

The CPDIG supported by Communications and Engagement will identify whether public and patient engagement is required. The Communications and Engagement team will arrange

engagement with relevant groups which may include patients, clinicians or focus groups. If it is necessary for the policy to be presented to the local Overview and Scrutiny Committee (OSC) this will also take place at this stage.

The Healthier Lancashire and South Cumbria Change Programme's Care Professionals Board will also be provided with the policy and an overview of the work undertaken to date.

Stage 7

Task:	Actioned By:
Review of engagement outputs	**Policy Development and Implementation Working Group**

The CPDIG will review the engagement responses, themes identified and review the rationale for any proposed amendments that are accepted or not accepted.

The CPDIG will confirm if the revised proposed policy following the engagement is approved and if there is a requirement for a further EIA following the changes made.

Stage 8

Task:	Actioned By:
Policy ratification and adoption	**Joint Committee of Clinical Commissioning Groups (JCCCG)**

The final draft of the proposed policy will be shared with the Healthier Lancashire and South Cumbria Change Programme's Joint Committee of Clinical Commissioning Groups (JC CCG) who will be asked to adopt and ratify the policy on behalf of all eight CCGs.

Stage 9

Task:	Actioned By:
Implementation	**CCGs & MLCSU**

The adopted policy will then be implemented by each CCG supported by MLCSU. A plan will be agreed for each policy to confirm the actions required for implementation, confirm data monitoring and impact evaluation and ensure that relevant stakeholders such as NHS Trusts, primary care

clinicians and contract leads are notified of the new policy. New and updated policies will be placed on the CCGs websites for public access.

Version 1.5

Written: April 2017

Annual Review Date: April 2018

Briefing paper: Response to the feedback from the public engagement exercise on the policies for complementary and alternative therapies and rehabilitation after damage to the facial nerve.

1. Introduction

The comments received during the public engagement exercise on the Policy for complementary and alternative therapies and the Policy for rehabilitation after damage to the facial nerve have been reviewed by the IFR Policy Development Manager and a Public Health representative to determine what, if any, changes should be made to the policies in response to the feedback.

The comments received for both policies are shown in Table 1 below. A separate document with data on number of responses received has been produced by the Communications and Engagement Team.

2. Response to feedback

Policy for rehabilitation after damage to the facial nerve

Upon review of the feedback received we were of the opinion that the public were generally supportive of the proposal therefore we did not feel that consideration need to be given to altering the draft policy.

Policy for complementary and alternative therapies

A large number of comments were received from the public in relation to this policy. On review it was noted that there were some common themes. Those themes, and our view are set out below for the group.

- Patients who were supportive of the approach taken.
- Patients who felt these procedures should be commissioned more widely than the proposal as a result of previous treatment they had undergone (responses did not make it clear whether that treatment had been privately of NHS funded). Whilst we acknowledge these views, individual patient statements of benefit alone are not routinely considered sufficient to demonstrate the effectiveness of treatments.
- Those who believed psychological based therapies, such as Mindfulness, fell within the remit of the policy. These types of interventions are not within the scope of this policy.
- Those who highlighted that individual patients may require a different provision to that allowed for under the policy. It remains an option that clinicians can submit and individual funding request (IFR) for patients who do not fulfil the policy requirements when they feel there are grounds for clinical exceptionality.
- Respondents who felt the policy needed to be clearer in stating these procedures will only be commissioned when they are evidence based. We accept this and have

made a suggested amendment in response to the same query from the Care Professionals Board.

The view of the policy leads was that no information had been provided that meant further consideration should be given to extending the provision in the policy, as the basis upon which access to treatment is limited remains a lack of robust evidence of the effectiveness of some of these treatments.

3. Conclusion

The CPDIG is asked to:

- Consider the comments received and reach a consensus decision on whether any changes are required to the policies as a result of the public engagement exercise.

Rebecca Higgs
IFR Policy Development Manager
10.11.2017

Table 1: Comments received from the public

Policy for rehabilitation after damage to the facial nerve	
Question: **If you disagree with the policy please tell us why:**	There are always problems with the interpretation/application of criteria. Some will get the treatment they need while others not.
Question: Please provide us with any further comments you would like to make about this policy or to explain your answers further.	Distrusting experts has become the modern fashion - but I'm afraid that I made my living as an expert (in a non-medical field) and I learnt that the only way to succeed in that role was to trust the other experts around me - so I apply that same rule to my medical dealings. I might have some preferences - but they are always lower priority than expert opinion.
Policy for complementary and alternative therapies	
Question: If you disagree with the policy please tell us why:	• I have M.E/cfs and apparently do not meet any criteria in which I could access Reflexology or Osteopathy which both help me enormously to cope with my constant muscle pain, nerve pain, migraine, vertigo, stomach problems and allows me to function. Not only am I unable to work full time or claim benefits but somehow I am now supposed to self fund the only things that actually help. • Complimentary therapies work to balance the body and mind and are an early intervention solution to the demand that is currently upon the CCG's. • The problems with criteria lies in their different interpretations/applications by decision makers. People deserving treatment may get approval from one person but not another. • Very little provable research available. Little or no testing on safety or efficacy of alternative procedures. NHS does not have the money for 'pie

