Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 05 March 2020, 13:00-15:00,
Padiham Town Hall, 83 Burnley Rd, Padiham, Burnley, BB12 8BL

AGENDA

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

Time	Item	Description	Owner	Action	Format
Standing Items					
13:00	1.	Welcome and apologies	Chair	Information	Verbal
	2.	Declarations of interests	Chair	Information	Attached
	3.	Notes of the meeting held on 09 January 2020	Chair (to follow)	Approval	Attached
	4.	Items for any other business/ Update action tracker	Chair	Information	Verbal
Improving Population Health					
	5.	IPA CHC Business Case	J Hawker	Decision	Attached
	6.	Planned Care	A Harrison	Decision	Attached
	7.	Commissioning Policies • Policy for Extracorporeal Shock Wave Therapy for the treatment of Tendinopathies • Policy for Assisted Conception Services • Policy for Breast Implant Removal and Replacement • Policy for Complementary and Alternative Therapies.	R Higgs (to follow)	 Endorse Endorse Endorse Endorse	 Attached Attached Attached Attached
	8.	Work Programme – 2020/21	A Bennett	Approve	Attached
	9.	Learning Disability Services	P Tinson	Information	Presentation
	10.	Medicine Management Policies • Agomelatine for the treatment of major depressive episodes in adults. • NICE Technology Appraisals (December 2019 and January 2020). • Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome. • Melatonin (Colonis tablets and liquid) for all indications. • Nortriptyline for chronic neuropathic pain. • Octreotide and lanreotide in	B Horrell	 Endorse Endorse Endorse Endorse Endorse	 Attached Attached Attached Attached Attached

		secretory gastrointestinal disorders. • Octreotide and lanreotide in orthostatic intolerance disorders. • Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis.		Endorse Endorse	Attached Attached
Any Other Business					
14:55	10.	Any other business	Chair	Information	Verbal
Date and time of next meeting: Thursday 07 May 2020, 13:00-15:00, **Venue to be confirmed** Dates of future meetings: 02 July 2020 03 September 2020 05 November 2020					

Declaration of Interests for members of the Joint Committee of CCGs

Introduction

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

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

Process

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

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

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and

Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defense organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE);
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend;

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

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

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

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

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

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

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

JCCCG Meeting
05 March 2020 13:00 – 15:00

Title of Paper	BUSINESS CASE Transforming the Commissioning & Operational delivery of Individual Patient Activity (IPA) services		
Date of Meeting	5th March 2020	Agenda Item	05

Lead Author	Jerry Hawker – Chair Lancashire & South Cumbria IPA Programme Board & Chief Officer Morecambe Bay CCG	
Contributors	Margaret Williams, Jackie Hadwen	
Purpose of the Report	Please tick as appropriate	
	For Information	X
	For Discussion	
	For Decision	
Executive Summary	This paper concludes 9 months of work by the Lancashire & South Cumbria IPA Programme Board to produce a business case setting out the proposed transformation of the commissioning and operational delivery of Individual Patient Activity (IPA) services. The business case sets-out an ambition to transform the way we work, supporting individuals presenting with health and social care needs to access the most appropriate care. Our ambition is to match the very best approaches in England, but goes beyond a traditional commissioning structure to fully embrace a proactive whole system approach. The business case proposes to replace the fragmented multiagency approach with a single Lancashire & South Cumbria IPA business unit which will bring together the economies of scale of a strategic hub together with 5 locality teams ensuring patient facing decision making via neighbourhood teams drives a more proactive approach to managing complex and deteriorating care that unnecessarily result in people inappropriately accessing care via IPA. The Business Case presents a radical change in the way Individual Patient Activity services should be commissioned and operational delivered in the future. The required recurrent investment of £796,000 /annum is essential to meeting the challenges set out in the case for change and delivering the following key benefits: • Fundamentally improve the experience and outcomes for patients and families that access IPA services. • Ensure that Lancashire & South Cumbria delivers services that fully comply with legislative responsibilities and meets the National quality	

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	standards • Significantly improves assurance around leadership, operational delivery, provider management and effective financial management. • Progresses a phased approach towards a fully integrated health and care model.		
Recommendations	*This is a level 2 Decision under the JCCCG Terms of Reference.* The Committee is asked to: 1. Support the proposals set-out in the business case 2. Support a recommendation that the business case is submitted to each CCG Governing Body for approval, enabling progress to mobilisation in 2020/21.		
Next Steps	Approval of the business case by each CCG Governing Body		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		
If Yes : Risk	• Failure to provide an acceptable standard of care to the population of Lancashire & South Cumbria. • Non-compliance with NHS CHC Framework		
Report Authorised by:	Jerry Hawker		

Healthier Lancashire & South Cumbria

BUSINESS CASE

Transforming the Commissioning & Operational delivery of Individual Patient Activity (IPA)

February 2020

Version 4.0

Contents

Glossary of Terms

Term or Acronym	Description
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
FNC	Funded Nursing Care
ICP	Integrated Care Place
ICS	Integrated Care System

MCP	Multi-Specialty Community Provider
MDT	Multi-Disciplinary Team
LA	Local Authority
LSC	Lancashire and South Cumbria
Overdue Reviews	Reviews that are outstanding beyond 3months for new CHC cases and 12 months annually thereafter
POC	Package of Care
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Our Vision

1.1.1 Individual Patient Activity (IPA) is an umbrella term for the commissioning and operation delivery and support of a defined package of care to a named individual. Across Lancashire & South Cumbria over 6600 people accessed a package of care under IPA with total expenditure close to £200 million / year. The package of care is specific to that individual and may range from a single episode of care through to the provision of a long term complex care package for some of the most vulnerable individuals, frequently with the highest levels of need within the care system.

1.1.2 This business case sets-out an ambition to transform the way we work, supporting individuals presenting with health and social care needs to access the most appropriate care. Individuals and families will be better supported in their decision making and care across all IPA services. These may include arrangements via Continuing Health Care, Funding Nursing Care, End of life Fast Track, Children Continuing Care and 117 After Care. Our ambition is to match the very best approaches in England, but goes beyond a traditional commissioning structure to fully embrace a proactive whole system approach. Our vision is based firmly on developing the future strengths of local decision making via neighbourhood teams to drive a more proactive approach to managing complex and deteriorating care that unnecessarily result in people inappropriately accessing care via IPA.

1.1.3 We will work in a way that improves leadership and accountability, improves our financial management and commercial relationship with the care market as critical partners. Agency boundaries with be removed and we will address the broader issues that are vitally important to individuals and families including whether or not an individual will remain at home to receive their care, access a supported living arrangement or make a decision that it is best for an individual to live and be cared for in a care home environment.

1.1.4 The vision is for each care assessment to enhance an individual's quality of life, promote their inclusion and that of their family and wider community. The Service vision recognizes the need to respond to the needs of an individual as an important underpinning concept of personalisation and the development of a responsive service that is truly patient-centred.

1.2 The Case for Change

1.2.1 The JCCCG has acknowledged that the current level of Individual Patient Activity services provided across Lancashire and South Cumbria (with the exception of Blackpool) is providing standards of care that fall well below an acceptable standard and should be of concern to all CCG Governing Bodies.

1.2.2 A 2018 independent review highlighted 7 specific thematic areas where sustained improvement was required. The thematic review highlighted key failings in the governance arrangements, poor leadership within both commissioning and operational delivery, fragmented services leading to poor patient experience and poor delivery against National standards.

1.2.3 The Case for Change is set-out in section 3 and expands and reinforces the key messages shared with the JCCCG in previous papers. These can be summarized as:

- The current commissioning & operational delivery model is highly fragmented, delivered by multiple commissioners and providers leading to poor system leadership, a lack of appropriate commercial due diligence, and an unstable and unsustainable delivery model resulting in a poor quality & underperforming service.
- Lancashire & South Cumbria is a national outlier with a consistent failure to meet National quality targets and performance leading to heightened regulatory scrutiny.
- There is significant and unwarranted variation across the IPA service.
- There is a failure to act in accordance with some statutory responsibilities particularly in regard to overdue reviews.
- IPA services are extensively reliant on the care sector, yet there is no systematic approach to developing and supporting the market. This has directly impacted commercial management, financial control and patient experience.
- The current service model has been significantly under resourced (excluding Blackpool CCG) for a sustained period of years and has had a direct impact on patient care.

1.3 A Transformed Model of Care

1.3.1 The business case proposes to replace the fragmented multiagency approach with a single Lancashire & South Cumbria IPA business unit bringing together the economies of scale of a strategic hub together with 5 place based delivery team. All financial, commercial and operational responsibilities will be delegated to the business unit. The business unit will have an appointed executive officer accountable either to the Joint Committee or to any successor organisation. The IPA Programme board will be reconstituted to continue to provide system oversight with a particular focus on progressing integration with local authorities.

1.3.2 The model of care has been developed using a broad range of resources and expertise including; the NHS maturity matrix, best practice models from across England, and the skills, knowledge and expertise of those who work locally within IPA from both a health and care perspective.

1.3.3 The Hub will bring together expertise from within CCGs and Midlands & Lancashire CSU to create a single leadership team with expertise in commercial and financial management, provider market management, quality and patient & family experience. It will also include senior operational leadership supporting care delivery in each ICP footprint.

1.3.4 The five spokes in each place location will provide the direct patient facing services and will over time become embedded as part of each ICP's neighbourhood teams. The current multi-provider delivery model will be replaced by a single operational management structure. The development of the five spokes represents the most critical initial investment to bring patient facing services up to a minimum standard.

1.4 Resource Impact (Finance and People)

1.4.1 It is anticipated that resourcing (staff & finance) of the hub will be achieved through appropriate redeployment from CCG's and MLCSU. Subject to the approval of the business case, this will need to be reviewed during mobilisation.

1.4.2 The IPA programme board has used national benchmarking evidence and worked closely with NHS England's Nation Strategic Improvement team to model the required operational staffing levels in each locality. The business case sets-out a strong rationale for investment based on available evidence and prolonged system poor performance. Specific roles are set out in section 4.5.3

1.4.3 Although the NHSE CHC resource tool projects an IPA service cost significantly in access of £5 per head of population (similar to Blackpool CCG), the business case proposes a more conservative approach based on phased investment. This is based on recognised challenges in recruitment, the potential for redeployment from community providers and the expected productivity gains from the business unit approach. **The business case therefore seeks approval from CCG's for an initial recurrent investment of £796,000 annum.**

1.4.4 Analysis of per capita spend on IPA services shows significant variation between CCGs both in terms of investment in service provision and in terms of the total packages of care. Evidence shows there is no clear current link between the levels of investment in the service provision with the total cost of packages. This is due to multiple factors driving the costs of care including variability in application of eligibility criteria, level of use of fast track packages, and market forces factor. There is however a direct correlation between the level of investment in the service provision and the delivery of the national quality standards. **A key responsibility of the business unit will be to significantly improve the current level of financial and commercial management.**

1.5 Benefits Realisation

1.5.1 The Business Case presents a radical change in the way Individual Patient Activity services should be commissioned and operational delivered in the future. However the proposed approach is based on sound National evidence draws on best practice models and more innovatively, places significant focus on a more holistic approach to complex care linked to the ICS aspirations for neighbourhood working.

1.5.2 Approval of the business case will: -

- Fundamentally improve the experience and outcomes for patients and families that access IPA services.
- Within 6 months eliminate all incomplete referrals.
- Within 6 months expand capability to provide Personal Health Budgets (PHB's)
- Within 6 months provide a single point of access.
- Within 12 months complete overdue reviews (previous approved business case)
- Within 12 months enable full implement and operationalise the business model
- Within 12 months significantly improved assurance around leadership, operational delivery, provider management and effective financial management.
- Within 18 months deliver all National quality standards.

- Within 24 months progress to implement a fully integrated health and care model.

2 Introduction & Background

2.1 Individual Patient Activity (IPA)

2.1.1 IPA is an umbrella term for the commissioning and operation delivery and support of a defined package of care to a named individual. Across Lancashire & South Cumbria over 6600 people accessed a package of care under IPA. The package of care is specific to that individual and may range from a single episode of care through to the provision of a long term complex care package for some of the most vulnerable individuals, frequently with the highest levels of need within the care system.

2.1.2 Individual packages of care are provide to people and patients across all demographics (from Children to older people) and across the broadest spectrum of care needs covering physical and mental health, long term conditions, complex care and end of life.

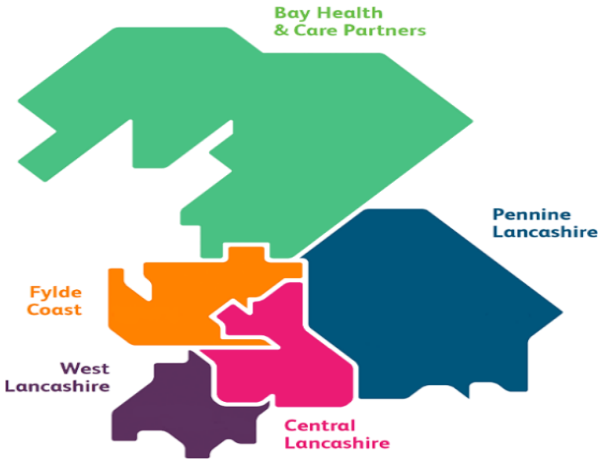
2.1.3 Patients, families and carers often access IPA services when things are in crisis and when normal routine services have been exhausted or do not meet the individual's specific needs.

2.1.4 Commissioning and operational delivery of all IPA services across Lancashire & South Cumbria includes the following services

- NHS Continuing Health Care
- NHS Funded Nursing Care
- Personal Health Budgets
- Fast Track Applications (CHC, FNC,PHB)
- Complex Packages of Care
- Individual Funding Requests

2.2 Lancashire and South Cumbria

2.2.1 The Lancashire and South Cumbria region is diverse, with areas of differing geographies and local challenges. The region has a population of 1.7 million and consists of five local areas (Central Lancashire, West Lancashire, Pennine Lancashire, Fylde Coast, and Morecambe Bay).



2.2.2 These areas provide a way for organisations and groups involved in health and care to join up locally and 'Healthier Lancashire and South Cumbria' partners include:

- Clinical Commissioning Groups (CCGs): Greater Preston, Chorley and South Ribble, East Lancashire, West Lancashire, Blackpool, Fylde and Wyre, Morecambe Bay, Blackburn with Darwen;
- Five Acute and Community Trusts: Lancashire Teaching Hospitals NHS Foundation Trust, University Hospitals of Morecambe Bay NHS; Foundation Trust, East Lancashire Hospitals Trust, Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Care NHS Foundation Trust;
- Two upper tier councils (Lancashire and Cumbria) and two unitary councils (Blackpool and Blackburn with Darwen).

2.2.3 As an Integrated Care System (ICS), 'Healthier Lancashire and South Cumbria' is working to invest in health and deliver high quality healthcare within the resources that all the partners have at their disposal. This will drive the health, wellbeing and cohesiveness of all its towns and communities, so that all of the diverse populations have the fairest access to good care and the best possible chance to have healthy fulfilling lives. The ICS priorities are:

- Out of Hospital Care
- Acute and Specialised Care
- Mental Health
- Prevention and Population Health
- Commissioning
- Workforce
- Digital
- Urgent and Emergency

2.2.4 Individual Patient Activity is a thread that runs through all these priorities. It has a direct impact on how well some of the most vulnerable people in Lancashire and South Cumbria are cared for in the community and helps to keep people out of hospital. CHC can have an impact of discharge from hospital and patient flow in an acute setting and in reducing emergency admissions.

2.3 Place Based Commissioning and Prevention

2.3.1 Healthier Lancashire and South Cumbria is focused on a model for health and social care that supports place-based commissioning and prevention. The view is that ccollaboration through place-based systems of care offers the best opportunity for NHS and Care

organisations to tackle the growing challenges that they are faced with. Organisations should work together to govern the common resources available for improving health and care in their area. Naturally this means that major changes to the role of commissioners are needed to support the development of systems of care.

2.3.2 It is envisaged that the new model of care for IPA services will facilitate and support the continued development of place-based commissioning and also population health management at a localised level. The new model of care needs to be able to flex and develop alongside system maturity always making sure it is best placed to operate efficiently whilst maximising benefits for patients.

2.4 The Current Service Model

2.4.1 The current service model for IPA across Lancashire and South Cumbria has evolved from provision in individual Primary Care Trusts to being brought together in 2013 under one NHS provider with the exception of Blackpool CCG who have developed an integrated model with Blackpool Borough Council. In many ways this mix of models has provided an ideal comparator, each to the other and underpins much of the learning evidenced in this business case.

2.4.2 In Blackpool an end to end service is provided to a registered population of approximately 170,000 people. A team of approximately 16 staff provide this service at a cost of £960k (2019/20 figures) and the service is regarded as high performing by both NHSE and patients. The IPA service in Blackpool has worked hard to be at the vanguard of Personal Health Budget development and at the forefront of IPA development. The service across the rest of Lancashire and South Cumbria is provided primarily but not exclusively by Midlands and Lancashire Commissioning Support Unit (MLCSU). The MLCSU service has approximately 100 staff providing a service at a cost of £4.8m. It should be noted though, that this is not a like for like comparison, more a statement of fact as each service works differently. In addition there are a wide range of community services involved in the IPA pathway alongside MLCSU provision operating under block contracts.

2.4.3 The MLCSU service provides a service to a population of 1.6 million and currently operates with four locality teams, South Cumbria, Pennine, North and Central supported by centralised 'back office' functions. Some of MLCSU back office functions are 'at scale' within the CSU and cover a wider geographical area than Lancashire and South Cumbria.

2.4.4 IPA performance specifically CHC performance across Lancashire and South Cumbria is variable but as a whole the region is one of the worst performing in the country against a wide range of indicators. This is not due to a single or even a single set of issues, it is a highly complex and dynamic service impacted by many of the 'expected' things such as staffing availability but also by the 'unexpected' such as the way in which D2A works in each area, some community providers having moved away from providing a service and stating that they are not commissioned, changes to provision for mental health, learning disability and social care services. In addition, the knowledge of professionals across the system as to exactly who is commissioned to do what seems to have been eroded.

The current position is mapped out at Appendix C and indicates that there are six different providers directly engaged directly in the provision of CHC across Lancashire and South Cumbria. A map of IPA providers is not available due to being multifaceted and complex in nature

2.5 Demographics and Demand

2.5.1 Based on CHC demand over the next 25 years the population of Lancashire is projected to increase by 4.5%. By 2039, people aged 85 and over will make up 5.5% of the Lancashire population – around 69,000 people in Lancashire. This is an increase of 135% compared with 2014[1]. South Cumbria forms part of Cumbria County Council and the JSNA indicates a similar pattern of population growth and by 2041 it is projected that the population over 65 years of age living in Cumbria will have increased by 32.4% compared with 2016[2]. This pattern of underlying growth in population but with significantly more people over the age of 65 and living longer over 85 years of age has substantial implications for health and social care budgets in the future.