	in the sky' procedures. • The criteria needs to include other treatments in priority order so that a full clear reason can be given as to why regular NHS treatment has not been successful. • Therapies can be beneficial to many patients suffering from stress, anxiety, depression, as well as physical complaints. They should be used as a compliment to drug therapy reducing the need for pharmaceutical drugs, which could be more cost effective for the CCGs. CCGs need to look in the long term not for the term of the political cycle. • Complementary therapy a can help. Due to my medical history I can only take paracetamol as painkiller. I looked at alternatives with the pain clinic but again they couldn't help me. I had previously been recommended Mindfulness by an NHS counsellor to help me cope with stress, which I have now practiced for over 7 years. I saw on west lancs NHS website re 'Mindfulness for Health' which teaches you how to deal with pain. but was told it was no longer funded. I researched and found 'Breathworks' and paid for my self to go on the 8 week 'Mindfulness for Health' which helped me deal with my pain and the associated stress caused by being in constant pain. Other patients would benefit from this and it should be offered through the NHS. I had surgery last year at Whiston Hospital for a repair to my stomach muscles and abdominoplasty after surgery there. I was offered the opportunity to take part in a trial of using Holistic Therapy after surgery. The Holistic Therapist worked with me for an hour each day for 5 days after my surgery, she used reiki, reflexology, Indian head massage. I feel it helped me cope better with my pain and helped me relax and lowered my stress levels. • The N.H.S is struggling with funding and yet your considering spending cash on Alternative Therapy, most of which have not been not been thoroughly research - only small groups and small numbers of clients - that is not good enough. Stop throwing the tax payer's money down the drain.
Question: If you disagree with the policy please tell us why:	• You only look at the BMI case studies that prove or disprove the findings that meet your own needs. Never mind studies which are carried out outside the confine of NICE as they are not 'medical' etc. Try asking the people who use these therapies if they actually work. • See previous (The problems with criteria lies in their different interpretations/applications by decision makers. People deserving treatment may get approval from one person but not another.) • It is dictating who can have what treatment.

	People are individuals and this needs to be remembered. • Patients should be offered the opportunity to use complementary treatments as part of /instead of traditional medicine for treatment of their condition • Insufficient research on Alternative Therapies. More is required before you should consider throwing away N.H.S. money - our money.
Question: Please provide us with any further comments you would like to make about this policy or explain your answers further.	• Agree for pain and end of life patients but feel there is a place for complementary therapies for people with mental health problems to destress • What else is there to say? Thousands of patients with M.E/cfs, M.S, Migraine and cancer etc would really benefit from the relief brought by these therapies. However to cut costs we can suffer more and pay privately. Perhaps then we'll spend more money on more drugs which will help cover the nhs black hole, via the funding received from multi national drug companies.... oh and whilst paying our prescription fees we can line the pockets of drug company • Alternative therapy can be useful but not at expense of other more usual treatments • While medical experts should always be broad minded enough to bring in treatments that work - whether from big-pharma or from the witch-doctor down the street, there needs to be strong medical evidence that the treatments are both effective and safe long-term. This can only be assessed by well-funded academic studies - personal opinion is not enough to accredit the applicability or safeness of a treatment. • Could be firmer in saying these will not be paid for. • Some complimentary therapies are very beneficial and a lot of people cannot afford them. It is refreshing to see that the NHS is now recognising that some of these should be included in treating patients. • Patients need to be responsible for their own care and medical staff need to work with them to allow them to do this. Traditional medicine isn't the only option and complementary medicine can work alongside and sometimes instead of traditional. I.e. Mindfulness to help with pain and stress instead of medication • I received mindfulness and acupuncture for pain and benefited • The eligibility criteria for the use of alternative therapies to support conditions where there is a good evidence base isn’t clear on this policy • Overall, it is my view that the NHS should only fund the complimentary therapies that have a robust evidence base. • I feel chiropractors have a part to play.I don’t think

	treatment for cultural reasons should be funded by the NHS • Far more advanced research is required, before you should consider throwing money down the drain. Once the research has been completed, evaluated and reported upon, then and only then should this survey be carried out. Your trying to run before you can walk. • I am aware that the Royal Family use homeopathy as well as orthodox medicines, I have also used homeopathy in the past, so I am not convinced that this should be ignored. • I am pleased to see this policy excludes use of alternative and complementary therapies except in circumstances where there is good evidence for their use or other exceptional circumstances such as end of life care. The NHS should not spend money on unproven treatments, whatever their origin. This is especially true where practitioners make exceptional claims that may be seen to be supported by NHS use. The risk of harm by use of these therapies is often overlooked (for example herbal products may well do something, but without gold standard evidence, those effects may be harmful).

Midlands and Lancashire Commissioning Support Unit

Survey results from the public engagement exercise on the Policy for Complementary and Alternative Therapies

Q1. (*) Which CCG area do you live in?	Response Percent	Response Total
NHS Morecambe Bay Clinical Commissioning Group		
NHS East Lancashire Clinical Commissioning Group		
NHS Fylde and Wyre Clinical Commissioning Group		
NHS Greater Preston Clinical Commissioning Group		
NHS Chorley and South Ribble Clinical Commissioning Group		
NHS West Lancashire Clinical Commissioning Group		
NHS Blackburn with Darwen Clinical Commissioning Group		
NHS Blackpool Clinical Commissioning Group		
Other (please specify)		

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

Q2. (*) Have you received any of these treatments/procedures?	Response Percent	Response Total
Yes, in the last 12 months	**13.73%**	**7**
Yes, but over 12 months ago	**5.88%**	**3**
No, but I care/look after someone	**3.92%**	**2**
No, but I know someone who has	**11.77%**	**6**
No	**64.71%**	**33**

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

Q3. (*) Please indicate below how you tend to view the CCGs funding or not funding these complementary or alternative therapies for people who meet the criteria	Response Percent	Response Total
Yes, always fund them, regardless of criteria	15.69%	8
Yes, fund them but only for those who meet the criteria	29.41%	15
No, fund them only in exceptional circumstances	27.45%	14
No, do not fund these procedures, the NHS has other priorities	27.45%	14

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

Q4. (*) Have you read the updated draft policy for complementary and alternative therapies?	Response Percent	Response Total
Yes	84.31%	43
No	15.69%	8

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

Q5. (*) Please tell us how much you agree or disagree with the criteria that people must satisfy in order to recieve these procedures (Section 8 of the policy)?	Response Percent	Response Total
I strongly agree	35.29%	18
I tend to agree	37.26%	19
I tend to disagree	3.92%	2
I strongly disagree	11.77%	6
I neither agree nor disagree	11.77%	6

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

If you disagree, please tell us why	Response Total
	8

Total # of respondents **51**.
Statistics based on **8** respondents; **0** filtered; **43** skipped.