2.5.2 Consequently the demand for and costs associated CHC can be expected to rise. The current CHC caseload across Lancashire and South Cumbria where individuals are in receipt of NHS funding for standard CHC, fast track CHC or Funded Nursing Care, FNC is 4473 cases, 84% of people within this caseload are over the age of 65. The demographic impact at scale is significant and by 2023 is projected to mean that there is a projected demand for a further 236 cases[3].

Blackpool CCG Demographic Impact on Caseload	Caseload @Oct 2019	Variance 2020 to 2023	Projected Caseload Impact 2023
Under 65 years	87	-0.93%	-1
Over 65 years	459	3.83%	18
Total	**546**	**3.08%**	**17**

Rest of LSC CCGs Demographic Impact on Caseload	Caseload @Oct 2019	Variance 2020 to 2023	Projected Caseload Impact 2023
Under 65 years	619	-0.34%	-2
Over 65 years	3,308	6.69%	221
Total	**3,927**	**5.58%**	**219**

Total LSC System Demographic Impact on Caseload	Caseload @Oct 2019	Variance 2020 to 2023	Projected Caseload Impact 2023
Under 65 years	706	-0.42%	-3
Over 65 years	3,767	6.34%	239
Total	**4,473**	**5.27%**	**236**

[1] JSNA Lancashire Annual Commentary 2017/18 (Lancashire County Council)

[2] JSNA Cumbria County Council (Cumbria Health Observatory)

[3] ONS Population Projections

NB: excludes Section 117 after care, children's continuing care and joint funded complex cases.

2.5.3 The table below applies the current average costs of packages of care to the demographic increase in number of cases and demonstrates a potential cost pressure of over £6m associated with the demographic impact of the projected increase in the age of people over 65 years of age by 2023.

Type	Current Caseload Blackpool	Average £ per POC Annum*	Demographic Impact	Case Increase	Potental Cost Increase £
CHC	288	£54,885	3.08%	9	£486,852
Fast Track	45	£37,836	3.08%	1	£52,440
FNC	213	£8,614	3.08%	7	£56,513
Total	**546**			**17**	**£595,805**

Type	Current Caseload MLCSU	Average £ per POC Annum*	Demographic Impact	Case Increase	Potental Cost Increase £
CHC	1149	£54,885	5.58%	64	£3,518,905
Fast Track	620	£37,836	5.58%	35	£1,308,965
FNC	2158	£8,614	5.58%	120	£1,037,305
Total	**3927**			**219**	**£5,865,175**

* Costs are MLCSU current average per package type

2.5.4 It is not sustainable for the projected growth in demand and cost to remain unchallenged by continuing to work in the same way. Part of what any new service model must do is at least offset the financial impact of increases in package costs associated with growth by operating in an efficient way and working better with universal NHS services to prevent or delay the need for CHC or FNC altogether.

3 Case for Change

3.1 Case for Change Introduction

3.1.1 In November 2018 Julie Haywood Consulting presented a stocktake report to the Lancashire & South Cumbria Joint Committee of CCG's on the commissioning, provision and governance of activity and services falling under the collective term of Individual Patient Activity (IPA). The key findings and recommendations are summarised below.

- **Leadership –** *Lack of coherent and consistent intention from the system. No clear executive lead, lack of clear mandate, direction and strategy at ICS, ICP and ICC level.*
- **Relationships –** *Lack of system and organisational transparency and suspicion about motivation. High levels of frustration, system inertia and a view that collaboration is risky.*

- **Governance –** *Established IPA board, but not enough of the wider system engaged. No real accountability or delegated authority to the JCCCG/ICS. No executive leadership and all-encompassing work plan.*

- **Finance –** *Lack of confidence and quality in forecasts, reporting and figures. Lack of clear and consistent commissioning, contracting and financial management. Significant variability in funding levels and approaches. System is focused on total spend and lack of intelligence at each service level. Significant system risk of incentivising cost shunting. Available financial, performance and quality information on IFR appears to be missing.*

- **Operational Model –** *The Health and Social Care System **is not** accessing core services as it should. This leads to unacceptable delays in assessment of care need. There is a lack of grip, traction and long term commitment to improvement and reform. Lack of consistent operating model, lack of understanding agreement of how model will work across ICS/ICP/ICC. Variability and inconsistent funding and delivery model across the CCGs.*

In addition to the thematic areas above identified in the initial paper the following thematic areas needed to be considered within the case for change

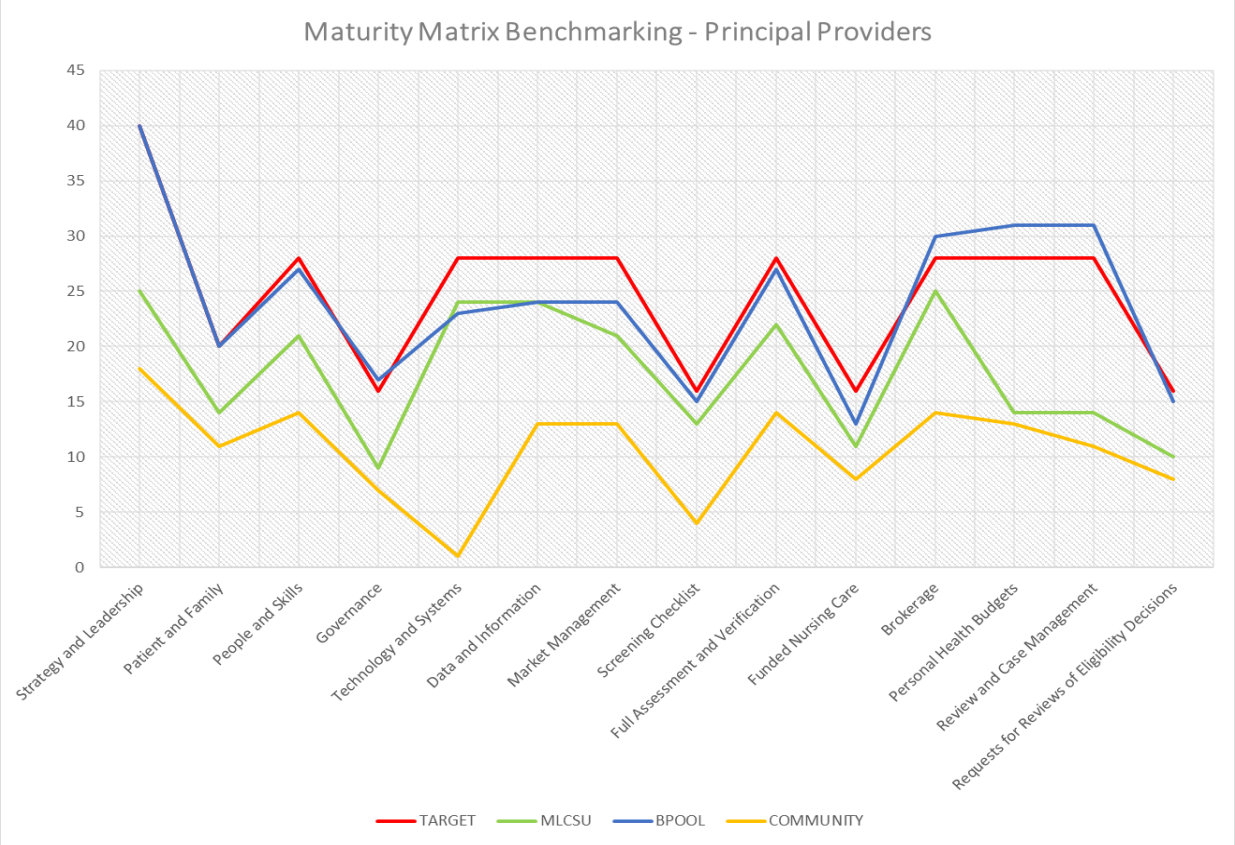
- **Access & Quality variability –** *There is significant variability in referral rates, eligibility rates, and conversion rates. Significant delays in reviews represent poor patient care. High levels of complaint represent poor patient and carer experience.*

- **Performance –** *Across Lancashire & South Cumbria there is a significant level of poor performance and variability against National KPI's, Access standards, and Quality Indicators. Improvement must be linked to the operating model.*

3.2 Gap Analysis

3.2.1 Using the National SIP CHC Maturity Matrix members of the Delivery Group were able to undertake a broad assessment of current service provision. This assessment tool takes the dimensions in the CHC SIP Maturity Matrix and provides a snapshot of system maturity against the key lines of enquiry (KLOE) within it at a set point in time. Fifteen of the dimensions are fully scoped in terms of key statements indicating maturity progression. The matrix can therefore be used to track service improvement progress. Each dimension has within it a number of key lines of enquiry ranging in number from 4 to 9 and for each line there are a set of statements ranked Initial, Developing, Progressing, Advanced and Leading as shown in the example below.

3.2.3 The IPA Delivery Group undertook a gap analysis against the national maturity matrix the outcome of which is demonstrated below. The outputs informed us that the Blackpool CCG model of delivery is very close to or at target whilst others have some distance to close the maturity gap. The benchmarking work indicated that it would make no sense to curtail development of the Blackpool model but rather the aim should be to bring the rest of the system up to a similar level. Most importantly the tool also demonstrated where development needs to be targeted and in which key area's the current providers and commissioners across the system can work together and learn from each other to close gaps and mature the service. There are parts of the Blackpool model that may not be scalable across the rest of Lancashire and South Cumbria and there may also be merit in looking to the rest system to help with resilience of the Blackpool model through stronger management and system links.



3.2.4 In summary assessment of current commissioning and provision against the maturity matrix dimensions indicate that Lancashire and South Cumbria mostly operate a model of care that is either immature or at best trying to progress, this informed the developments for the future delivery model. Lancashire and South Cumbria IPA service provision currently lack:-

- An end to end service model.
- A core service components/specification.
- A system approach to staff development and training.
- A system approach to CHC funding, budgets, QIPP.
- A system performance management framework.
- A system digitisation strategy including interoperability.
- A system SOPs (Standard Operating Process).

3.2.5 Significant gaps that are dimension specific include:

- Strategic commissioning plan for IPA Market Management.
- End to end service that includes personalisation
- Business planning and prioritisation.
- Individual, family support and engagement.

3.3 Budgetary Control and QIPP

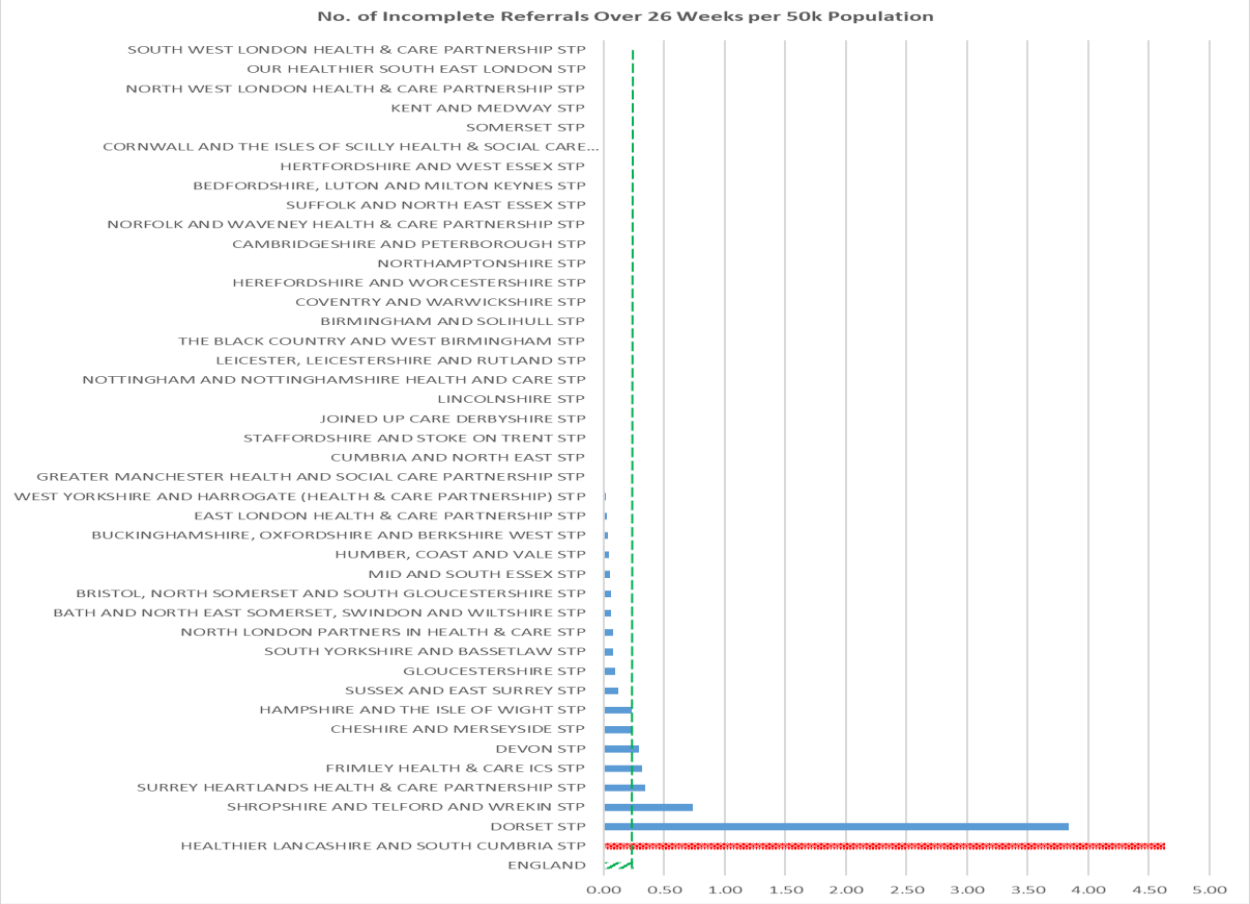
3.3.1 The gap analysis indicates that clear and agreed budgetary controls including QIPP are a feature of mature IPA delivery. Pooled budgets, risk sharing and delegated authority are all features. At present there is significant variation in the costs of delivery by CCG per head of population and also in the costs of packages of care. Budgets and QIPP are managed independently by each CCG.

3.4 Performance Management

3.4.1 Incomplete Referrals- CHC

3.4.1.1 For CHC incomplete referrals Healthier Lancashire and South Cumbria is the second worst STP/ICS in the country for the number of incomplete referrals. As a system Lancashire and South Cumbria have over 90% of the incomplete referrals in the North of England and almost 56% nationally. Incomplete referrals are those referrals for CHC assessment which have not been assessed within 28 days. The ICS IPA programme is addressing this issue in conjunction with both CCGs, Local Authorities and providers but it is indicative of a myriad of issues as a root cause including, fragmented provision, growth and provider capacity.

Snapshot - National CHC Data end of Q2 2019/20 (Reported 19/11/19)		Number of Incomplete Referrals Exceeding 28 days (Standard NHS CHC (non Fast Track))											
		Up to 2 weeks		Above 2 and up to 4 weeks		Above 4 and up to 12 weeks		Above 12 and up to 26 weeks		Over 26 weeks		Total	
Code	Organisation	Total	Per 50k	Total	Per 50k	Total	Per 50k	Total	Per 50k	Total	Per 50k	Total	Per 50k
E1	ENGLAND	397	0.41	277	0.29	478	0.50	212	0.22	237	0.25	1,601	1.67
QE1	HEALTHIER LANCASHIRE AND SOUTH CUMBRIA STP	26	0.91	34	1.19	59	2.07	56	1.97	132	4.64	307	10.78
QOP	GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP STP	15	0.31	7	0.14	22	0.45	4	0.08	0	0.00	48	0.99
QYG	CHESHIRE AND MERSEYSIDE STP	22	0.51	14	0.33	15	0.35	11	0.26	10	0.23	72	1.68
QWO	WEST YORKSHIRE AND HARROGATE (HEALTH & CARE PARTNERSHIP) STP	35	0.81	26	0.60	15	0.35	1	0.02	1	0.02	78	1.81
QOQ	HUMBER, COAST AND VALE STP	5	0.21	6	0.26	30	1.28	11	0.47	1	0.04	53	2.27
QF7	SOUTH YORKSHIRE AND BASSETLAW STP	15	0.59	6	0.24	10	0.39	2	0.08	2	0.08	35	1.38
QHM	CUMBRIA AND NORTH EAST STP	29	0.55	11	0.21	2	0.04	0	0.00	0	0.00	42	0.80
North STP/ICS Total		147		104		153		85		146		635	
HL&SC % of North Total		17.69%		32.69%		38.56%		65.88%		90.41%		48.35%	
HL&SC % of England Total		6.55%		12.27%		12.34%		26.42%		55.70%		19.18%	



3.4.2 Overdue Reviews- CHC, FNC, Fast Track

3.4.2.1 The NHS CHC Framework requires that all individuals receiving CHC/FNC are required to have a review of their care to check that the care package in place still continues to meet their care requirements and to ensure that any changes are made and approved as necessary. In Lancashire and South Cumbria as at January 2020 there are approximately 3,800 reviews outstanding of which over 2,800 are overdue. This includes individuals receiving packages of care after they have met assessment criteria for fast track, funding nursing care and standard CHC. The overdue review issue issues date back to 2013 when

approximately 2000 overdue reviews were transferred to MLCSU from Primary Care Trusts without commensurate resource to address. It is a legacy issue that needs to be addressed prior to any new model of care being established.

3.4.2.2 Reviews are critical to ensuring patients receive the right care in the right place at the right time. Lancashire and South Cumbria ICS current has the worst performance in the North of England against the National NHS Continuing Healthcare Activity Assurance Framework. Clinical Commissioning Groups (CCGs) have a statutory responsibility to ensure that reviews are undertaken in accordance with the Continuing Health Care Framework 2018.

3.4.2.3 Current capacity in the CHC service across all providers is only sufficient to maintain a "standstill" position and therefore addressing the overdue reviews is only resolvable through investment in an incremental programme of work combined with action to address the sustainability of the service model as a whole which is being undertaken by the wider IPA programme.