Q6. (*) Please tell us how much you agree or disagree overall with the updated draft policy	Response	Response Total
I strongly agree	25.49%	13
I tend to agree	39.22%	20
I tend to disagree	3.92%	2
I strongly disagree	11.77%	6
I neither agree nor disagree	19.61%	10

Total # of respondents **51**.
Statistics based on **51** respondents; **0** filtered; **0** skipped.

If you disagree please tell us why	Response Total
	6

Total # of respondents **51**.
Statistics based on **6** respondents; **0** filtered; **45** skipped.

Q7. Please provide us with any further comments you would like to make about this policy or to explain your answers further	Response Total
	18

Total # of respondents **51**.
Statistics based on **18** respondents; **0** filtered; **33** skipped.

Q8. Your age	Response Percent	Response Total
16 or under	0%	0
17-24	0%	0
25-34	2%	1
35-44	16%	8
45-54	22%	11
55-64	32%	16
65-74	22%	11
75-84	6%	3
85 or over	0%	0
Prefer not to say	0%	0

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q9. How would you describe your gender	Response Percent	Response Total
Male	26%	13
Female	74%	37
Prefer not to say	0%	0

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q10. Is this the same gender you were given at birth?	Response Percent	Response Total
Yes	100%	50
No	0%	0
Prefer not to say	0%	0

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q11. Please choose the category that best describes your level of disability	Response Percent	Response Total
No disability	64%	32
Learning disability	0%	0
Wheelchair user	4%	2
Hearing impairment	6%	3
Mental health	6%	3
Visual impairment	4%	2
Physical impairment	16%	8
Multiple impairments	4%	2
Prefer not to say	4%	2

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q12. What is your sexual orientation?	Response Percent	Response Total
Heterosexual/straight (attracted to the opposite sex)	88%	44
Bisexual (attracted to both sexes)	4%	2
Gay/Lesbian (attracted to the same sex)	4%	2
Prefer not to say	4%	2

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q13. What is your religion/belief?	Response Percent	Response Total
Christian	48%	24
Jewish	2%	1
Hindu	0%	0
Muslim	4%	2
Sikh	0%	0
Buddhist	2%	1
No religion/belief	32%	16
Prefer not to say	12%	6

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Q14. Your ethnic group	Response Percent	Response Total
White British	94%	47
White Irish	2%	1
Gypsy/Roma/Traveller	0%	0
East European	0%	0
White other	0%	0
Mixed White/Black Caribbean	0%	0
Mixed White/Black African	0%	0
Mixed White/Asian	0%	0
Mixed Other	0%	0
Asian or Asian British - Pakistani	0%	0
Asian or Asian British - Indian	0%	0
Asian or Asian British - Bangladeshi	0%	0
Asian or Asian British - Other	0%	0
Black or Black British - Caribbean	0%	0
Black or Black British - African	0%	0
Black or Black British - Other	0%	0
Chinese	0%	0
Any other ethnic group	0%	0
Prefer not to say	4%	2

Total # of respondents **51**.
Statistics based on **50** respondents; **0** filtered; **1** skipped.

Other ethnic groups please specify	Response Total
	0

Total # of respondents **51**.
Statistics based on **0** respondents; **0** filtered; **51** skipped.

Public engagement survey results on the Policy for rehabilitation after damage to the facial nerve

Q1. (*) Which CCG area do you live in?	Response Percent	Response Total
NHS Morecambe Bay Clinical Commissioning Group	0%	0
NHS East Lancashire Clinical Commissioning Group	0%	0
NHS Fylde and Wyre Clinical Commissioning Group	81.25%	13
NHS Greater Preston Clinical Commissioning Group	6.25%	1
NHS Chorley and South Ribble Clinical Commissioning Group	6.25%	1
NHS West Lancashire Clinical Commissioning Group	6.25%	1
NHS Blackburn with Darwen Clinical Commissioning Group	0%	0
NHS Blackpool Clinical Commissioning Group	0%	0
Other (please specify)	0%	0

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q2. (*) Have you received this treatment/procedure?	Response Percent	Response Total
Yes, in the last 12 months	0%	0
Yes, but over 12 months ago	0%	0
No, but I care/look after someone who has	0%	0
No, but I know someone who has	6.25%	1
No	93.75%	15

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q3. (*) Please indicate below how you tend to view the CCGs funding or not funding this procedure for people who meet the criteria?		Response Percent	Response Total
Yes, always fund it, regardless of criteria		12.5%	2
Yes, fund it but only for those who meet the criteria		68.75%	11
No, fund it only in exceptional circumstances		12.5%	2
No, do not fund this procedure, the NHS has other priorities		6.25%	1

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q4. (*) Have you read the new draft policy for rehabilitation after damage to the facial nerve?		Response Percent	Response Total
Yes		87.5%	14
No		12.5%	2

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q5. (*) Please tell us how much you agree or disagree that tailored exercises are the only effective healthcare for rehabilitation after damage to the facial nerve (Section 4 of the policy)?		Response Percent	Response Total
I strongly agree		18.75%	3
I tend to agree		31.25%	5
I tend to disagree		0%	0
I strongly disagree		0%	0
I neither agree nor disagree		50%	8

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

If you disagree, please tell us why	Response Total
	0

Total # of respondents **16**.
Statistics based on **0** respondents; **0** filtered; **16** skipped.

Q6. (*) Please tell us how much you agree or disagree with the criteria that people must satisfy in order to receive this procedure (Section 8 of the policy)		Response Percent	Response Total
I strongly agree		37.5%	6
I tend to agree		43.75%	7
I tend to disagree		0%	0
I strongly disagree		6.25%	1
I neither agree nor disagree		12.5%	2

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

If you disagree, please tell us why	Response Total
	1

Total # of respondents **16**.
Statistics based on **1** respondents; **0** filtered; **15** skipped.

Q7. (*) Please tell us how much you agree or disagree overall with the new draft policy	Response Percent	Response Total
I strongly agree	31.25%	5
I tend to agree	37.5%	6
I tend to disagree	0%	0
I strongly disagree	0%	0
I neither agree nor disagree	31.25%	5

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

If you disagree please tell us why	Response Total
	0

Total # of respondents **16**.
Statistics based on **0** respondents; **0** filtered; **16** skipped.

Q8. Please provide us with any further comments you would like to make about this policy or to explain your answers further	Response Total
	2

Total # of respondents **16**.
Statistics based on **2** respondents; **0** filtered; **14** skipped.

Q9. Your age	Response Percent	Response Total
16 or under	0%	0
17-24	0%	0
25-34	0%	0
35-44	18.75%	3
45-54	18.75%	3
55-64	25%	4
65-74	25%	4
75-84	6.25%	1
85 or over	0%	0
Prefer not to say	6.25%	1

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q10. How would you describe your gender	Response Percent	Response Total
Male	37.5%	6
Female	56.25%	9
Prefer not to say	6.25%	1

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q11. Is this the same gender you were given at birth?	Response Percent	Response Total
Yes	93.75%	15
No	0%	0
Prefer not to say	6.25%	1

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q12. Please choose the category that best describes your level of disability	Response Percent	Response Total
No disability	43.75%	7
Learning disability	0%	0
Wheelchair user	6.25%	1
Hearing impairment	6.25%	1
Mental health	18.75%	3
Visual impairment	0%	0
Physical impairment	18.75%	3
Multiple impairments	6.25%	1
Prefer not to say	12.5%	2

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q13. What is your sexual orientation?	Response Percent	Response Total
Heterosexual/straight (attracted to the opposite sex)	75%	12
Bisexual (attracted to both sexes)	6.25%	1
Gay/Lesbian (attracted to the same sex)	6.25%	1
Prefer not to say	12.5%	2

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q14. What is your religion/belief?

	Percent	Response Total	Response
Christian	43.75%	7	
Jewish	6.25%	1	
Hindu	0%	0	
Muslim	0%	0	
Sikh	0%	0	
Buddhist	0%	0	
No religion/belief	43.75%	7	
Prefer not to say	6.25%	1	
Other please specify	0%	0	

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

Q1	Response Percent	Response Total
White British	93.75%	15
White Irish	0%	0
Gypsy/Roma/Traveller	0%	0
East European	0%	0
White other	0%	0
Mixed White/Black Caribbean	0%	0
Mixed White/Black African	0%	0
Mixed White/Asian	0%	0
Mixed Other	0%	0
Asian or Asian British - Pakistani	0%	0
Asian or Asian British - Indian	0%	0
Asian or Asian British - Bangladeshi	0%	0
Asian or Asian British - Other	0%	0
Black or Black British - Caribbean	0%	0
Black or Black British - African	0%	0
Black or Black British - Other	0%	0
Chinese	0%	0
Any other ethnic group	0%	0
Prefer not to say	6.25%	1

Total # of respondents **16**.
Statistics based on **16** respondents; **0** filtered; **0** skipped.

For all other ethnic groups, please specify	Response Total
	0

Total # of respondents **16**.
Statistics based on **0** respondents; **0** filtered; **16** skipped.

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Policy for Complementary and Alternative Therapies		
	Version Number:	**Changes Made:**
Version of 14.12.17	V 0.5	- OPCS/ICD codes added as per CPDIG agreement
Version of 08.11.17	V 0.4	- Inclusion of migraine in section 4.4 - Rewording of section 8 to clarify the procedures will only be funded via existing NHS commissioned services following engagement and CPB feedback
Version of: 24.07.17	V 0.3	A number of amendments were made in line with the CPDIG directive following Stage 3 comments on the policy For full details see CPDIG minutes and supporting paper.
Version of: March 2017	V 0.2	Policy re-drafted in line with the directive of the January CPG
Original Draft: November 2016	V 0.1	Policy drafted

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Policies for the Commissioning of Healthcare

Policy for Complementary and Alternative Therapies

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right, but will be applied with reference to other polices in that suite.
1.2	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Scope and definitions**
2.1	This policy addresses a wide range of healthcare services that are often regarded as being outside the scope of conventional medical practice, and are often used alongside or instead of standard treatment. Such therapies tend to be non-invasive and non-pharmaceutical and they often take a holistic approach to the patient.
2.2	The scope of this policy includes requests for: • Homeopathy • Herbal Medicine • Acupuncture • Alexander Technique • Aromatherapy • Reflexology • Chiropractic • Osteopathy • Hypnotherapy This policy's principles may be applied to other therapies with similar characteristics that are considered 'alternative' or 'complementary'.
2.3	This policy does not address and does not exclude: • The use of manipulative techniques as a professional tool by medical practitioners and physiotherapists. • The use of herbally derived medicines that are listed as prescribable in the British National Formulary (e.g. digitalis or opioid derivatives).
2.4	The CCG recognises that a patient may: • suffer from a condition for which a complementary therapy has been offered. • wish to have a service provided for their condition, • be advised that they are clinically suitable for the treatment, and be distressed by their condition, and by the fact that that this service is not normally commissioned by this CCG.