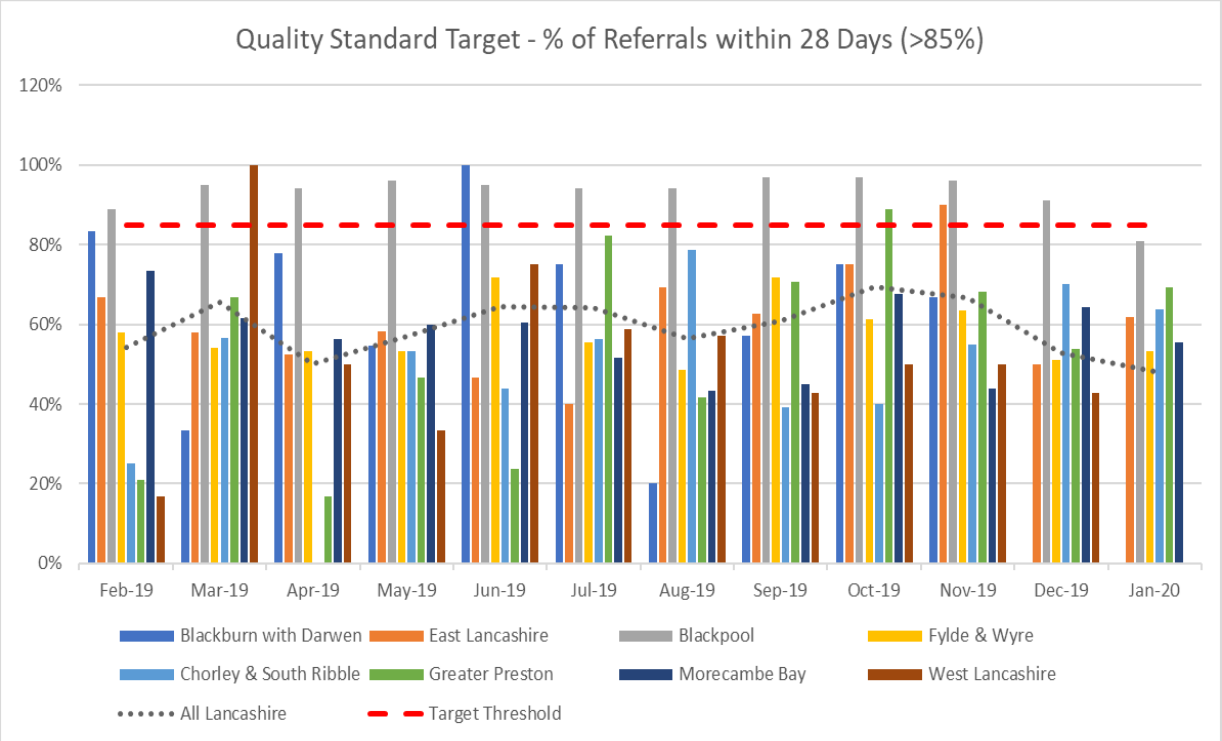
3.4.3 Quality Standard Targets

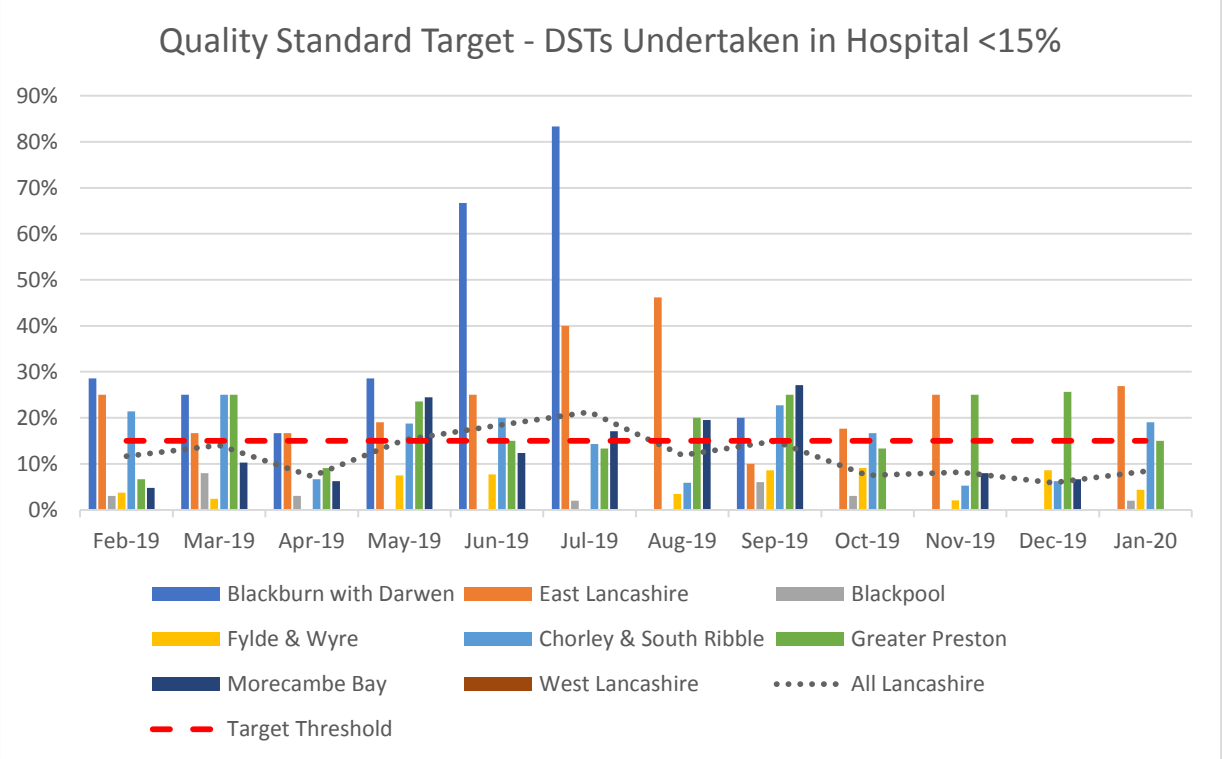
3.4.3.1 There are two key quality standard targets for CHC that the system is measured against. These are:

- A minimum of 85% of referrals screened in to have a decision on eligibility with 28 days
- Less that 15% of Decison Support Tools (DST's) to be undertaken in a hospital setting

3.4.3.2 Lancashire and South Cumbria have held an historical non achievement of this quality standard for many years, the position has been deteriorating over the last 12-18 month this is not an acceptable position and must be addressed. CCGs have recently agreed a performance improvement project to address over 26 week open referral decisions but this will only takes us so far with the move to a new service model required to prevent further deterioration.

3.4.3.3 For the percentage of DST's undertaken in a hospital setting there has been more consistent achievement of the target. However, some geographies have applied different delivery approaches to varying degrees of success, this is currently being reviewed to ensure consistency. The system has to adopt a zero-tolerance strategy in order to maximise achievement of this standard.





3.4.3.4 For the 28 day target CCGs across the system with the exception of Blackpool CCG consistently fail to achieve 85% or above. For DST's undertaken in hospital there has been an improvement which has been sustained from quarter two of 2019. Noticeably it is the two ICPs utilising CHC services/resource directly for D2A pilots that are now consistently breaching this target.

3.5 Personalised Care-

3.5.1 At the heart of personalisation is the aspiration to empower individuals, patients, families to be in control and put decision making, behaviour change and considered choice truly at the hands of the individual. An approach of personalisation that benefits many individuals notably those receiving NHS continuing healthcare, Children with complex care needs, those with mental health issues, those also for example suffering from long-term neurological conditions or chronic obstructive pulmonary disease is a Personal Health Budget (PHB).

3.5.2 A PHB is a process that seeks to marry the expertise of the clinician with the experiential expertise of the individual, patient and family. Its offer promotes patient choice and control by means of self-directed support, allowing individuals to manage budgets and purchase services and equipment according to their own needs and timetable. NHSE studies have established linkage of significant improvements in the quality of life and wellbeing of many individuals who utilise PHBs which in turn improve outcomes that can lead to reduced service use. PHBs put decisions about healthcare management coping and healing strategies firmly into the hands of individuals, patients and families, with appropriate oversight and controls via multi- agency cooperation and integrated approaches evaluations are positive. (2020 health.org 2013)

Example of PHBs in continuing healthcare

3.5.3 For individuals a PHB offers access to alternative care arrangements where care agency provision lacks suitable flexibility or consistency, or is indeed hopelessly inadequate. With a PHB, an individual (or their representative) can employ their own personal assistants (PAs) and exercise control over workloads and timetables. They can make immediate changes to care arrangements if necessary. The PHB also allows for continuity of care, enabling social care PAs to transfer seamlessly across with clients into NHS continuing care.

3.5.4 PHB execution is an integral part of IPA delivery which requires multi-agency cooperation to ensure each PHB is complimented and supported by a referral into core services to optimise improved outcomes. The new model of delivery over time will embed this aspect within its local neighbourhood teams. It is the local teams that support the oversight and continual review of clinical need, this is complimented with the service offer that supports the management of budget and purchasing services or equipment to meet individualised needs.

3.5.5 There are elements of risk that the Business Unit will need to consider and mitigate for, particularly where individuals are taking on employer's responsibilities, with the staffing overheads of maternity/paternity benefit and sick pay; and added to this are the potentially considerable staff redundancy costs on the death of PHB holders themselves. The possibility of Third Party insolvency creates yet more financial uncertainty.

3.5.6 The IPA Programme Board is clear that work needs to continue to develop the PHB Service offer across Lancashire and South Cumbria across all IPA activity. Personalisation is complimented through service connectivity and responsibility. It will require a collective acceptance and accountability to recognise the vital contributions each service makes to personalisation. The Business Unit will continue to play a significant role in personalisation

agenda and mature its PHB offer alongside the maturing placed based locality and neighbourhood teams.

3.6 Market Management

3.6.1 Work has commenced to develop an approach to support market management following the cessation of the North West Framework for Care Homes (NWFW) on 31 October 2019, there is a need for a different approach to the management of the total market. Work is underway across the health and social care system to:

- Develop a system approach to engagement with providers in the market to enable development of commissioner/provider relationships.
- Develop a system approach to transacting with providers. There was variable implementation of the NHS Standard contract with providers in the landscape and of those providers where an NHS standard contract was in place most did not fully understand their obligations under this contract or how to engage with the commissioner in a contractual manner i.e. to request a pricing review.
- Develop a system approach to cost and quality management. Not all providers are subject to the same assessment of quality and there are inconsistencies across the region with regards to the setting of annual uplifts with providers causing significant variation in bed prices for similar service delivery.
- Develop a system approach to replace the North West Framework to deliver robust procurement of care with providers in the region.
- Develop a system approach to developing the market to introduce diversity and innovation and ensure the continued development of a sustainable care market.
- Create an integrated approach to commissioning with the market via health and social care.

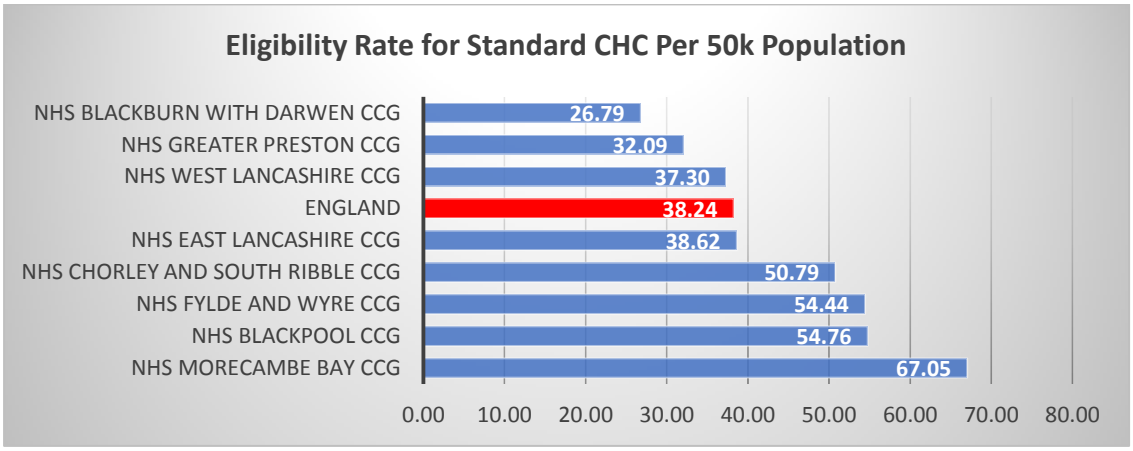
3.6.2 The Market Management Steering Group has developed a case for change and a set of recommendations in order to progress the issues in relation to lack of system approach and the cessation of the North West Framework. These are detailed in Appendix L. The market management case for change sets out an initial plan of work on provider market management for the Lancashire and South Cumbria region over the next 18 months to 2 years. The workstream for market management will develop a full business case with associated costings. There are three keys asks of the system for immediate action within the market management case for change:

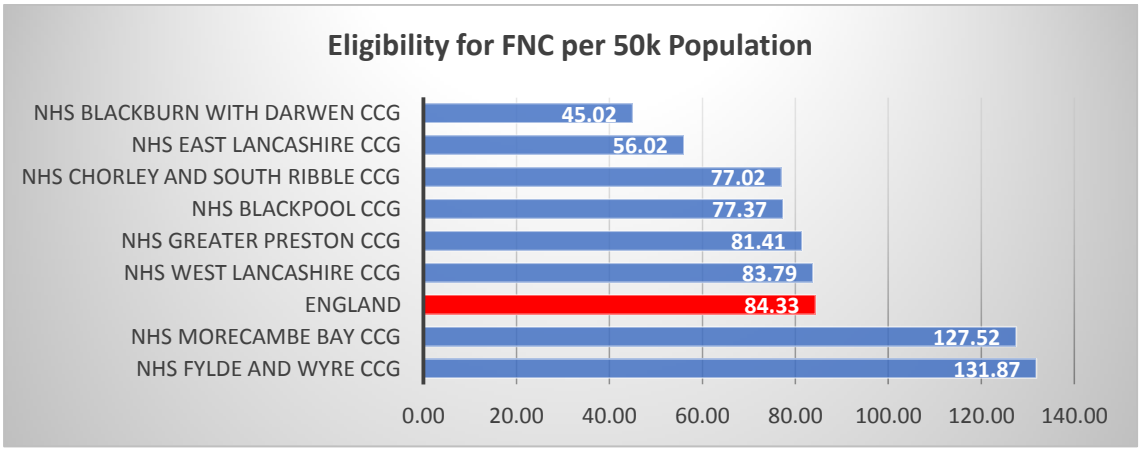
- Agreement of a % uplift to apply to provider contracts for Lancashire and South Cumbria.
- A phased approach to normalisation and alignment of the % uplift rate in conjunction with Local Authorities.
- A decision on the recommendation to invest in a Dynamic Purchasing System (DPS) that will automate the process of paying providers and assist with brokerage.

3.6.3 The current situation is unsustainable, potentially costly and a more structured approach to managing this market is required to bring clarity,focus and stability for the future.

3.7 Unwarranted Variation

3.7.1 There is also evidence of unwarranted variation across the CHC service in Lancashire and South Cumbria. Eligibility rates which are monitored nationally illustrate this. Whilst some variation is attributable to local demography the extent of variation is clearly greater than this.





3.7.2 For standard CHC there is a 150% variance in eligibility rates across the region from the highest to the lowest. Just three CCGs are below the England average. For FNC eligibility there is a 193% variance in eligibility rates across the region from the highest to the lowest. All but two CCGs are below the England average. No hard and fast conclusions can be drawn from this as each are is different. However, it would be logical to assume that different providers across the system may operate slightly differently and that an end to end service model as should enable the degree of variation to be reduced.

3.8 Supporting Patients/Families and Patient Experience

3.8.1 The CHC maturity matrix indicates that the leading services have dedicated both time and resource to supporting patients and families through what is undoubtedly a complex process. This goes above and beyond the normal every-day interaction and complaints management and ensures that information and media is consistent across all providers and CCG's and that there is equity of access to information and support.

3.8.2 In Lancashire and South Cumbria at present there is significant variation in information about the CHC process available on CCG websites, some include information, others don't. Similarly, PALS services have not been trained to deal with queries relating to CHC process and tend to refer on to the service. The service averages 12 complaints per month. Whilst some are inevitable due to the nature of this work many are attributable to poor communication and/or process.

3.8.3 Most importantly though, patient experience sits behind some of these statistics. Not just in terms of complaints but in terms of performance standards, variation and simply trying to navigate the process through a fragmented service model from across the region. The new service model must keep patient experience at its core and start to integrate the learning through complaints and direct engagement.

3.9 Case for Change Conclusion

3.9.1 The case for change demonstrates that there is clear need to develop and implement a new service model for CHC. The current service model is not sustainable and has more features in common with an immature model as described in the maturity matrix than a mature model for the operation of the service. The negative points in relation to the service are almost overwhelming:

- The current commissioning & operational delivery model is highly fragmented, delivered by multiple commissioners and providers leading to poor system leadership, a lack of appropriate commercial due diligence, and an unstable and unsustainable delivery model resulting in a poor quality & underperforming service.
- The projected cost pressures indicate demand for more care by 2023.
- There is a consistent failure to meet Quality Standard targets and the performance of the service in Lancashire and South Cumbria with the exception of Blackpool CCG (who operate with a different service model to the rest of the system) is unacceptable.
- There is significant and unwarranted variation across the IPA service.
- There is a loss of knowledge in the system about what exactly is commissioned from whom for different parts of different pathways leading to confusion and frustration for IPA practitioners and commissioners alike.
- The current contract with the principle provider Midlands and Lancashire Commissioning Support Unit does not have a specification but a series of statements in a matrix that are open to wide interpretation. This has led to the service taking on work for which it is arguably not commissioned to do which in turn impacts on performance.
- There is a failure to act in accordance with some statutory responsibilities particularly in regard to overdue reviews. Some 2000 had transferred to providers from Primary Care Trusts in 2013 without any resource to address.
- Most importantly the statistics about the service reflect the patient experience

3.9.2 The service must shift away from a system which is fragmented, reactive and adversarial to one that is proactively focusing on the most intensive care in the least intensive environment. The new model of care must both support patients, carers and families in a caring, responsive way an empowers individuals with better information and choice to manage their care through universal NHS services or Personal Health Budgets.

3.9.3 In January 2020 the Joint Committee of Clinical Commissioning Groups, endorsed the case for change and the proposed new model of care for Continuing Healthcare (CHC) for Lancashire and South Cumbria. The endorsement of the case for change enabled the business case for the model to be further developed.