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	Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.5	Terms used in this policy are explained and defined in Appendix 1. Throughout this policy any terms are used with the meaning described in that appendix.
3	**Appropriate Healthcare**
3.1	Some complementary therapists, including many practitioners of reflexology, aromatherapy, and the Alexander technique, may regard the purpose of their treatment in terms such as to help restore and maintain the body's natural equilibrium; to relax the mind and body and counteracting stress; to help patients to cope on a physical, mental and emotional level; to heal and maintain health in all areas of their lives. While those purposes may be important in terms of the overall wellbeing of the person, they are not purposes that place those therapies within the appropriate category for NHS commissioning.
3.2	Many complementary therapies seek to achieve the same aim as conventional therapies. In some circumstances conventional therapists may rely partly on similar or identical techniques to complementary therapists, including manipulation, acupuncture and hypnotherapy to achieve their aim. If the purpose of the proposed complementary therapy can be addressed by conventional therapists and those therapists are qualified and registered practitioner carrying out evidence based work in conjunction with clinical audit, then referral to those therapists is appropriate and referral to complementary therapists is not.
3.3	In some cases, including services intended to relieve musculoskeletal pain and disability, and services delivered to improve wellbeing as a part of a package of palliative care, complementary therapies will satisfy that criterion. As the number of complementary therapies is large, and each can address a wide range of conditions, the appropriateness of each treatment must be considered on its merits.
3.4	If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.
4	**Effective Healthcare**
4.1	This policy relies on the criterion of effectiveness as:
4.1	**Homeopathy** - There has been extensive investigation of the effectiveness of homeopathy. There is no good-quality evidence that homeopathy is effective as a treatment for any health condition. Ref: 1

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4.2	**Herbal medicine** - Evidence for the effectiveness of herbal medicine is generally very limited. Although some people find them helpful, in many cases their use tends to be based on traditional use rather than scientific research. This is therefore not funded on the NHS. Ref: 1
4.3	**Acupuncture** - Currently, the National Institute for Health and Care Excellence (NICE) only recommends considering acupuncture as a treatment option for chronic tension-type headaches and migraine, with or without aura (a course of up to 10 sessions of acupuncture over 5–8 weeks). NICE makes these recommendations on the basis of scientific evidence Ref: 5. NICE no longer recommend acupuncture for treating low back pain. There is also some evidence that acupuncture works for a small number of other problems, including neck pain and post-chemotherapy nausea and vomiting. For further evidence of effectiveness see http://aim.bmj.com/ Ref: 6 Acupuncture is sometimes used for a variety of other conditions as well, but the evidence is not conclusive for many of these uses.
4.4	**Alexander Technique** - There is evidence suggesting the Alexander technique can help people with: • long-term back pain – lessons in the technique may lead to reduced back pain-associated disability and reduce how often you feel pain for up to a year or more • long-term neck pain – lessons in the technique may lead to reduced neck pain and associated disability for up to a year or more • Parkinson's disease – lessons in the technique may help you carry out everyday tasks more easily and improve how you feel about your condition Some research has also suggested the Alexander technique may improve general long-term pain, stammering and balance skills in elderly people to help them avoid falls but the evidence in these areas is limited and more studies are needed. There is currently little evidence to suggest the Alexander technique can help improve other health conditions, including asthma, headaches, osteoarthritis, difficulty sleeping (insomnia) and stress. Ref: 1
4.5	**Aromatherapy** - Studies show varied outcomes with the use of essential oils. Ref: 2
4.6	**Reflexology** - The poor quality of the existing studies prevents definitive judgements about the value of reflexology. Ref: 3
4.7	**Chiropractic** - There is good evidence that manual therapy which may include spinal manipulation (as practised by chiropractors) can be an effective treatment for persistent lower back pain. Ref: 9 Conventional treatments for persistent lower back pain include painkillers, exercise and physiotherapy. There is some, mostly poor-quality, evidence that spinal manipulation is an effective treatment for some other musculoskeletal conditions involving the bones, joints and soft tissue. The evidence of manual therapy, including spinal manipulation, is not strong enough in these cases to form the basis of a recommendation to use the treatment. There is no evidence that treatments offered by chiropractors are effective for other conditions. Ref: 1

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4.8	**Osteopathy** - There is good evidence that osteopathy is effective in treating persistent or recurrent low back pain. NICE recommends osteopathy as a treatment for this condition. Ref: 9 There is limited evidence to suggest it may be effective for some types of neck, shoulder or lower limb pain and recovery after hip or knee operations. There is currently no good evidence that osteopathy is effective as a treatment for health conditions unrelated to the musculoskeletal system (bones and muscles). Ref: 1
4.9	**Hypnotherapy** - Research studies have been conducted considering hypnosis as a treatment for various long-term conditions and for breaking certain habits, these include: Irritable bowel syndrome, losing weight, smoking cessation, skin conditions and anxiety. Overall, the evidence supporting the use of hypnotherapy as a treatment in these situations is not strong enough to make any recommendations for clinical practice. http://www.nhs.uk/Conditions/hypnotherapy/Pages/Introduction.aspx Ref: 10
4.10	For further information on all of the alternative therapies see: www.therapiesguide.co.uk/ Ref: 4
4.11	Complementary and alternative therapies which have a holistic benefit rather than a specific healthcare outcome will not be commissioned.
4.12	If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the purpose of the treatment is likely to be achieved in this patient without undue adverse effects before confirming a decision to provide funding.
5	**Cost Effectiveness**
5.1	NICE has not produced formal guidance on complementary therapies, and there is no other formal systematic assessment of cost effectiveness of complementary therapies. Most reports on effectiveness pay little attention to issues of cost effectiveness, and authoritative commentators suggest that the wisest approach is to target the NHS use of complementary therapies on areas where there is a gap in proven conventional effective treatments including chronic pain, mental disorders and palliative care. Treatment within each therapy must be considered on its merits and in the light of emerging evidence Ref: 7 and this policy does not exclude or confirm any complementary therapy for NHS commissioning on the basis of cost effectiveness.
5.2	If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be cost effective in this patient before confirming a decision to provide funding.
6	**Ethics**
6.1	Certain alternative therapies have their roots in cultures that, in a UK context, are of a minority nature. Members of those cultures may be particularly keen

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	to use such therapies. However the fact that a particular therapy may be preferred by a particular cultural group does not change the appropriateness of the purpose of that therapy, nor its effectiveness, cost effectiveness or affordability in delivering that purpose. The CCG therefore considers that the principles of ethical healthcare do not require it to make special provision for members of such cultural groups, and indeed it may be inequitable to do so.
6.2	It is widely recognised that many healthcare techniques can achieve some benefit or perceived benefit as a result of the patient believing that they are being given an effective treatment. This placebo effect needs to be taken into account in evaluating new treatments. Many alternative therapies may deliver genuine and possibly measurable benefits through this placebo effect. However it is inappropriate and probably unethical and disrespectful to patients to offer a treatment simply to achieve a placebo effect and services where the expected benefit is entirely of this nature will not be commissioned. Ref: 8 Otherwise the CCG recognises that complementary and alternative therapies satisfy the criteria within the “Ethics” section of the Statement of Principles document.
6.3	If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
7	**Affordability**
7.1	The CCG reserves the right to consider affordability above cost-effectiveness given the need for the CCG to prioritise the use of resources in accordance with the other principles set out in the Statement of Principles document.
7.2	If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
8	**Policy**
8.1	The CCG will only commission complementary and alternative therapies where there is clear evidence of effectiveness and when they are carried out by an agreed NHS provider as part of an existing NHS pathway of care (e.g. as part of a package of end of life care or pain management) or when exceptionality has been demonstrated in accordance with section 9 below.
8.2	The CCG will not commission complementary and alternative therapies as “stand alone” treatments either within or outside of the NHS.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
9.2	All requests to be considered as an exception to this policy will also need to

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	demonstrate good reasons why this service should be commissioned as an alternative to a conventional therapy and the CCG will need to further consider affordability. If the case is based on cost effectiveness, the commissioning body may reject the request on the grounds that the contractual arrangements do not enable the opportunity of the cost of the conventional therapy to be recovered.
9.3	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
10	**Force**
10.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
10.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However until it adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
11	**References**
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	6. Para 4.3 Acupuncture Society and available at Acupuncture in medicine http://aim.bmj.com/ 7. Para 5.1 Thompson, T. Feder, G. (2005) Complementary therapies and the NHS BMJ.331:Pp. 856–7 8. Para 6.2 http://www.parliament.uk/business/committees/committees-archive/science-technology/s-t-homeopathy-inquiry/ 9. Para 4.7 Para 4.8 Low back in in adults: early management NICE guidelines [CG88] Published May 2009 https://www.nice.org.uk/guidance/cg88/chapter/Introduction 10. Para 4.9 http://www.nhs.uk/Conditions/hypnotherapy/Pages/Introduction.aspx

Date of adoption

Date for review

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Appendix 1: Definitions

Homeopathy - A central principle of the "treatment" is that "like cures like" – that a substance that causes certain symptoms can also help to remove those symptoms. A second central principle is based around a process of dilution and shaking, called succussion.

Herbal medicine – also known as Herbalism. Herbal medicines are those with active ingredients made from plant parts, such as leaves, roots or flowers. Herbal medicines may contain active chemical ingredients that could have a pharmacological effect, and many medicines now used in conventional medicine were originally discovered as naturally occurring substances in plants. However the amount of active ingredient may vary between different preparations, and the side effects and interactions with other medicines (by the active substance or by other chemical ingredients in the preparation) may be unpredictable.

Acupuncture - Acupuncture is a treatment derived from ancient Chinese medicine in which fine needles are inserted at certain sites in the body for therapeutic or preventative purposes.

Alexander technique - The Alexander technique teaches improved posture and movement, which is believed to help reduce and prevent problems caused by unhelpful habits. During a number of lessons you are taught to be more aware of your body, how to improve poor posture and move more efficiently.

Aromatherapy - Aromatherapy is the use of oils extracted from plants (known as essential oils) for medicinal purposes. These essentials oils can be applied in a variety of ways: massage, compresses, baths or controlled inhalation.

Reflexology - Reflexology is based on the theory that different points on the feet, lower leg, hands, face or ears correspond with different areas of the body. Reflexologists work holistically to promote better health for their clients.

Chiropractic – Chiropractic is a form of alternative medicine concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the function of the nervous system and general health. Chiropractors use their hands to treat disorders of the bones, muscles and joints. Treatments that involve using the hands in this way are called "manual therapies".

Osteopathy – Osteopathy is a way of detecting, treating and preventing health problems by moving, stretching and massaging a person's muscles and joints. Osteopathy is based on the principle that the wellbeing of an individual depends on their bones, muscles, ligaments and connective tissue functioning smoothly together.

Osteopaths use physical manipulation, stretching and massage, with the aim of:
• increasing the mobility of joints
• relieving muscle tension
• enhancing the blood supply to tissues
• helping the body to heal

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Hypnotherapy - Hypnotherapy uses the power of suggestion, which can be a very strong force in the development of certain symptoms (e.g. irritable bowel syndrome) and can assist with promoting healthy behaviour (this differs from the placebo effect as the hypnotherapy patient is aware that the power of suggestion is being used).

Appendix 2: Associated procedure and diagnosis codes

Procedure code	Diagnosis code
X611, X612, X613, X614, X618, X619, Y331	Any

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Policy for rehabilitation after damage to the facial nerve		
	Version Number:	**Changes Made:**
Version of 14.12.17	V 0.6	OPCS/ICD codes added in line with CPDIG agreement
Version of 09.11.2017	V 0.5	Changes made to section 2.1 of the policy to clarify the policy does not replace the standard care pathway. Word “initial” removed from the sentence “This policy recommends a 12 week…” at section 4.3 (Agreed by November CPB) Policy transferred to correct template version.
Version of 24.07.2017	V 0.4	Following changes made following the stage 3 review: - Addition of “NHS” to the following sentence “A) where the cause is Bell’s palsy, it must have been present for a minimum of 12 months, prior to which the standard NHS pathway of care should be followed” at section 4.2 - The addition of “AND” between criterion A and B and B and C
Version of 18.05.2017	V 0.3	Policy formatted in an acceptable way for the May meeting of the CPDIG
Version of 13.03.2017	V 0.2	Alterations made by public health as part of the development process.
Version 1, original draft: 07.11.2016	V 0.1	