4 Future Commissioning and Operational Delivery

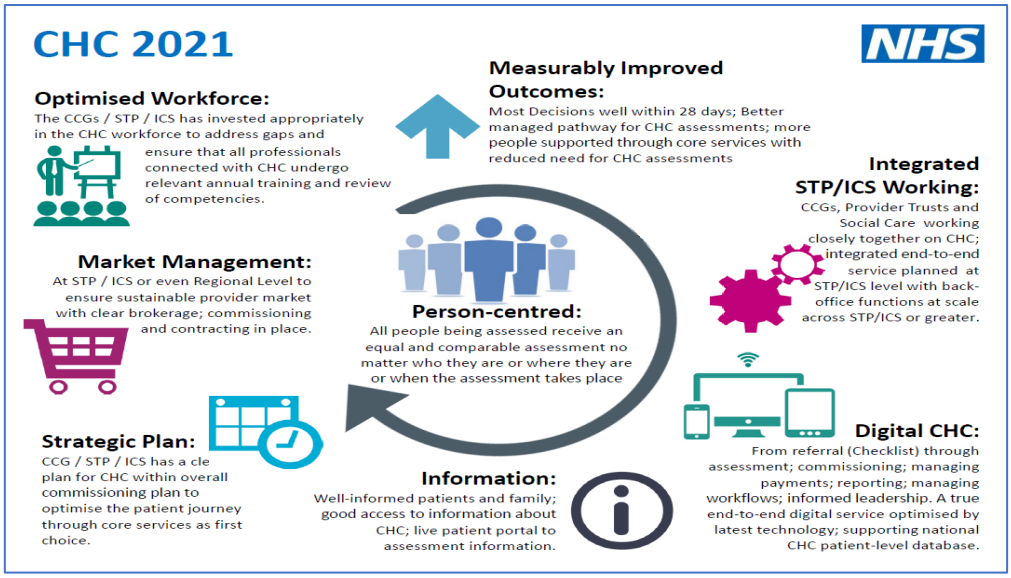
4.1 Future Vision for the CHC/IPA Service

4.1.1 The NHS National Strategic Improvement Programme (SIP) which commenced in 2017 has played a central role in highlighting best practice across CHC this has helped Lancashire and South Cumbria to determine where it needs to get to. However it is not currently stating or guiding best practice modelling of broader IPA.

NHS Maturity Matrix Dimensions

- Nationally recommended model of end to end CHC service requirements under seven enabling and nine process dimensions
- Has detailed development descriptors under each dimension which we have used for both benchmarking and helping to map new model requirements.
- The maturity matrix tells us what 'excellent' looks like.

4.1.2 Within the ICS IPA Programme, commissioners and principal providers came together to address how to improve and develop the service in accordance with best practice CHC standards and guidance. The templates for a future state for CHC nationally are driven by the National CHC SIP Programme and include an optimised service model for systems to move towards for 2021 and a detailed Maturity Matrix. The SIP optimised service delivery model is detailed below.



4.1.3 Within our region the integrated model of service delivery in Blackpool is well regarded nationally, locally and meeting Quality Standard targets. **The IPA Delivery Group considered how scalable the integrated model was and concluded that integration with local authorities is the ultimate aim but is felt to be a step too far from where we are now**. Having acknowledged that the Blackpool model is closer to a mature model of delivery as described in the maturity matrix for CHC it was clear that the focus needed to be on raising the level across the rest of the system.

4.1.4 NHS Blackpool CCG works with a Unitary Authority and whilst Blackburn with Darwen CCG also have a Unitary Authority, they do not have an integrated CHC/IPA offer at the moment. Lancashire County Council and Cumbria County Council work with the other six CCGs in the system. It's a complex picture and the Delivery Group felt that if the new service model concentrates on getting CHC/IPA delivery right in conjunction with ICP's then this is a good foundation for service integration with Local Authorities and a phased approach to delivery of a fully integrated IPA service including Children Continuing care, 117 After Care.

4.2 Best Practice Visits

4.2.1 A key part of the new model development involved visits to other systems and organisations to understand their commissioning and delivery model. Some of these sites have responded in recent years to similar challenges to those faced in Lancashire & South Cumbria and have been able to transform the care they provide through IPA services.

4.2.2 The IPA visiting team took a set of agreed questions based from the CHC maturity matrix. Visits were targeted at organisations within the same NHSE benchmarking clusters as Lancashire & South Cumbria and who all had demonstrated a sustained deliver of high standards of patient experience and care. The organisations/areas visited and/or contracted were:

- Blackpool
- Cheshire & Wirral
- Surrey Downs
- Sunderland
- South Devon & Torbay
- Sheffield

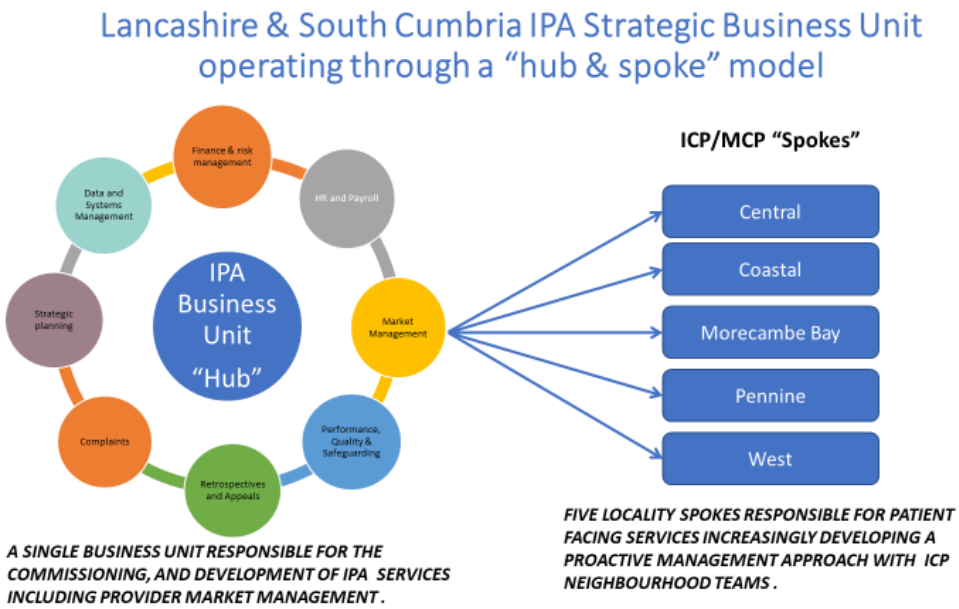
4.2.3 A number of key points of learning have been consistent across all the best practice systems. These include:

- A single "business unit" approach delivering end to end integrated health & care covering all commissioning and delivery elements.
- The importance of a single coordination centre (single point of access) but keeping face to face patient contact local.
- A level of investment in the service model (service and resources) which were significantly higher than in Lancashire & South Cumbria
- Consistent delivery of all quality standards at a lower average level of expenditure per package of care than in Lancashire and South Cumbria.
- Addressing a model of delivery that meets the requirements of 'all service IPA' remains a goal of all areas visited.

4.2.4 It was clear that no 'one size fits all' and that development of the service in each case has been mostly incremental over at least two to three years. Some of the best performing systems extended well beyond just CHC/FNC to include all complex care, ABI, provider management and in some cases end of life care. The visits served to reinforce the gap analysis undertaken against the maturity matrix and illustrate what was possible in terms of service development and improvement. A summary of the visit information and findings is at Appendix D.

4.3 A New Model of Care

4.3.1 The new model of care approved for development on 9th January 2020 by the JCCCG is designed to ensure efficiency at scale whilst also supporting localisation through a place-based approach. The model places functions which can be done once across the system on behalf of the system into a single business unit and has five spokes at ICP level. The Lancashire & South Cumbria IPA Business Unit will be accountable for the commissioning and operational delivery of all individual patient activity services (IPA). It is proposed that the business unit will be accountable to the Joint Committee of CCGs in 2020/21 and any successor CCG organisation from 2021/22 with a defined and delegated operating budget.



4.3.2 The business unit will replace all existing commissioning and provider organisations creating a single level of accountability with a single leadership, governance and management structure. The business unit will assume system wide (health & social care) responsibility for provider market management. A separate but related business case is being developed to support the market management proposal.

- The model lends itself to phased development recognising that it will be important to prioritise and structure the service transformation alongside system maturity. Whilst the Business Unit can exercise central control it could also in time delegate control and functions.
- The model could accommodate additional functions as well as CHC. Expanding the IPA delivery especially complex case management/ co-ordination.
- The model is capable of delivering and supporting the vision for an integrated service with Local Authorities and other agencies.
- The model in and of itself will not transform the service for individuals, families and for staff, we have to work differently within the framework that the new model of care will provide. This includes:

    - Forming a Partnership Board
    - Developing a Single Point of Access
    - Moving to an End to End Service
    - Having a system Management Board
    - System Driven Development of the Model
    - Developing a clear approach to Staff Retention and Training
    - Clear Service Improvement Objectives (beyond KPI's)
    - Transition Plan/ New Structure
    - Continuous Learning and Development
    - Budgetary Control

4.3.3 It is proposed that the development of and transition to the preferred service model should be led by a system wide management board with delegated responsibility for delivery and budget. This is explained in more detail in Section 4.3.2.

4.4 Structure of the Business Unit

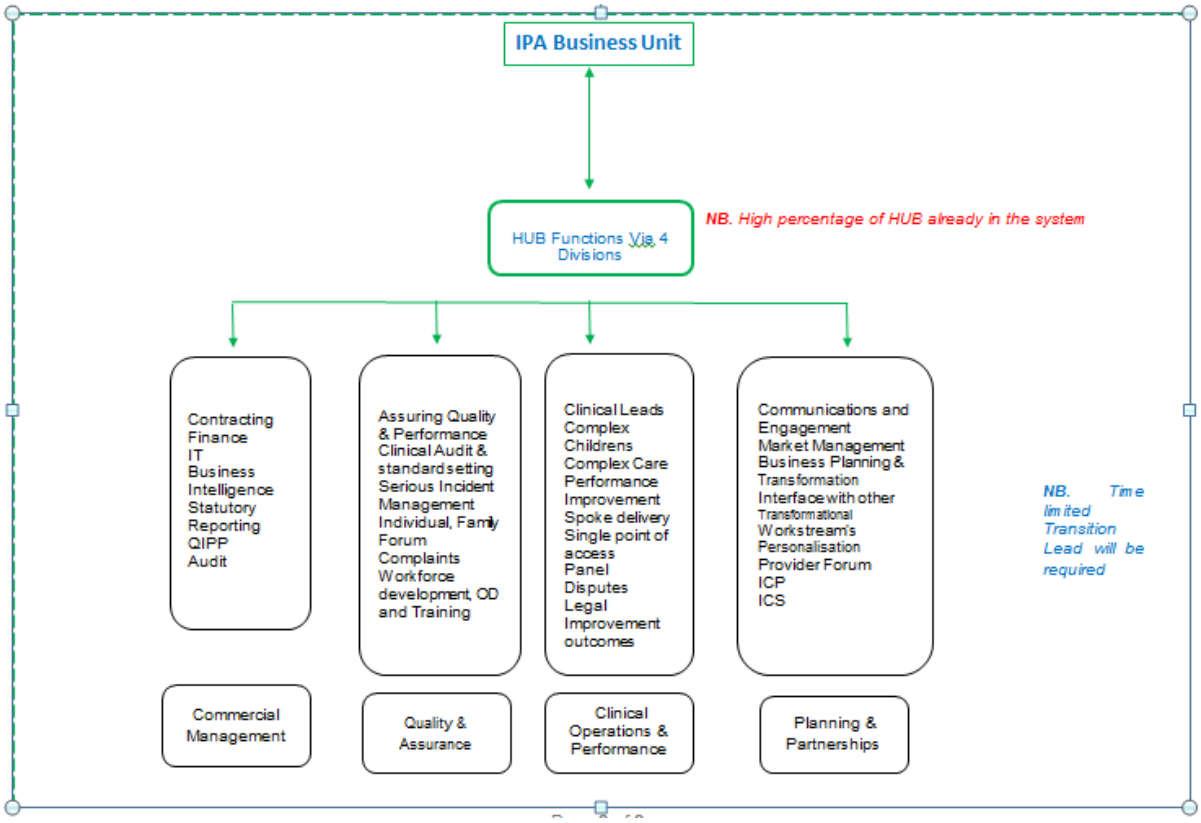
4.4.1 Functions of the Hub and Spoke

What it is	What it is accountable for	Centrally managed at Hub	Delivered at Spoke	Resources	Benefits
HUB A Hub is a centralised Business Unit that manages Commissioning and Delivery of IPA It manages processes and provides the tools, delivery in the spokes It sets the system approach for continuous improvement with local input and involvement at spoke	Leadership & Strategy Relationship management Market management Business planning QIPP Finance management Staff, recruitment and training Governance including reporting and accountability Performance management and Quality Optimising Digital Local liaison and management of Spokes NHSE Assurance	• System development • People & Skills • Governance oversight and Accountability • Client relationships Individuals & Families • Corporate functions including , FOI, SA, MP, Complaints and PALs, internal audit • Market management • Technology and Systems • Invoicing and Payment • Quality & Performance compliance • Standard Policy • Verification • Ratification of eligibility decisions • Personalisation-Personal Health Budgets • Brokerage • Retrospective Reviews and Appeals		HUB From existing CCG and CSU organisations *SMT requires interim Transition Lead and BI This will be funded from 1st April and run until front line operational recruitment concludes (see below)	BENEFITS of HUB Enables the use of ICS capability such as specific leadership and clinical skills to allow world class quality delivery Allows centralised control for skills development, resource utilisation, operational efficiency and having uniform operational processes across the spoke Improved time to delivery, created by a quicker turnaround for strategic decisions while supporting to unblock operational spoke decisions Supports central technology developments, commissioned once Provides greater flexibility to fulfil business needs
SPOKE A spoke is a locally personalised and customised model of service delivery	To work closely with the Hub to mature integration and neighbourhood service delivery. Reports performance to Hub Commissioning Fast track EoL differently	Seen ultimately as an End of Life service and expected to come out of CHC eventually but in the interim hub initially and spoke reviews	• Screening • CHC Assessment • Nursing Assessment • Review and Case Management • Complaints investigation	SPOKE Capacity requires the additional investment of 1 X b8a 1 X b7 3 X b6 2X b4 1X b3	BENEFITS of SPOKE Provides local ownership Facilitates neighbourhoods to be fully involved in case review and care management Facilitates additional new ways of working across neighbourhoods Facilitates neighbourhood integration

4.4.1.1 Whilst the new model is focused on IPA there is recognition that having strong community service provision and earlier intervention and support in the community is key to preventing people developing the health needs that trigger for IPA or at least would help to delay their onset. The aim through investment in IPA now is to develop the service so that eventually it can integrate with other services on a devolved basis at local level and focus on population health and prevention. IPA is an integral part of community care providing support to some of the most vulnerable people in our communities

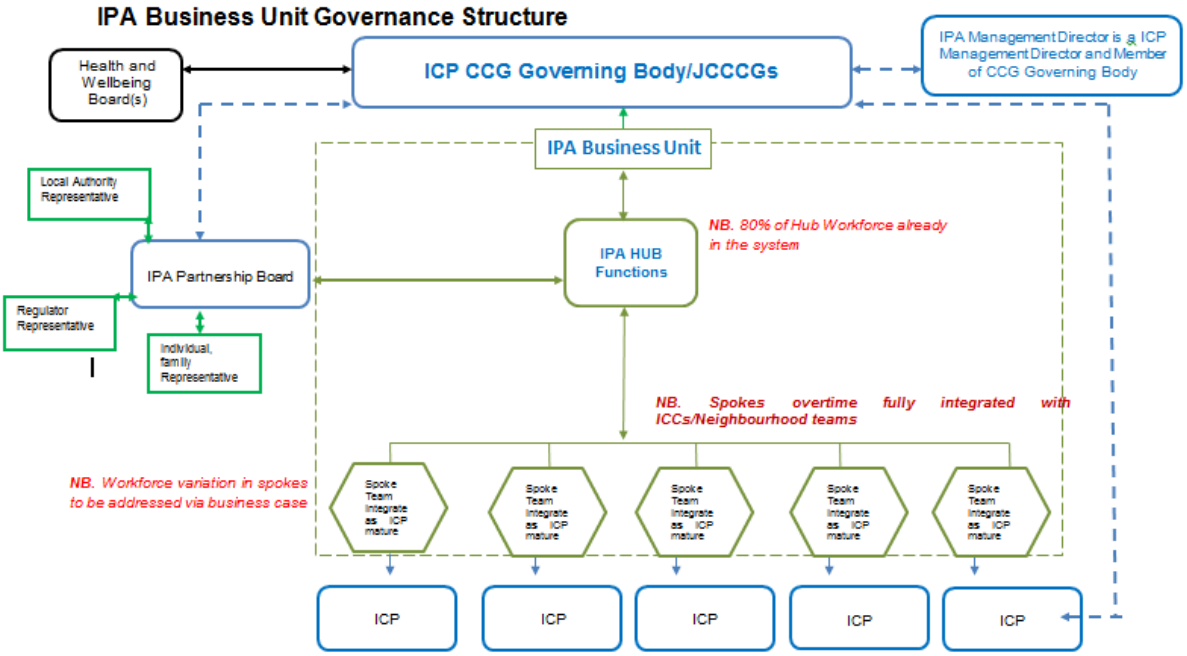
4.4.2 Proposed Structure of the Central Hub

4.4.2.1 The proposed structure of the Business Unit is built around the concept of four functional area's the chart below is a draft and will be subject to further engagement and review.



4.4.2.2 Collectively the SMT will hold the responsibility to ensure the most effective running of the service, on behalf of the Strategic Commissioner of Lancashire and South Cumbria, and in accordance with the quality and service priorities set out in the Business Unit plan and operational policy.Work is currently taking place to scope the key roles required and this has a potential impact on current staff both with both commissioning and provider organisations who currently have IPA management roles. The majority of the experience and skills needed at this senior level are already in the system. A proposed structure is not published here as there needs to be more engagement with providers regarding the potential impacts. Thought has been given to the work and the remit of the SMT and this is set out below.