Lancashire Clinical Commissioning Groups

Policies for the Commissioning of Healthcare

Policy for Rehabilitation after Damage to the Facial Nerve

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right, but will be applied with reference to other polices in that suite.
1.2	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Scope and definitions**
2.1	This policy does not replace the standard care pathway for the management of facial palsy, including referrals by general practitioners to secondary care. The policy covers physical therapy rehabilitation services for damage to the facial nerve and is intended to be used by secondary care clinicians to identify patients who may benefit from rehabilitation. Rehabilitation aims to improve muscle and nerve function through a range of interventions including: • Facial exercises • Biofeedback • Massage and myofascial release • Electrical stimulation • Acupuncture The seventh cranial (facial) nerve is largely motor in function, controlling the movement of facial muscles[1]. There are also some special sensory functions including fibres which control salivation and the conveyance of taste from the anterior two thirds of the tongue[1]. Facial nerve palsy refers to partial or complete weakness of the facial muscles arising from temporary or permanent damage to the facial nerve[1]. This damage can prevent the facial muscles from receiving the necessary impulses to function correctly and result in paralysis[1]. The degree of paralysis varies according to the extent of the damage to the facial nerve; ranging from partial to complete paralysis, typically occurring unilaterally but in some rare cases occurring bilaterally[1]. In addition to paralysis, patients may also experience hemi-facial spasm, contracture or synkinesis, reduced production of saliva and tears and inability to close the eye. The loss of function and aesthetic changes can result in both physical and mental health issues. Physical health issues arising from the damage to the facial nerve may include difficulty blinking and eye closure (leading to increased risk of damage

	to the eye), difficulty eating and swallowing, and dysarthia[1]. Further details of damage to the facial nerve are included in Appendix 1, which also describes the House Brackmann scale that is used for grading the severity of facial nerve palsy[2]. The most common cause of facial nerve palsy is Bell's palsy, which accounts for around 75% of all cases of facial nerve palsy[3]. The causes of Bell's palsy are not fully understood, although there is increasing evidence suggesting that the main cause of Bell's palsy is reactivation of latent herpes simplex virus 1 in the cranial nerve ganglia[4]. Incidence of Bell's palsy varies and is estimated to be between 11.5-40.2 cases per 100,000 population[4]. There are peaks of incidence in the 30-50 years and the 60-70 years age group, with pregnant women and people with diabetes mellitus also more likely to be affected[4,5]. Although the majority of patients will recover without treatment, around 23% of people will be left with moderate to severe symptoms[2]. Other diagnoses of facial nerve palsy depend on the identification of an attributed cause and are rare[5]. These include trauma, iatrogenic injuries during surgical procedures, tumours (most commonly acoustic neuroma, facial neuroma and tumours of the parotid gland) and inflammatory causes such as Ramsay Hunt syndrome and Lyme's disease[3,5].
2.2	The scope of this policy includes requests for physical therapy rehabilitation services following damage to the facial nerve resulting in a loss of function.
2.3	The scope of this policy does not include purely cosmetic rehabilitation. The policy also does not include rehabilitation from facial nerve paralysis resulting from a complete transection of the facial nerve.
2.4	The CCG recognises that a patient may have certain features, such as • Having experienced damage to the facial nerve; • Wishing to have NHS funded physical therapy to improve and restore function of the facial nerve and muscles; • Have been advised that they are clinically suitable for physical therapy, and • Be distressed by the facial nerve damage and by the fact that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
3	**Appropriate Healthcare**
3.1	The purpose of physical therapy is to improve and/or restore function of facial muscles. Damage to the facial nerve leading to a loss of functional capacity is a health problem and the consequences can be severe and can manifest in a variety of forms. Therefore, the CCG regards services to address the functional consequences of facial nerve damage as according to the Principle of Appropriateness. However, when the problem associated with facial nerve

	damage is predominantly cosmetic or aesthetic, the CCG would regard services to address it as not according with the Principle of Appropriateness.
3.2	This policy relies on the criterion of appropriateness in that the CCG considers damage to the facial nerve with a House Brackmann grade of three or lower to be predominantly cosmetic or aesthetic, with the exception of grade three where there is weakness of eyelid closure such that corneal damage is likely. Therefore, treatment for such a condition does not otherwise accord with the criteria for appropriateness in the Statement of Principles.
3.3	If a patient is considered exceptional in relation to the criteria that rely on other Principles, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.
3.4	The CCG considers that physical therapy to improve and/or restore function of facial muscles falls within the category of services that are appropriate for commissioning. This is because the intended outcome is to preserve life, prevent or relieve pain, disability or physical discomfort, directly address the distress or disability associated with a diagnosed mental health condition or maintain dignity at the time of death.
3.5	In a case where damage to the facial nerve has resulted in a House Brackmann score of six, it is possible that there may have been a complete transection of the facial nerve and this should be assessed. In such a case, there would be no capacity to benefit from physical therapy rehabilitation.
4	**Effective Healthcare**
4.1	A high quality (Cochrane) systematic review forms the basis of the evidence used to determine effective healthcare[4]. The details of the effectiveness of physical therapy rehabilitation interventions are included in Appendix 2. The following statements summarise the conclusions of the systematic review, regarding the effectiveness and safety of interventions. • There is no high quality evidence to support significant benefit or harm from any physical therapy for idiopathic facial paralysis. • There is low quality evidence that tailored facial exercises can help to improve facial function, mainly for people with moderate paralysis and chronic cases. • There is low quality evidence that facial exercise reduces recovery time and consequences in acute cases. • There is insufficient evidence to determine the effectiveness of electrical stimulation or to identify risks of these treatments. • There is insufficient evidence to determine the effectiveness of massage and myofascial release.

	• There is insufficient evidence to support the addition of acupuncture to facial exercises or other physical therapy.
4.2	This policy therefore only considers tailored exercises to be effective healthcare for rehabilitation after damage to the facial nerve. This service will be provided for patients meeting the criteria set in 3.2 and 3.5 and: A) where the cause is Bell's palsy, it must have been present for a minimum of 12 months, prior to which the standard NHS pathway of care should be followed; or B) where the cause is not Bell's palsy, there will be no minimum duration of condition.
4.3	There is no consensus for the optimal duration of therapist-led tailored exercises, although the studies included in the systematic review provided weekly sessions for 12 weeks. This policy recommends that a regimen of 12 weeks duration be provided, as 12 weeks was the initial period of follow-up for outcome measurements in the two studies with long-term follow-up[6,7].
5	**Cost Effectiveness**
5.1	Where appropriate and effective, the CCG does not challenge the cost effectiveness of facial nerve rehabilitation. This policy does not rely on the principle of value for money, and therefore the issue of value for money has not been considered in developing the policy. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to represent value for money in this patient before confirming a decision to provide funding.
6	**Ethics**
6.1	This policy does not rely on the principle of ethics, and therefore the issue of ethics of facial nerve rehabilitation has not been considered in developing the policy. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
7	**Affordability**
7.1	This policy does not rely on the principle of affordability, and therefore the issue of affordability of facial nerve rehabilitation has not been considered in developing the policy. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise affordability concerns in this patient before confirming a decision to provide funding.
8	**Policy**
8.1	The CCG will commission physical therapy rehabilitation (consisting of tailored facial exercises only) for facial nerve damage in the following circumstances:

	• Criterion A: Cases reported with a House Brackmann grade of four or above or of a grade three but with weakness of eyelid closure such that cornea damage is likely AND; • Criterion B: In cases reported as House Brackmann grade six, the facial nerve is confirmed as intact by electromyography (EMG) AND; • Criterion C: Where Bell's palsy is the cause, the condition has been present for a minimum of 12 months. Or, when exceptionality has been demonstrated in accordance with section 9 below.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies (Lancashire Clinical Commissioning Groups Policy Number 3).
10	**Force**
10.1	This policy remains in force until it is superseded by a revised policy.
11	**References**
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12	**Appendices**
12.1	**Appendix 1: Background on damage to the facial nerve and the House Brackmann grading scale.** There are different methodologies available to assess and describe the extent of the facial nerve damage. These include indirect measures which are used

to grade the extent of the resulting paralysis and direct methods which measure the electrical activity in the facial nerve.

In terms of indirect methods, the most widely used system of grading is the House Brackmann Scale, which assigns patients to one of six categories on the basis of facial function (Table 1)[2]. Patients with grades one to three would not typically be considered to have experienced a loss of function, unless there is grade three but with weakness of eyelid closure such that cornea damage is likely. In these instances, the condition would be more likely to be considered as an aesthetic issue.

At the other end of the House Brackmann scale, in the most severe cases (grade six), it is possible that there may have been a complete transection of the facial nerve. In such a case, there would be no capacity to benefit from physical therapy rehabilitation. However, in some grade six cases the facial nerve may remain intact. In such cases the patient could benefit from physical therapy rehabilitation. Therefore, in grade six cases it may be necessary to use electromyography (EMG) to determine the status of the facial nerve using direct measures.

Table 1. House Brackmann facial nerve grading scale

Grade	Description	Characteristics
I	**Normal**	Normal facial function in all areas
II	**Slight Dysfunction**	**Gross:** slight weakness noticeable on close inspection; may have very slight synkinesis. **At rest:** normal symmetry and tone. **Motion:** forehead - moderate to good function; eye - complete closure with minimum effort; mouth - slight asymmetry.
III	**Moderate Dysfunction**	**Gross:** obvious but not disfiguring difference between two sides; noticeable but not severe synkinesis, contracture, and/or hemi-facial spasm. **At rest:** normal symmetry and tone. **Motion:** forehead - slight to moderate movement; eye - complete closure with effort; mouth - slightly weak with maximum effort.
IV	**Moderate Severe Dysfunction**	**Gross:** obvious weakness and/or disfiguring asymmetry. **At rest:** normal symmetry and tone. **Motion:** forehead - none; eye - incomplete closure; mouth - asymmetric with maximum effort.
V	**Severe Dysfunction**	**Gross:** only barely perceptible motion. **At rest:** asymmetry. **Motion:** forehead - none; eye - incomplete closure; mouth - slight movement.
VI	**Total Paralysis**	No movement.

Direct measurement of facial nerve activity is completed using EMG. EMGs are used to detect muscle activation in the selected areas of the face to indicate the extent of nerve activity in each nerve branch of the face when

	performing or attempting to perform specific movements or expressions. EMGs can be completed using either needle or surface electrodes.
12.2	**Appendix 2: Evidence summary: physical therapy for rehabilitation after damage to the facial nerve.** A recent systematic review of the efficacy of physical therapy strategies and devices for idiopathic facial paralysis provides the foundation of the evidence used in this policy[4]. A total of twelve studies met the inclusion criteria for the review (a total of 872 participants). Of these: • four trials studied the efficacy of electrical stimulation (313 participants)[8-11]; • three trials studied exercises (199 participants)[6,7,12]; • five studies compared or combined some form of physical therapy with acupuncture (360 participants)[13-16]. It was not possible to perform meta-analysis for most outcomes because the interventions and outcomes were not comparable. There is evidence from a single study of moderate quality that exercises are beneficial to people with chronic facial palsy when compared with controls and from another low quality study that it is possible that facial exercises could help to reduce synkinesis, and the time to recover[6,7]. Furthermore, there is low quality evidence from a single study that facial exercises reduce sequelae in acute cases[12]. There is insufficient evidence to decide whether electrical stimulation works, to identify risks of these treatments or to assess whether the addition of acupuncture to facial exercises or other physical therapy could produce improvement[8-11,13,17]. There have been no good quality and/or experimental studies on physical therapy strategies for facial nerve paralysis published after the search period of the systematic review.
12.3	**Codes** The codes applicable to this policy are:

OPCS codes	ICD codes
A304, U531, Z041	G51, G51.8, G51.9

Date of adoption
Date for review