4.4.2.3 To date the governance of the IPA Programme has focused on the actions needed to analyse the current position, learn from best practice and deliver this business case. From April 2020 the IPA Programme Board will continue but from October 2020 it is proposed that it relinquishes some of its responsibilities to a Senior Management Team for the service and becomes the IPA Partnership Board. The draft terms of reference for the IPA Partnership Board are available in draft. The proposed governance structure from October 2020 is:



4.4.2.4 It is also proposed that from October 2020 there is a new management structure in place. The purpose of the IPA Senior Management Team (SMT) is to make decisions and recommendations on behalf of the IPA Business Unit reporting into the IPA Partnership Board with regard to strategic and operational management of all age services delivering and commissioning IPA. This includes, assessment and review of Continuing Health Care, Funding Nursing Care, Fast Track, Children's Continuing Care, 117 MH After Care and Joint Funding. The senior clinical and non-clinical staff of the Shadow Individual Patient Activity (IPA) Business Unit will constitute the Senior Management Team (SMT). Additionally, the SMT have decision making authority for market management and relationship management, workforce OD and business planning including QIPP delivery.

4.4.3 Key Roles in Hub and Spoke

4.4.3.1 Key Senior Management Roles in the Hub

Managing Director

The Managing Director has overall responsibility for the Business Unit ensuring it delivers against its delegated statutory functions including Financial, Performance to the standards required, appointment of nominated position post holders, Quality Systems and assurance and compliance with the requirements of the agreed business plan. The Managing Director reports into the Strategic Commissioning Governance arrangements and is accountable to the Joint Committee of the Clinical Commissioning Groups or the accountable officer of any successor organisation. The Managing Director will provide assurance via the proposed governance arrangements.

Commercial Director

Reporting directly to the Management Director this post holder will hold full strategic responsibility for developing and implementing the business unit financial plans, expanding opportunities and maintaining sustainable growth, demonstrating value. They will management the whole budgetary implications of activity.

Quality and Assurance Director

Reporting directly to the Management Director the post holder ensures delivery of quality improvement, surveillance and assurance including safeguarding and experience. They will provide professional clinical leadership to sustain service delivery and transform ways of working.

Operations and Performance Director

Reporting to the Management Director the post holder will have a key role in leading our locality teams through integration which bring a population personalisation focus, they will collaborate with partners to deliver best outcomes for our populations. They will provide strong and expert business support to clinical services, particularly in operational planning and in ensuring the delivery of high quality services.

Planning and Partnership Director

Reporting directly to the Management Director the post holder will continuously develop the business unit to meet the populations future needs and the aspirational development of our ICPs and neighborhood teams. They will also the development of future integration with local authorities.

4.4.3.2 Key Role in the Locality Spoke

In order to ensure that the service retains a focus on population health at a local level each locality will have a dedicated Locality IPA Lead.

Locality IPA Lead will be accountable to the Operations and Performance Director with a key responsibility to act as the partner in each locality area working closely with the ICP. They will have direct operational responsibility for the staff in each locality. Each locality will also have a nominated personalisation lead. Resources will be assigned on a weighted population basis. Development of this role is subject to further discussion and engagement.

4.4.4 Phased Development of the Service Model

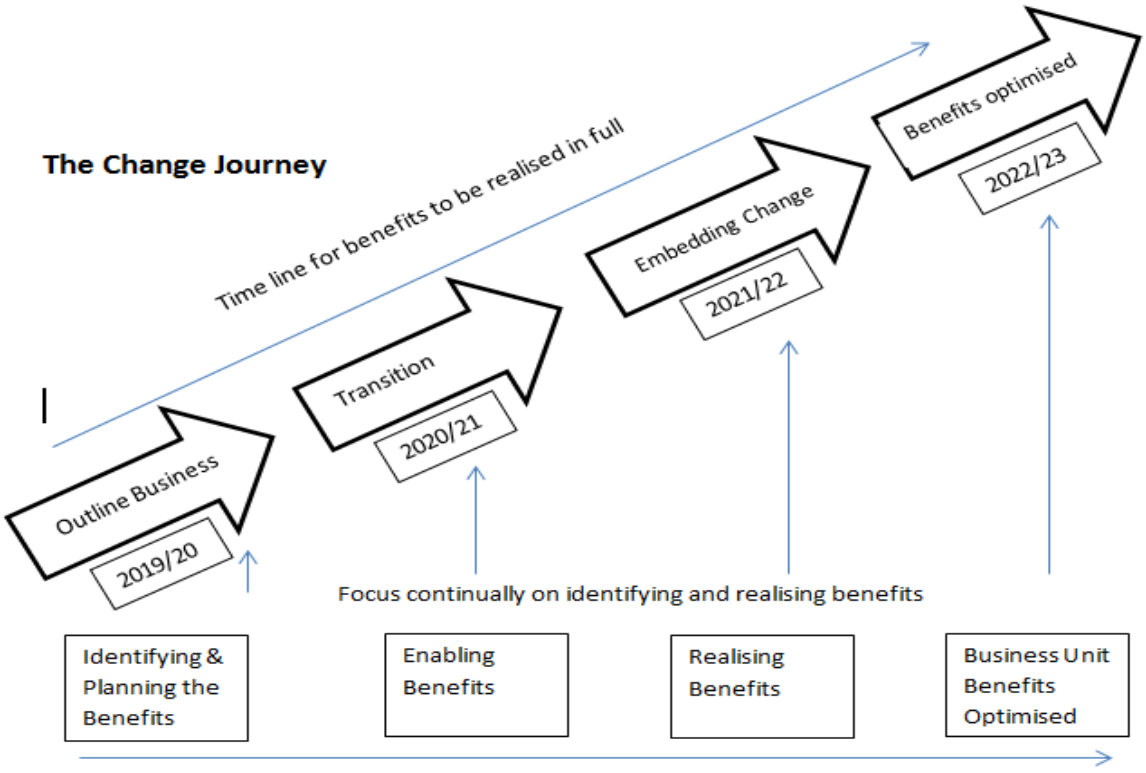
4.4.4.1 The new model of care is not a quick fix. It is not possible to take the highly complex and in some respects vulnerable CHC and wider IPA service across Lancashire and South Cumbria and change everything overnight whilst continuing to provide a service. It is suggested that there are four phases of development as follows:

Phase	Headline	Date
Phase 1	New Model of Care Development	2019/20
Phase 2	Mobilisation of New Model of Care & Set up of Business Unit	April 2020
Phase 3	New Model of Care Fully Implemented	April 2021
Phase 4	Integration with Local Authorities and Devolution to ICPs & Neighbourhoods	2022/23 – 2023/24

4.4.4.2 Phase 1 is subject to business case sign off in March 2020. In Phase 2 'mobilisation' the proposal is that the IPA Programme focuses on the creation of an end to end service through provider engagement commencing in April 2020. The Business Unit in the new model is formed from October 2020 alongside a Senior Management Team whilst new contractual arrangements and staffing implications are worked through with respective organisations. It is expected that the new model of care and Business Unit will be fully operational by April 2021.

4.4.4.3 In Phase 3 the new model of care is embedded and developed further. In Phase 4 the focus turns to integration with local authorities and utilising the business unit for health and social care combined with devolution to ICP's and neighbourhoods. It is envisaged that ICP's will have developed more integrated pathways at this stage.

4.4.4.4 As the Change Journey and Who Benefits map below illustrates there are phases in the service transition plan needed in order to reach optimum benefits realisation.



Who is going to benefit from the Transformation of Commissioning and Operations delivery of IPA

INDIVIDUALS, FAMILIES, COMMUNITIES

- Agency boundaries removed
- Transparent inclusive partnership in care decisions
- Supported decision making
- Timely assessment and decisions
- Optimum experience

WORKFORCE

- Right skills, right place, right time
- Fulfilled careers
- Collaborative workforce OD programme

COMMISSIONING ORGANISATIONS & STAKEHOLDERS

- An accountable Business Unit
- One point of contact
- Timely response
- Mature local decision making

PROVIDER MARKET

- Integrated contracting
- Joint Provider, Health and LA co-production
- Business planning built on population demographics
- Fair pricing model for care

4.4.4.5 There are a number of natural checkpoints through transition where a formal progress report to the proposed IPA Partnership Board and Joint Committee of CCGs should be produced.

Checkpoint	Requirement	Date
Checkpoint 1	Business Case	March 2020
Checkpoint 2	Progress Report re the formation of transition arrangements	September 2020
Checkpoint 3	Progress Report re full implementation of the new service model from April 2021	March 2021
Checkpoint 4	Progress report on new service model operation	September 2021
Checkpoint 5	Progress report on the implementation of integrated service delivery from April 2022	March 2022

4.4.4.6 There will be a requirement for further checks as the transition of the service progresses beyond April 2022 but the initial focus has to be on the next 12 months and establishing an annual planning and development cycle that both enables the transition of the service and provides assurance to all stakeholders in regard to both progress and outputs.

4.5 Workforce Transition

4.5.1 Introduction

4.5.1.1 The focus for workforce in this business case is threefold:

- How to ensure enough capacity to deliver performance turnaround in regard to CHC in 2020/21?
- How to move to an end to end service for IPA given the current fragmentation of the service model and different providers involved?
- How to incorporate IPA within the model during 2020/21 and also strengthen this aspect of the service via the IPA Business Unit?

4.5.1.2 The business case proposes to resource the new central hub functions predominantly via the redeployment of existing staff within the eight CCGs and Midlands and Lancashire CSU. The capacity and capability implications of this will be largely contingent on progress around commissioning reform in Lancashire and South Cumbria.

4.5.2 Workforce Capacity

4.5.2.1 Workforce benchmarking for CHC is fraught with difficulty as no two delivery models are the same. The programme has considered three benchmarks to date and is continuing to work with the National SIP programme in particular:

Benchmark Source	Constraints and Exclusions	Output
National SIP Workforce Tool	CHC only, excludes FNC and Complex and PHB other than notional PHB	This outputs from this exercise indicates a deficit of 38.4 whole time equivalents (WTE). A shortfall 15.2 WTE administrative staff and 23.2 WTE CHC practitioners compared with current MLCSU staffing with the same constraints and exclusions applied. This is to be expected to an extent as some current activity is undertaken via community block contracts from which workforce and cost information applicable to CHC is not currently available. The combination of exclusions relating to the model itself plus gaps in workforce information from all providers makes it difficult to reach a conclusive conclusion other than there is a deficit.
NHS Blackpool CCG	Integrated service model – CHC only including PHB service (includes complex cases that are CHC eligible) and appeals.	Average 'open' caseload per practitioner in Blackpool is approximately 55 cases. CHC practitioners in MLCSU in Lancashire and South Cumbria average 106. The complication with this benchmark is the treatment of complex cases and appeals within the respective service models which is different.
NHS Midlands and Lancashire Commissioning Support Unit	Benchmarking within the MLSCU service comparing other geographies commissioned with Lancashire and South Cumbria. Each geography commissions differently.	In Lancashire and South Cumbria the average open caseload per CHC practitioner is 106 cases. Across other area's that MLCSU cover, Lincolnshire, Leicestershire, Staffordshire, Birmingham and Merseyside the average is 81 cases per practitioner.

4.5.2.2 This benchmarking is inconclusive in terms of indicating what the staffing level should be for Lancashire and South Cumbria as this is dependent on local commissioning preferences and operating conditions. What it does indicate is that capacity within Lancashire and South Cumbria remains a concern in direct relation to delivering performance improvement.

4.5.3 Workforce Investment

4.5.3.1 Whilst at this stage the workforce benchmarking needs to be further developed the IPA Programme proposes a pragmatic approach to workforce transition to improve capacity and resilience. The CHC workforce proposals through phase 2 of transition 'mobilisation' are for investments in Personalisation, Single Point of Access, the introduction of Associate Practitioners and support for training and development. All of these will unpin performance improvement by increasing capacity and resilience in readiness for adoption within the new model of care. The benefits for 'hub' and for 'spoke' are:

Investment	Key Details	Hub Benefits	Spoke Benefits
Personalisation	Incorporation of an all-age PHB proposal for IPA in the core service enabling CCGs to meet their statutory requirements with regard to IPA personalisation. Incorporation of improved personalisation training.	Personalisation and PHB in particular will be a mainly hub-based service to ensure economies of scale and standardisation of approach for individuals requesting PHB.	Spokes will have access to a personalisation lead for their cohort of patients and will be able to request support from the hub for IPA PHB. Practitioners working in spokes will have improved personalisation training and support.
Introduction of Associate Practitioners	Investment in x 5 Band 5 CHC Associate Practitioners to train and start to strengthen and diversify the CHC workforce.	The hub will employ the Associate Practitioners and determine with spoke representatives the training plan for development.	Workplace training will be based with Practitioners working in spokes. Practitioner teams in spokes will have capacity released to target CHC performance improvement via the introduction of these posts.
Single Point of Access	Investment to support the introduction of a single point of access. Single point of access expected to improve productivity – additional scheduling and CSO capacity required.	The single point of access will operate from the business unit. All referrals subject to standard processing.	Tracking of 28 day target performance in real-time based on spoke populations. Improved predictive modelling.
IPA Training and Development	Investment in a training and development officer to help mobilise the Business Unit but also to deliver a continuous programme of training across the system.	The business unit will plan the training and development programme with the involvement of spoke representatives.	Staff working in spokes will have improved training and development support. Spokes will have an annual training plan.

4.5.3.2 These investments would lead to an increase in staff of 15 WTE, 9 Practitioners, 1 Training and Development Manager, 5 administrative staff at an annual recurrent cost of £796,000.

4.5.3.3 One of the key issues that emerged through the gap analysis undertaken was training and development and in particular the lack of a system approach to training and development. Once the Business Unit is in shadow form from October 2020 then in order to implement the new service model training and development of all staff in regard to what is expected etc will be critical. The service will be essentially rebranded from April 2021 and staff have an active part to play in that. This is a role that does not currently exist in known IPA structures within Lancashire and South Cumbria.

4.5.4 Workforce Transition

4.5.4.1 The focus from the investment in 2020/21 is on improving capacity and resilience to improve and sustain a level of improved performance that addresses the critical performance issues that the service faces. For the mobilisation of the Business Unit management structure from October 2020 and operational service delivery structure from April 2021 it is expected that the majority of resource required will be drawn from existing CCGs and providers.

4.5.4.2 The development of a workforce strategy will be crucial in ensuring that all organisations and individuals are treated fairly and equitably. It will be important not to destabilise service provision at the same time and ensure that organisations are not left with stranded costs. The approach to workforce transition is illustrated below.

4.5.4.3 In conclusion the workforce aspects of this transition are highly complex, likely to have TUPE implications and at the same time the IPA Programme wants to maintain every effort to value and to retain the excellent staff already in the service. The staff working across CHC and IPA in Lancashire and South Cumbria are incredibly dedicated, hardworking and highly skilled but they are working in a highly fragmented service model that hinders rather than helps. This business case acknowledges that position and sets out the work needed to deliver a sustainable service model, fit for purpose for both staff and patients.

4.5.5 Performance Transition

4.5.5.1 The current position in relation to the performance of the CHC service in Lancashire and South Cumbria is unacceptable. The Case for Change demonstrates that for some important aspects of CHC performance that impact patient care such as incomplete referrals and overdue reviews we are one of the worst performers in the country. For clarity this is the responsibility of the whole system and not any one provider. A priority for 2020/21 is to deliver on the following key critical performance indicators:

Critical Performance KPI	Actions Required
Eliminate incomplete referrals over 12 weeks	• Referral management system tracking • Scheduling • Escalation • Project Management for legacy cases
Reduce overdue reviews for standard CHC and Fast Track to a sustainable level for business as usual	• Overdue Reviews Project • Referral management system tracking • Scheduling • Implementation of review prioritisation matrix • Escalation
Reduce overdue reviews for FNC	• Overdue Reviews Project • Referral management system tracking • Scheduling • Implementation of review prioritisation matrix • Escalation
Meet the quality standard for 85% of screened referrals reaching an eligibility decision with 28 days	• Single point of access • Agreement re core CHC service excluding D2A slots for x 2 ICPs (releases approximately 100 sessions per month for CHC) • Referral management system tracking • Scheduling • Escalation • Training refresh
Meet the quality standard for less than 15% of DSTs to be undertaken in hospital	• Regular training refresh • Zero tolerance policy by CCGs

4.5.5.2 There can be an assumption that CHC is simply a process of inputs in and outputs out. In operation this is not the case and this makes performance trajectory prediction very difficult. The CHC process is highly sensitive to changes and barriers. In reality it is more of a chain and a weakness in any one aspect impacts the whole. Some examples of system changes and barriers impacting like this include:

- An increase in fast track numbers impacting availability for standard CHC.
- The sustained use of CHC resource in pilot schemes for D2A, when there are either recruitment difficulties where the pilot is funded leading to a lack of resource to undertake the work and/or no resource at all when the pilot isn't funded regardless of recruitment. Despite this numerous sessions are requested each week to support D2A.

This is the case for two ICP's and not only is it a barrier to effective CHC delivery in accordance with the national framework it isn't equitable in terms of the overall service model across the system.

- Failure to address an increase in demand with a commensurate increase in resource or action to mitigate.
- Availability of staff, both health and social care. Holiday periods, recruitment gaps, sickness, absence can all impact at different times of the year. Historically CHC providers find issues if two or more of these issues occur at the same time, e.g. it's the Christmas period and staff expected on duty go off sick over and above what has operationally been planned for.
- The impact of PHB on CHC in terms of additional time needed for visits for anything other than notional CHC.
- Handling queries relating to service fragmentation or not addressing and assuming another service has picked up and is managing a case appropriately.
- The impact of not having a commissioning framework (re market management) in Lancashire and South Cumbria on brokerage resource is significant in terms of the time taken to source a package of care and the level queries that have to be handled from and with providers in the market re variable pricing etc.
- An increase in CHC and Fast Track referrals of approximately 11% compared with 2017/18.

4.5.5.3 All of these are challenges currently in the system and addressing them is key to improving CHC performance. Fixing one aspect such as overdue reviews will not fix the whole. It is a series of layering actions that will build a sustained improvement in performance over time. Going forward each month there will be a stock take built into the performance framework for the programme which is summarised at Appendix E. Most of this work is dependent on the investment outlined at 5.3. The system has reached the position where sustainable improvement will not be possible without investment in this service.

4.5.5.4 With the investment in workforce outlined at 5.3 targeting the critical performance KPI's the improvements should be seen coming through into reporting Q2 of 2020/21. For incomplete referrals which is an immediate priority then improvement is expected in Q1 of 2020/21.

5 Finance

5.1 Financial Overview IPA

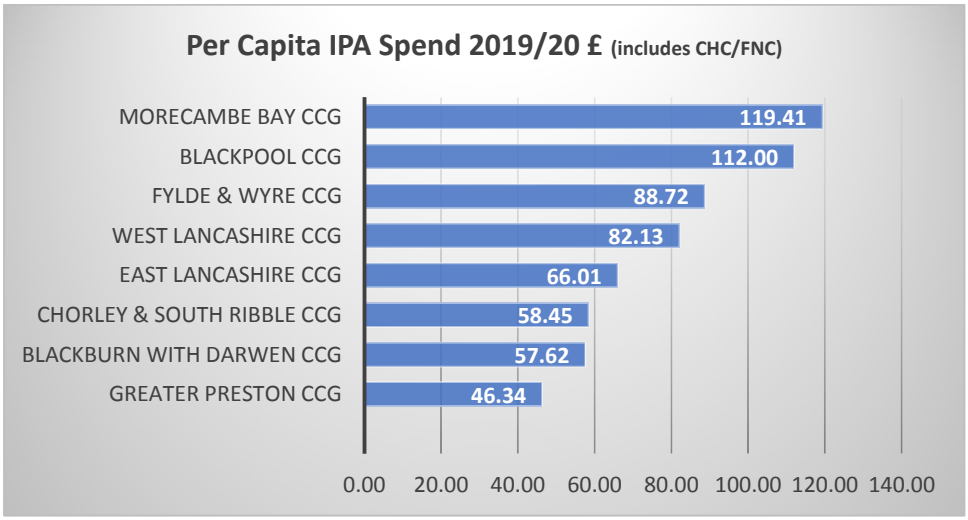
5.1.1 In 2018/19 Clinical Commissioning Groups across Lancashire and South Cumbria are forecasted to spend £204m on IPA rising to £209m in 2020/21. This represents an average growth of 2.41% across the system although there is significant CCG to CCG variability.

Financial Year	2018/19	2019/20	2020/21
Total Expenditure IPA £	£200m	£204m	£209m
CHC/FNC Expenditure £	-	£143m	£144m
Packages of Care £	£194m	£198m	£201m
Service Delivery £ *	£5.4m	£5.8m	£5.7m
Service Delivery %	2.70%	2.84%	2.72%

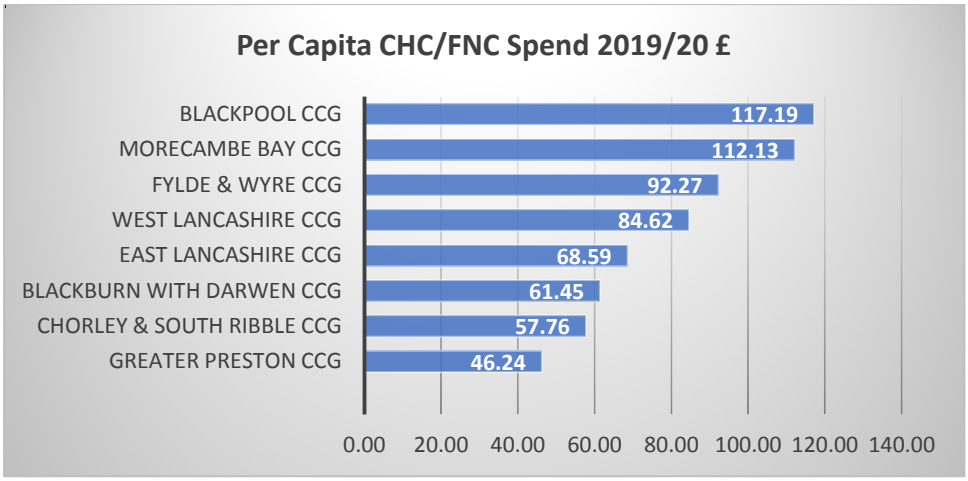
* Excludes any expenditure associated with community contracts and decision on the IPA Business Case.

5.1.2 Forecast out-turn and projections for 2020/21 were sought from CCGs. A detailed breakdown is at Appendix G and includes per capita spend. It should be noted that no CCG could separately identify IPA expenditure within community contracts and so the full cost of service delivery is under stated. It is also not clear whether all submissions from CCGs were made on the same basis e.g. net of any QIPP assumed.

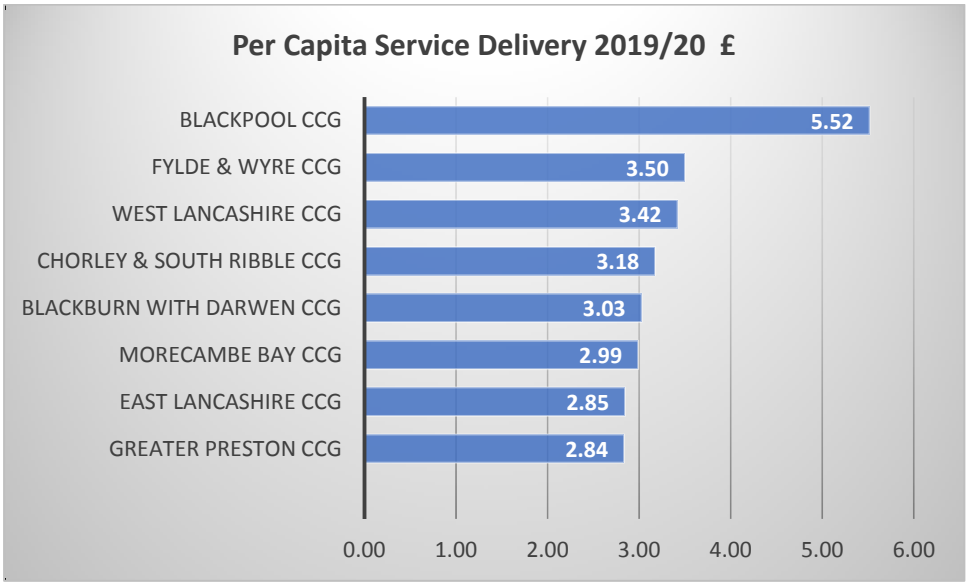
5.1.3 There is significant variation between CCG's in terms of cost per capita or head of population. For the total IPA including CHC/FNC the CCGs spending the most are spending more than double those with the lowest spend.



5.1.4 Isolating the expenditure on CHC/FNC the pattern is much the same with some CCGs spending more than twice as much as others.



5.1.5 Service delivery costs are slightly narrower in their range of variation although again the highest cost is almost twice the cost of the lowest.



5.1.6 In 2018/19 Blackpool CCG had the highest service costs but the lowest overall expenditure on packages of care per capita. In 2019/20 that is no longer the case and cannot be used as a basis for estimating a savings opportunity across the rest of the system. This is not to say savings opportunities are not there but further work needs to be done on benchmarking costs. The system is in the position of having an inequitable contribution to service costs from some CCGs. This statement is combined with the fact that some providers are known to be in deficit year on year in regard to IPA. The potential to move to a pooled budget in the future may be impacted by the level of variation in contribution to service delivery costs. This is a challenge that will need to be addressed as part of the mobilisation for the new IPA

5.2 Financial Transition in 2020/21

5.2.1 For absolute clarity the £796,000 will be used to invest in operational staff as set out in the table at section 4.5.3 and to cover the initial phase of business unit mobilisation. Clinical Commissioning Groups will remain statutorily accountable for IPA throughout 2020/21 and

must therefore set and manage budgets for this period. The mobilisation of the Business Unit in shadow form from October 2020 will involve exploring mechanisms for the Business Unit taking delegated control of IPA funding resource across the system from April 2021. Principle considerations will be budget pooling and financial risk sharing.

5.2.2 The potential to pool budgets for IPA may be impacted by the significant variation in current costs by CCG in relation to contribution to service delivery costs and the costs of package of care. For example, moving to a per capita expenditure model to set future budgets would have significant financial implications for all CCGs with those currently at the lower end of cost per capita incurring additional cost and those with higher current costs potentially saving.

5.2.3 One of the potential ways the movement towards an equitable per capita budgeting model could be articulated is via the use of QIPP (Quality, Innovation, Productivity, Patient Safety). The Business Unit would have responsibility for setting and delivering QIPP and would seek to reinvest savings in continuing to develop the service. Any risk sharing model suggested for QIPP could also take account of movement towards equitable per capita funding.

5.2.4 In order to take this work forward a Finance Workstream will be formed form April 2020 and further develop the approach to the system management of IPA finance.

5.3 Financial Planning for 2020/21

5.3.1 Non- Recurrent Expenditure

5.3.1.1 In 2020/21 the following non-recurrent expenditure is :

- Prior agreement from CCGs (excluding NHS Blackpool CCG) to £1.4 million (excluding VAT) to significantly reduce overdue reviews and eradicate incomplete referrals over 26 weeks. There is an expected return on investment which should mean that as minimum the project pays for itself.
- Prior commitment of £50k from the ICS to support IPA programme management costs needs to be carried forward into 2020/21.

5.3.1.2 All other non-recurrent project expenditure in IPA would cease on 31st March 2020. For example the current non-recurrent funding of PHB. The only exceptions to this would be any bespoke arrangements which relate to safeguarding investigations, legal, appeals and audit.

5.3.2 Recurrent Expenditure

5.3.2.1 According to figures received from CCGs have forecast expenditure in 2020/21 of:

- £203 million on packages of care
- £5.7 million on service delivery

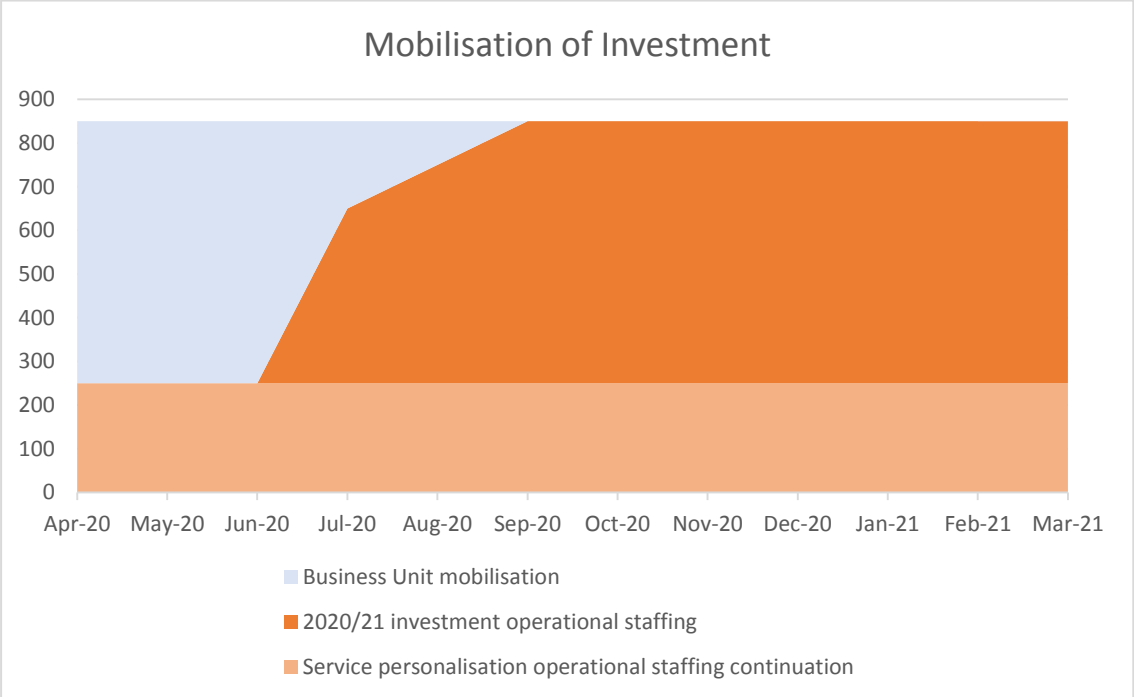
5.3.2.2 This business case sets out the rationale for the transformation of IPA across Lancashire and South Cumbria. The case for change and proposed new model of care provides a compelling argument for the proposed changes. Approval and mobilisation of the business case will require an additional recurrent investment of £796k from April 2020. This is a pragmatic

response to the challenge of both improving and sustaining performance in the next financial years and also moving towards and end to end service.

5.3.2.3 This would mean that the proposals for the continued development of Personalisation, the introduction of CHC Associate Practitioners, Single Point of Access and an IPA Training and Development officer become part of core service. Without investment the service will not be able to deliver the performance improvement required or move towards end to end provision for Lancashire and South Cumbria. The position that the system finds itself in currently in terms of performance and needing to invest in non-recurrent projects to address would be repeated year on year with no discernible improvement in patient care. The recurrent investment proposed is a major step towards both working differently and developing a sustainable service model.

5.3.2.4 As the work through mobilisation develops then there may be opportunities to utilise resources more effectively and deliver savings. If the opportunity is there it will be taken, the increased scrutiny that the SMT will have across system finance for this service will assist the system as whole to take decisions. The first obligation, working as system is to try and deliver improvements across the critical performance KPIs described in the Outline Performance Framework at Appendix E in the next six months.

5.3.2.5 In order to do this the programme would utilise the additional resource this year to mobilise the actions to improve performance and deliver the Business Unit switching it into frontline operational staffing over a number of months. There is an acknowledgement in the model that a provider already has some staff in post for PHB and that this would continue from April 2020 whilst other developments are mobilised.



5.4 End to End Service Costs

5.4.1 End to end service costs are currently unknown due to the lack of information relating to provision within community block contracts. Estimates are that £2m - £4m deployed resources could need to be attributed to IPA to create an end to end service. This will require further understanding of the interdependencies with other programmes of transformation impacting community services. This figure is consistent with our work with the NHS SIP Programme workforce tool but it is recognised that significant work needs to be done to validate these findings. What is clear is that the average service delivery cost per capita as currently calculated for Lancashire and South Cumbria (excluding Blackpool CCG) would need to rise to become closer to the level of expenditure in Blackpool. Every benchmark the programme has looked at indicates that the service across the rest of Lancashire and South Cumbria is under resourced. It is also acknowledged that the system does not have an extra £2m to £4m readily available. Consequently, the pragmatic approach suggested to recurrent investment is that in 2020/21 an additional £796k targeted at critical performance improvement and working differently should be made.

5.4.2 This will support critical performance improvement through improving capacity and resilience whilst enabling through mobilisation the IPA Programme to continue to test and develop resource plans considering what resource may already be available elsewhere in the system. Every effort will be made to contain and control costs appropriately whilst developing the service and working differently.

6 Programme Management and Priorities for 2020/21

6.1 Programme Management

6.1.1 Programme management continues to be delivered with limited dedicated resource for a service transition of this scope and complexity. As the programme moves into the mobilisation phase prior to operation of the shadow business unit in October 2020 there is an element of programme 'reset' that will occur. What began as a focus on CHC has already widened to IPA and other groups such as the Market Management Steering Group and Childrens' and Young People Continuing Care Group have started to report to the Programme Board. The workstream for performance management will be retained but it is recommended that the following workstreams are also enabled:

- Finance and reporting
- HR/Workforce
- IT development and interoperability
- Communications and engagement

6.1.2 The programme will effectively handover in October to the Business Unit SMT and the draft governance structure for operation form October 2020 is detailed at Section 4.3.2.

6.2 Programme Risks

6.2.1 A programme risk register is maintained, and this detailed at Appendix P.

6.3 Quality Impact Assessment

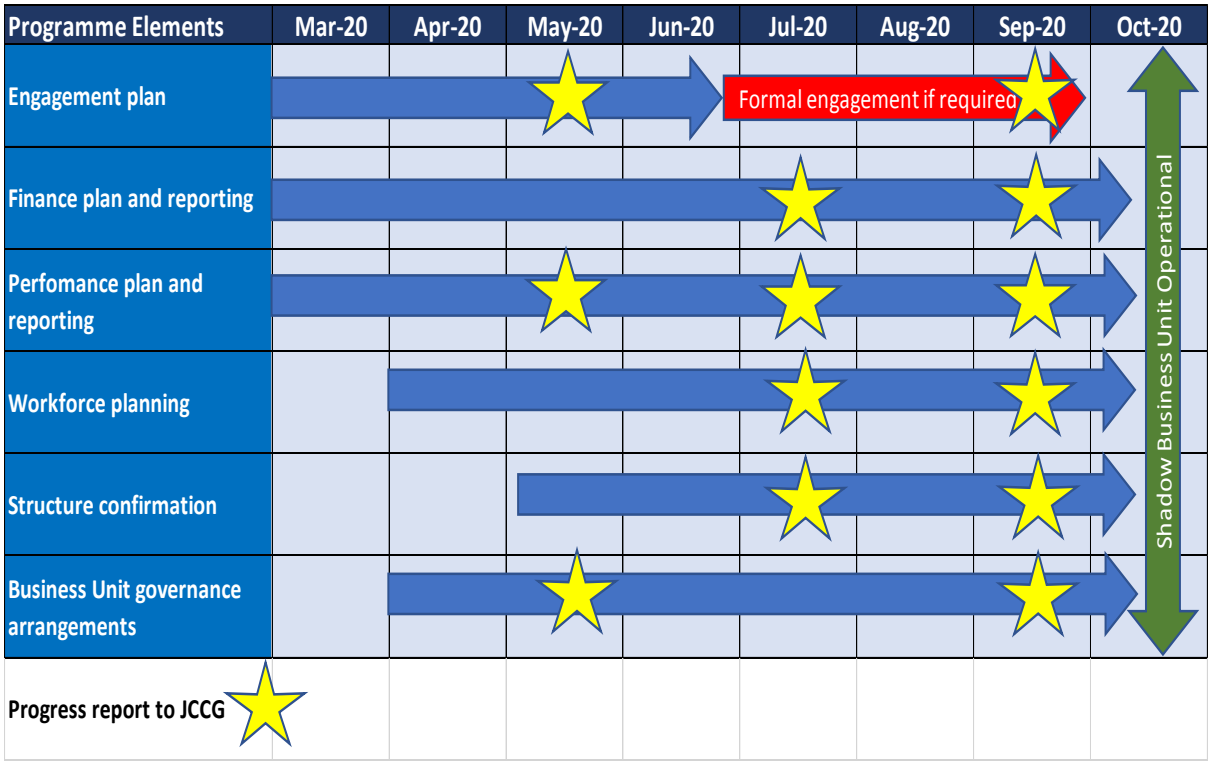
6.3.1 A quality impact assessment is completed and available on request at Appendix Q. This demonstrates that the quality impact for both staff and patients is positive. The only risks to this position is failure to invest.

6.4 Priorities and Next Steps

6.4.1 The IPA Programme has not waited for permission to take action but can now see that investment is required to move beyond the work already being undertaken as follows:

- Introduction of 'scheduling' at MLCSU making the tracking cases through to MDT decision within 28 days more visible in real time. This also applies for reviews at 3 and 12 months.
- Brokerage of CCG support to tackle 135 incomplete referrals over 26 weeks and approximately 2477 overdue reviews through a separately resourced project that will run until Match 2021.
- Deep dive into the Pennine locality to better understand and act on some of the performance challenges being experienced.
- Introduction of 'referral management' at MLCSU in line with NHSE instruction to digitise CHC. This programme of work should lead to more standardised and better quality of checklist completion. The programme is supported by training for partners.
- Review of D2A arrangements to try and ensure appropriate use of CHC resource and equity of provision across the system.
- Visits to 'exemplar' sites across the country to look at their model of care and bring back learning to Lancashire and South Cumbria to inform new model of care development.
- Engagement and relationship building with local authorities and ICP/MCPs.
- Connecting with the National CHC Service Improvement Team.

6.4.2 In 2020/21 the focus will remain on CHC and in particular the critical performance KPIs for targeted improvement over the next six month. All require additional resource to be able to achieve the performance improvement sought.



7 Business Case Conclusion

7.1 Closing the Gaps

7.1.1 The gaps between the maturity of the current service model for CHC in Lancashire and South Cumbria and the 'leading' criteria in the National SIP maturity matrix are stark. The creation of a business unit for CHC/IPA as described will enable the work to take place to implement an end to end service model in a sustainable way. This is the key requirement that underpins everything else.

7.1.2 Moving to an end to end service right away isn't the answer either, it's complex. Multiple organisations are involved and need to be consulted, there are cost and workforce implications, including potentially TUPE transfer. There are processes that need to be put in place to assure any transition between organisations makes sense for the staff involved and is equitable. It will take time and there will be learning along the way that influences what comes next. Our programme to do this in 12 months from April 2020 is ambitious.

7.1.3 Whilst the mobilisation of the new service model is the start of a journey to a more mature, robust and patient centred service, without investment, the service could fail to set off. There are a range of critical performance issues that need to be addressed and that need to improve in the next six months. NHSE&I have been extremely supportive of the work to develop the new service model but are losing patience in terms of performance across the key CHC indicators. Both providers and commissioners have worked within current resources to understand, diagnose and lead improvements but have reached the point where transitional targeted actions need to be taken and need to be resourced to tip the balance from failing to starting to succeed.

7.1.4 The investment required for an end to end service model for Lancashire and South Cumbria is estimated at £3-£4 million. We know that some of this resource is in community block contracts and that extracting that in total would be likely to be counter-productive. The risk would be of simply moving critical performance issues elsewhere in the health and social care economy. The IPA programme has concluded that a more pragmatic and balanced approach for 2020/21 is to seek targeted investment that addresses critical performance issues at the same time as providing greater capacity and resilience to the service.

7.2 The Investment Ask in 2020/21

7.2.1 Non- Recurrent Expenditure

In 2020/21 the following non-recurrent expenditure is :

- Prior agreement from CCGs (excluding NHS Blackpool CCG) to £1.4 million (excluding VAT) to significantly reduce overdue reviews and eradicate incomplete referrals over 26 weeks. There is an expected return on investment which should mean that as minimum the project pays for itself.
- Prior commitment of £50k from the ICS to support IPA programme management costs needs to be carried forward into 2020/21.

7.2.1.2 All other non-recurrent project expenditure in IPA would cease on 31st March 2020. For example the current non-recurrent funding of PHB. The only exceptions to this would be any bespoke arrangements which relate to safeguarding investigations, legal, appeals and audit.

7.2.2 Recurrent Expenditure

7.2.2.1 According to figures received from CCGs have forecast expenditure in 2020/21 of:

- £203 million on packages of care
- £5.7 million on service delivery

7.2.2.2 This business case sets out the rationale for the transformation of IPA across Lancashire and South Cumbria. The case for change and proposed new model of care provides a compelling argument for the proposed changes. Approval and mobilisation of the business case will require an additional recurrent investment of £796k from April 2020. This is a pragmatic response to the challenge of both improving and sustaining performance in the next financial years and also moving towards and end to end service.

7.2.2.3 This would mean that the proposals for the continued development of Personalisation, the introduction of CHC Associate Practitioners, Single Point of Access and an IPA Training and Development officer become part of core service. Without investment the service will not be able to deliver the performance improvement required or move towards end to end provision for Lancashire and South Cumbria. The position that the system finds itself in currently in terms of performance and needing to invest in non-recurrent projects to address would be repeated year on year with no discernible improvement in patient care. The

recurrent investment proposed is a major step towards both working differently and developing a sustainable service model.

7.2.2.4 As the work through mobilisation develops then there may be opportunities to utilise resources more effectively and deliver savings. If the opportunity is there it will be taken, the increased scrutiny that the SMT will have across system finance for this service will assist the system as whole to take decisions. The first obligation, working as system is to try and deliver improvements across the critical performance KPIs described in the Outline Performance Framework at Appendix E in the next six months.

7.2.2.5 In order to do this the programme would utilise the additional resource this year to mobilise the actions to improve performance and deliver the Business Unit switching it into frontline operational staffing over a number of months. There is an acknowledgement in the model that a provider already has some staff in post for PHB and that this would continue from April 2020 whilst other developments are mobilised.

7.2.2.6 This will improve capacity and resilience in the service and will run in parallel with project actions addressing the critical performance issues.

Performance Management Framework Actions 2020/21	Action Implemented	Performance Impact from	Expected Impact
Resolve D2A issue with x 2 ICPs	Q1 - 2020/21	Q2 - 2020/21	Release of approximately 100 sessions per month for CHC
Referral Management System fully implemented	Q1 - 2020/21	Q2 - 2020/21	Faster screening time, improved tracking and escalation - productivity improvement
Single point access and scheduling fully implemented	Q1 - 2020/22	Q2 - 2020/21	Improved tracking and escalation management - productivity improvement
Improved PHB support	Q1 - 2020/21	Q2 - 2020/21	Principally a quality improvement but may also improve productivity by releasing clinical time/ admin do more of the process. Moves from CHC only service to an all age service incorporating CYP and S177.
Incomplete referrals project	Q4 - 2019/20	Q1 - 2020/21	CHS will be used to address incomplete referrals over 26 weeks. MLCSU will run an internal project to address legacy over 12 weeks and up to 26 weeks. Scheduling will track to BAU position from Q1 2020/21
Overdue reviews project and implementation of reviews prioritisation matrix	Q4 - 2019/20	Q1 - 2020/21	CSU/MLCSU partnership to address approximately 2500 overdue reviews for standard CHC, Fast Track and FNC
Progress recommendations from Market Management Case for Change	Q1 - 2020/22	Q3 - 2020/21	% uplift agreed/ DPS decision positive assumed for performance framework
Improved support for training and development	Q2 - 2020/22	Q3 - 2020/21	Dedicated resource for system-based training and development (health and social care)

Recruitment of x 5 Band 5 CHC Assistant Practitioners	Q2 - 2020/22	Q3 - 2020/21	Will work initially on FNC, and train re CHC and on vacancies at Band 6 may progress to be a CHC Practitioner - increases capacity

7.2.2.7 In addition to undertaking this work and addressing the critical performance issues the IPA Programme will begin a programme of engagement across the system to look at the development of an end to end service using the new service model. This will involve doing an assessment of the potential impacts to identify the most productive way forward that will deliver an improved CHC and IPA service for both patients and staff.

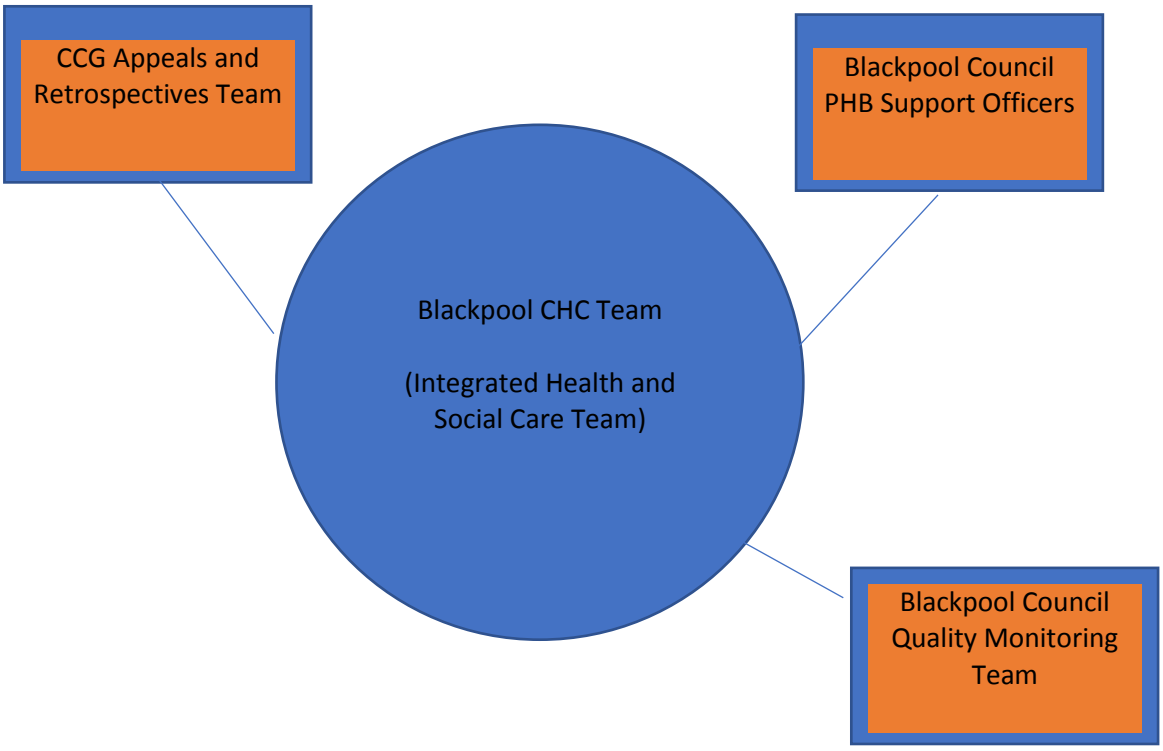
APPENDICES

Appendix A -Blackpool Service Model

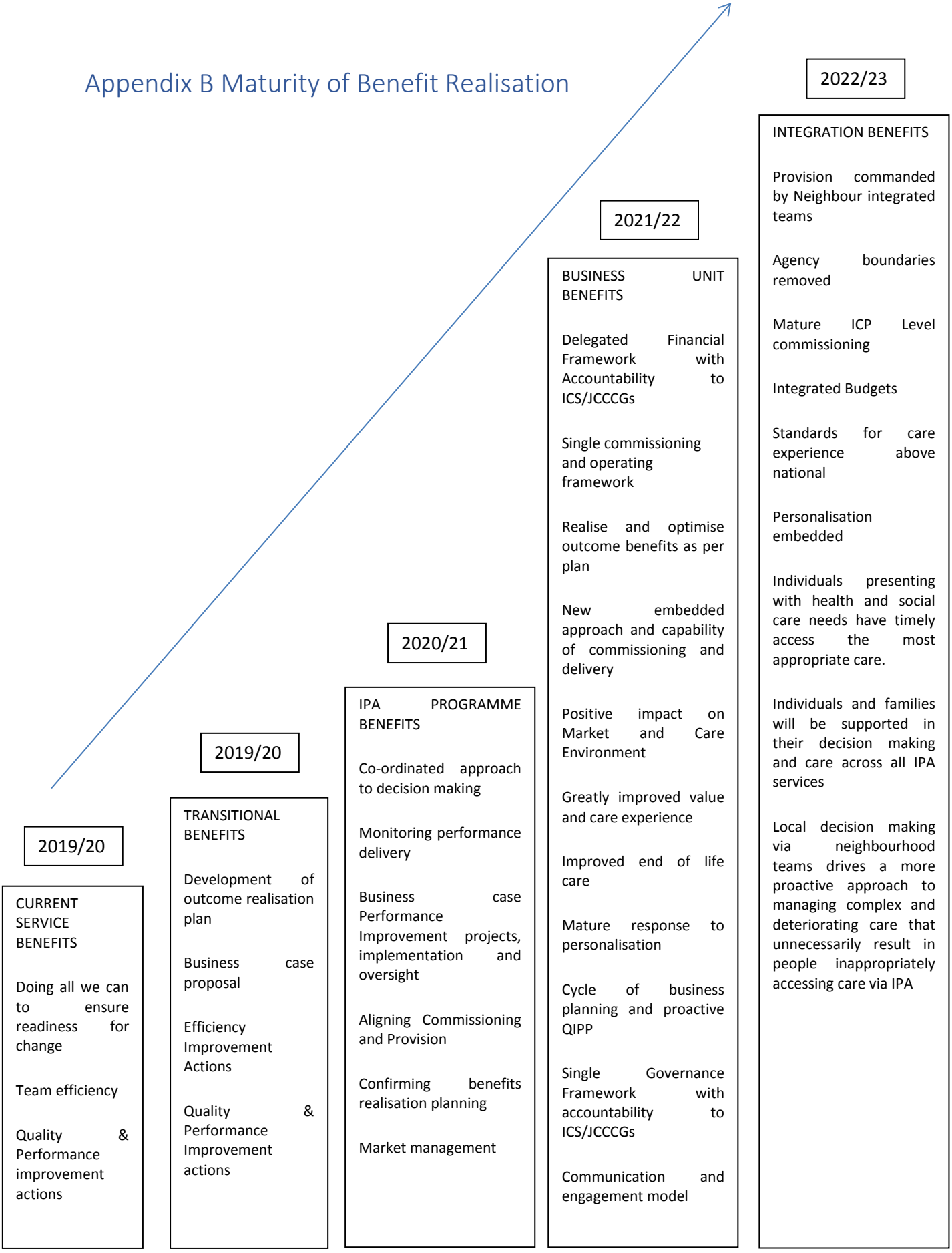
Blackpool CCG host an integrated health and social care CHC team which is supported by PHB Support Officers who are part of the Direct Payments Team at Blackpool Borough Council, a Quality Monitoring Team and a small Retrospectives and Appeals Team. The main duties of each team are:

Team	Hosted By	Main Duties
Integrated CHC Team	Blackpool CCG	CHC team do all new referrals. They review CHC, FNC and Fast Tracks. All Court of Protection work is done by the CHC team. The Team work with Personal Health Budget project officers and set up and review PHBs for patients eligible for CHC. Whole process from receiving the referral to making the payment and authorising the invoice is done within the CHC team. Benchmarking and all reporting done by the administrators within the team. The team lead on Best Interest meetings and DOLs applications where necessary. CHC team provide training to the Hospital discharge team, district nurses, hospice, social workers. Rolling programme of training offered and a database held of people who have completed the NHSE on-line CHC training. Care home contracts are done within the team and responsibility sits with overall service manager. CHC Team are involved with care homes and care at home - quality monitoring and Safeguarding investigations with Quality Monitoring Team and Safeguarding Social Worker who sits across both teams.
PHB Support Officers	Blackpool Borough Council	CHC nurses work with 3 PHB Project Officers (based within Blackpool Council's Direct Payments Team). The project officers spend days with the CHC team and personal support plans are developed and monitored by the PHB officers and nurses. Blackpool is a development and mentorship site and are responsible for supporting 3 other CCG's and NHS England to spread the PHB work more widely. They speak at events and conferences and have had funds awarded from NHSE for this work. Blackpool have met the target for PHBs.
Quality Monitoring Team	Blackpool Borough Council	Team report to Service Manager for CHC. They are responsible for all care homes and care at home contract reviews and quality monitoring. Work with CHC team on investigations and

		quality issues. Link in with adult social care and safeguarding social worker for safeguarding investigations.
Appeals and Restitution Team	Blackpool CCG	The team do all restitution cases and appeals. Attend NHSE IRPs on behalf of the CCG.



Appendix B Maturity of Benefit Realisation



Appendix C – Provider Matrix- CHC only

CHC PROVIDER MATRIX	NHS Blackpool	NHS Blackburn with Darwen	NHS Chorley and South Ribble	NHS East Lancashire	NHS Fylde and Wyre	NHS Greater Preston	NHS Morecambe Bay		NHS West Lancashire
							North Lancs	South Cumbria	
Referral Request for Checklist	Various	Various	Various	Various	Various	Various	Various	Various	Various
Checklist Submission	Various	Various	Various	Various	Various	Various	Various	Various	Various
Checklist Receipt for Residential or Nursing Care Home	BPCCG	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU
Checklist Receipt Domicillary	BPCCG	LSCFT DN's	LSCFT DNs/CSU	MLCSU	BTHT DN's	LSCFT DNs/CSU	MLCSU	UHMB DN's	Virgin Healthcare
Fast Track for Residential or Nursing Care Home	BPCCG	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU
Fast Track Domicillary	BPCCG	LSCFT DN's	LSCFT DNs/CSU	MLCSU	BTHT DN's	LSCFT DNs/CSU	MLCSU	UHMB DN's	Virgin Healthcare
DST for Residential or Nursing Care Home	BPCCG	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU
DST Domicillary	BPCCG	LSCFT DN's	LSCFT DNs/CSU	MLCSU	BTHT DN's	LSCFT DNs/CSU	MLCSU	UHMB DN's	Virgin Healthcare
Reviews in for Residential or Nursing Care Home	BPCCG	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU	MLCSU
Reviews Domicillary	BPCCG	LSCFT DN's	LSCFT DNs/CSU	MLCSU	BTHT DN's	LSCFT DNs/CSU	MLCSU	UHMB DN's	Virgin Healthcare

BPCCG = NHS Blackpool CCG

LSCFT = Lancashire and South Cumbria Foundation Trust

BTHT = Blackpool Teaching Hospitals Trust

MLCSU = Midlands and Lancashire Commissioning Support Unit

UHMB = University Hospitals of Morecambe Bay

Virgin Healthcare

Appendix D- Site Visits Summary Points

Organisation	Visiting Cluster	ICS/ICP footprint and population served	Model Delivered and Population size served	Reason for Visiting/Call	Key learning
SITE VISIT- COMPLETED Surrey Downs (national team recommendation due to size of geographical coverage)	5	1 CCG delivers on behalf of the ICS, includes 5 CCGs, 4 ICPs CCGs yet to merge 1.34 Million	Strategic Commissioner Hosted and delivers into ICP spoke. Full management and delivery Runs as a business unit	Large geographical area Moved from multiple provider model to 1 NB: 1 LA across ICS	Single point of contact, duty desk Hub and spoke model Team centralised 1 management team Broad skill mix
SITE VISIT- South Devon and Torbay	2	Devon (recently amalgamated all CCGs across Devon) 1.2 million	Strategic Commissioner is via Devon CCGs (Base Plymouth)	Recent move to 1 CCG Strategic commissioner Within Geographical cluster Visiting ICP 'spoke' area to understand local delivery	Telephone contact – hub and spoke model
PREV SIGHT VISIT Need follow up call- MW Cheshire CCGs	2	Hosted by 1 CCG In Cluster	CCG delivers on behalf of majority of the CCGs across the ICS	Within Geographical cluster	
SIGHT VISIT- COMPLETED Sunderland CCG (they additional have an alliance with LA for this work area)	6	CCG level in house deliver ICP- Sunderland, South Tyneside and Durham. ICS- North east and North Cumbria (X4 ICPs in total)		Consistent delivery of QP Within Geographical cluster	

Appendix E – Performance Management Framework

Performance Management Framework Action Plan Q1 2019/20 to end of Q2 2020/21

Performance Management Framework Actions 2020/21	Action Implemented	Performance Impact from	Expected Impact	Critical KPI Positively Impacted					
				85% of screened in referrals to decision in 28 days	Less that 15% of DSTs undertaken in hospital	Elimination of incomplete referrals over 26 weeks	Elimination of incomplete referrals over 12 weeks	Reduce overdue reviews for standard CHC and Fast Track to a sustainable level for business as usual	Reduce overdue reviews for FNC
Resolve D2A issue with x 2 ICPs	Q1 - 2020/21	Q2 - 2020/21	Release of approximately 100 sessions per month for CHC	YES	NOT APPLICABLE	YES	YES	YES	YES
Referral Management System fully implemented	Q1 - 2020/21	Q2 - 2020/21	Faster screening time, improved tracking and escalation - productivity improvement	YES	NOT APPLICABLE	YES	YES	NOT APPLICABLE	NOT APPLICABLE
Single point access and scheduling fully implemented	Q1 - 2020/22	Q2 - 2020/21	Improved tracking and escalation management - productivity improvement	YES	NOT APPLICABLE	YES	YES	YES	YES
Improved PHB support	Q1 - 2020/21	Q2 - 2020/21	Principally a quality improvement but may also improve productivity by releasing clinical time/ admin do more of the process	YES	NOT APPLICABLE	YES	YES	YES	YES
Incomplete referrals project	Q4 - 2019/20	Q1 - 2020/21	CHS will be used to address incomplete referrals over 26 weeks. MLCSU will run an internal project to address legacy over 12 weeks and up to 26 weeks. Scheduling will track to BAU position from Q1 2020/21	YES	NOT APPLICABLE	YES	YES	NOT APPLICABLE	NOT APPLICABLE
Overdue reviews project and implementation of reviews prioritisation matrix	Q4 - 2019/20	Q1 - 2020/21	CSU/MLCSU partnership to address approximately 2500 overdue reviews for standard CHC, Fast Track and FNC	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	YES	YES
Progress recommendations from Market Managemant Case for Change	Q1 - 2020/22	Q3 - 2020/21	% uplift agreed/ DPS decision positive assumed for table	YES	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Improved support for training and development	Q2 - 2020/22	Q3 - 2020/21	Dedicated resource for system based training and development (health and social care)	YES	YES	YES	YES	YES	YES
Recruitment of x 5 Band 5 CHC Assistant Practitioners	Q2 - 2020/22	Q3 - 2020/21	Will work initally on FNC, and train re CHC and on vacancies at Band 6 may progress to be a CHC Practitioner - increases capacity	YES	NOT APPLICABLE	YES	YES	YES	YES

Appendix F – Market Management Case for Change Recommendations

1. Examine all current resources across health and care within contracting, commissioning and quality.

2. Develop a market engagement strategy and appropriately resource.

   Determine what a contracting repository might look like and understand the overlaps.

3. Interrogate £300m spend by care category.

4. Undertake a gap analysis.

5. Mandate an e-invoicing model.

6. Develop a system wide uplift solution.

7. Identify appropriate CQUIN measures if at all (approach currently being agreed at deputy CFOs).

8. Agree a phased approach to market development with residential and nursing care homes being the start.

9. Agree implementation of a DPS for residential and nursing care homes.

10. Approaches to joint procured packages in line with national guidance as it emerges.

11. Develop EoL service.

12. Agree the AT support over health and care.

Appendix G – Finance Overview

		IPA Spend		CHC/FNC Spend		CSU/ Bpool Service		Community Provision		Total Spend			Per Capita Spend	
		19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	Growth	19/20	20/21
	Population*	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	%	£	£
Morecambe Bay CCG	348,584	50,619	49,569	41,626	39,088	1,042	1,055	0	0	51,661	50,624	-2.01%	148.20	145.23
Morecambe Bay ICP	***348,584***	***50,619***	***49,569***	***41,626***	***39,088***	***1,042***	***1,055***	***0***	***0***	***51,661***	***50,624***	**-2.01%**	***148.20***	***145.23***
Blackpool CCG	174,737	28,281	29,326	19,570	20,478	964	960	0	0	29,245	30,286	3.56%	167.37	173.32
Fylde & Wyre CCG	178,319	22,532	23,481	15,820	16,453	624	645	0	0	23,156	24,126	4.19%	129.86	135.30
Fylde Coast ICP	***353,056***	***50,813***	***52,807***	***35,390***	***36,931***	***1,588***	***1,605***	***0***	***0***	***52,401***	***54,412***	**3.84%**	***148.42***	***154.12***
Chorley & South Ribble CCG	185,612	14,201	14,776	10,849	10,722	589	463	0	0	14,790	15,239	3.04%	79.68	82.10
Greater Preston CCG	210,477	13,363	13,514	9,754	9,733	597	463	0	0	13,960	13,977	0.13%	66.32	66.41
Central Lancashire ICP	***396,089***	***27,563***	***28,291***	***20,603***	***20,455***	***1,186***	***926***	***0***	***0***	***28,750***	***29,216***	**1.62%**	***72.58***	***73.76***
Blackburn with Darwen CCG	177,837	16,875	18,207	10,247	10,929	538	688	0	0	17,414	18,896	8.51%	97.92	106.25
East Lancashire CCG	386,326	39,900	41,500	25,500	26,500	1,100	1,100	0	0	41,000	42,600	3.90%	106.13	110.27
Pennine Lancashire ICP	***564,163***	***56,775***	***59,707***	***35,747***	***37,429***	***1,638***	***1,788***	***0***	***0***	***58,414***	***61,496***	**5.28%**	***103.54***	***109.00***
West Lancashire CCG	113,455	12,238	12,609	9,318	9,601	388	400	0	0	12,626	13,009	3.03%	111.29	114.66
West Lancashire MCP	***113,455***	***12,238***	***12,609***	***9,318***	***9,601***	***388***	***400***	***0***	***0***	***12,626***	***13,009***	**3.03%**	***111.29***	***114.66***
L&SC Total	**1,775,347**	**198,009**	**202,983**	**142,684**	**143,504**	**5,843**	**5,774**	**0**	**0**	**203,852**	**208,757**	**2.41%**	**114.82**	**117.59**

Notes

1. No CCG could separately identify IPA-related expenditure in their Community contracts
2. There may be differences between CCGs in terms of categorisation of expenditure and assumptions underpinning 20/21 planning figures (e.g inclusion of QIPP targets)

* NHAIS registered population 2019

3. CHC/FNC spend is a component of the total IPA spend

Appendix H – Programme

Shadow Business Unit Mobilisation	
Draft Project Plan	
Date	21/02/2020
Updated by	J Hadwen

Gantt Chart Key	
Activity	
Milestone	

The gantt chart will auto-populate once you enter the start and finish dates.

Reference	Activity	Milestone	Start Date	End Date	Lead	02-Mar-20	09-Mar-20	16-Mar-20	23-Mar-20	30-Mar-20	06-Apr-20	13-Apr-20	20-Apr-20	27-Apr-20	04-May-20	11-May-20	18-May-20	25-May-20	01-Jun-20	08-Jun-20	15-Jun-20	22-Jun-20	29-Jun-20	06-Jul-20	13-Jul-20	20-Jul-20	27-Jul-20	03-Aug-20	10-Aug-20	17-Aug-20	24-Aug-20	31-Aug-20	07-Sep-20	14-Sep-20	21-Sep-20	28-Sep-20	05-Oct-20	12-Oct-20	19-Oct-20	26-Oct-20	02-Nov-20	09-Nov-20	16-Nov-20	23-Nov-20	30-Nov-20	07-Dec-20	14-Dec-20	21-Dec-20	28-Dec-20	04-Jan-21	11-Jan-21
n/a	IPA Programme Board Meetings								27th				24th					29th				26th					31st				28th				25th				30th				27th			18th				
n/a	JCCG Meetings					5th									7th								2nd								3rd								5th											
1	**Engagement**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
1.1	Engagement plan draft		01/03/2020	28/03/2020																																														
1.2	Informal engagement period		30/03/2020	30/06/2020																																														
1.3	Formal consultation period if required	y	01/07/2020	30/09/2020																																														
1.4	Shadow BU engagement materials prep for formal consultation		01/04/2020	30/06/2020																																													
1.5	Complaints Analysis		01/04/2020	30/04/2020																																													
1.6	Patient/Public Forum Establishment		01/04/2020	30/05/2020																																													
2	**Workforce**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
2.1	Workforce plan		01/03/2020	17/04/2020																																														
2.2	Draft structure		01/03/2020	17/04/2020																																													
2.3	Workforce impact assessment	y	20/04/2020	30/04/2020																																													
2.4	Job Descriptions		01/04/2020	30/04/2020																																													
2.5	Recruitment process to shadow business unit	y	01/05/2020	30/09/2020																																														
2.6	Training and induction		01/05/2020	30/09/2020																																													
3	**Performance**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
3.1	Establish Incomplete referrals/ ODR project governance	y	26/02/2020	15/03/2020	JAH																																													
3.2	Undertake, track and report on IC/ODR project		27/02/2020	31/03/2021	JAH																																												
3.3	Track and report on critical performance KPIs		01/03/2020	31/09/20	DS																																												
3.4	Liaise with service providers on performance issues and with NHSE&I		01/03/2020	31/03/2021	DS																																												
3.5	Develop business unit performanace management plan	y	01/03/2020	30/04/2020	JAH/DS																																												
4	**Finance**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
3.1	Prepare financial plan for 2020/21		01/04/2020	30/04/2020																																														
3.2	Draft scheme of reservation and delegation from CCGs/JCCCG		20/04/2020	30/05/2020																																													
3.3	Draft Business Unit SFI's		01/05/2020	30/05/2020																																													
3.4	Establish the basis for budgets in shadow form	y	01/06/2020	30/07/2020																																														
3.5	Develop divisonal budgets for implementation from 01/10/20	y	01/07/2020	30/08/2020																																													
5	**Management**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
5.1	Agree and establish business unit governance arrangements		01/07/2020	30/09/2020																																														
5.2	Agree and establish business planning cycle		01/07/2020	30/09/2020																																														
5.3	Establish corporate identity and values	y	01/08/2020	30/10/2020																																														
5.4	Establish business unit SOP		01/06/2020	30/09/2020																																														
5.5	Establish corporate policies		01/06/2020	30/09/2020																																														
6	**IT and Reporting**					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
6.1	Establish IT and interoperability group		01/07/2020	30/09/2020																																														
6.2	Establish business intelligence analysis and reporting		01/07/2020	30/09/2020																																														
6.3	Develop IT systems development strategy	y	01/08/2020	30/10/2020																																														
6.4	Establish process for manageing data quality		01/06/2020	30/09/2020																																														
6.5	Assess licensing implications of establishing the business unit		01/06/2020	30/09/2020																																														
6.6	Assess hardware implications of establishing the business unit		01/06/2020	30/09/2020																																														
6.7																																																			
						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46

Appendix I – Risk Register

No.	Description of Risk			Assess Current Risk		Risk Rating	Control Measures in Place	Status	Risk Owner
	Description of Risk	Cause	Consequence	L	I				
1 Programme Management									
1.1	Insufficient staff resources to deliver the projects - project management	Lack of effective programme planning	Lack of programme progress and/or delay	3	4	12	IPA Board members and IPA Delivery Group members to share the workload and liaise with their organisations for support	Open	MW
1.2	Failure to maintain CHC/IPA performance at current levels	Failure to understand potential impact of changes	Poor performance/ failure to achieve performance targets	4	4	16	Action plans and assurance plans to control referrals with no decision and 28 day Quality Premium	Open	Board
1.3	Failure to undertake overdue reviews for CHC, Fast Track and FNC	Failure to understand capacity requirements of the IPA system, system with mulitple providers	Poor performance/poor quality of acre for patients	4	4	16	IPA Board recommend to CCGs that a separate piece of work is financed to clear the backlog.	Open	JHa
2 Programme Commitment and Continuity									
2.1	Lack of clarity and detail in relation to the CHC models options to be considered	Failure to understand the requirementd and actions for task and finish group	Lack of programme progress and/or delay	3	4	12	Urgent action at July Delivery Group for members to submit list of model options in preparation for options appraisal at the August Delivery Group	Closed	Board
3 Finance									
3.1	Failure to develop a robust commercial model for ICP/ICS in relation to CHC/IPA	Failure to address potential financial impacts of change	No or poor clarity re financial performance potential delays to approvals	2	4	8	Finance representation on IPA Board, constant communication with CCH CFO's	Open	JH
4 Engagement and Approvals									
4.1	Failure to enagage with CCGs	Lack of clinical commissioning input	Potential delays to programme and impact on quality of proposals	2	4	8	IPA Board members and IPA Delivery Group members to share the workload and liaise with their organisations for support	Open	Board
4.2	Failure to engage with providers	Lack of provider representative input	Potential delays to programme and impact on quality of proposals	3	4	12		Open	IF
4.3	Failure to engage with patients	Lack of patient forums/representative input	Potential delays to the programme and impact on quality proposals	3	4	12		Open	MW
4.4	Failure to secure relevant programme approvals	Lack of enagement about proposals and/or poor quality proposals	Potential delays to programme	3	3	9	ICS IPA Accountable officer to provide egular updates to JCCG meeting.	Closed	JH
5 Quality									
5.1	Failure to produce deliverables of sufficient quality for sign off	Lack of clarity about quality required	Potential delay to programme and/or loss of programme credibility	3	3	9		Open	
5.2	Failure to address qualitative elements of service delivery within the preferred operating model	Failure to address potential financial impacts of change	Potential delay to programme and/or loss of programme credibility	3	3	9		Open	

Appendix J –completed Quality Impact Assessment available on request

Appendix K –completed Equality Impact Assessment available on request

5th March JCCCGs

Title of Paper	Planned Care Commissioning Workstream - Update		
Date of Meeting	5th March 2020	Agenda Item	06

Lead Author	Andrew Harrison (FCCCGs)– ICS Planned Care Workstream Lead	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	√
Executive Summary	The ICS Planned Care Workstream has been working towards delivering against the delegated authority provided by JCCCG for the year, namely to 'Agree prioritised list of pathways and timeline for development of outcome based consistent clinical pathways across Lancashire and SC' Having completed the first stage of that process the group have subsequently been dealing with the pathways associated with that prioritised list. Our first clinical engagement events relating to Ophthalmology have been well received and have resulted in an agreed set of pathways. These are now being used to consider and determine procurement, contracting, and financial frameworks for these services to support the published Eye Care JSNA for Lancs. In addition to this first priority scheme, work has been undertaken aligned to provider and Rightcare/GIRFT colleagues regarding Musculo-skeletal services. This will require a PID to be formulated to align to the broader monitoring requirements for JCCCG. A further piece of work has taken place to inform a contractual change to allow continued provision of dermatology services across LSC which will now lead to a broader pathway review planned for the next year. It is expected that this will create an opportunity for a LSC wide Dermatology procurement to take place during the next 12 months. Colleagues remain closely engaged in this process across the ICP and monthly meeting s have been extended to fortnightly to enable continued progress against the broad range of pathway priorities. The Progress report is endorsed by local CCG commissioning leads to be supported by JCCCG	
Recommendations	JCCCGs are requested to review and support the continuation	

	of the planned care workstream for HLSC		
Next Steps	Ophthalmology Public Engagement Process, Standards Confirmation, Procurement and Adoption for Ophthalmology, MSK, and dermatology		
Equality Impact & Risk Assessment Completed	Yes	~~No~~	Not Applicable
Patient and Public Engagement Completed	~~Yes~~	No	Not Applicable
Financial Implications	Yes	~~No~~	Not Applicable
Risk Identified	~~Yes~~	No	
If Yes : Risk			
Report Authorised by:			

5th March JCCCGs

PLANNED CARE COMMISSIONING WORKSTREAM UPDATE

1. Introduction

1.1 The purpose of this report is to update JCCCG on the above workstream.

1.2 The report follows on from previous reports to JCCCG where the work in this area has been supported by colleague to take place as part of the alignment of pathways for services..

1.3 The first area of review undertaken on the prioritised work-plan was Ophthalmology which is nearing conclusion.

1.4 Further Work on MSK and Dermatology have commenced with a view to accelerating these base on the programme of work undertaken for the Ophthalmology pathway.

1.5 Additional work regarding procurement and financial framework for delivery are now deemed necessary to progress the standards metrics and outcomes proposed for each pathway.

2. Ophthalmology

2.1 Two clinical engagement events have taken place with provider and commissioner clinicians to agree the standards metrics and outcomes for three key areas for Ophthalmology; Cataracts, Glaucoma, and wet Age-Related Macular Degeneration (AMD).

2.2 Pathways have been agreed by clinicians to support these three key areas of disease, these will be presented by a clinical lead to the Care Professionals Board. These can now form the basis of a standard method of delivery across LSC, albeit with the flexibility for local discretion of provider.

2.3 Patient reviews will be taking place regarding the pathway proposals in clinic settings across the LSC patch over the spring to ensure that patient input to the proposals is achieved.

2.4 Any future contractual changes will take place in the light of the approved standards metrics and outcomes to ensure consistency across LSC.

3. Musculo-Skeletal Opportunity

3.1 During last year LSC were identified as having a high level of efficiency opportunity in this field using Rightcare and Getting it Right First Time (GIRFT) data.

3.2 ICS led a piece of work to identify how to unlock this efficiency opportunity using provider and commissioner colleagues. Work on this is progressing but is required to be incorporated into a standardized PID format to be used by the LSC Planned Care group.

3.3 This will be completed in the next few weeks and work to create the consistent standards metrics and outcomes will flow from this PID in the expectation that this will align the provider efficiency drive for MSK as identified

4. Dermatology

4.1 As Part of the work to determine priorities, one area of review was the existing timeline for the contract end point for different services. Dermatology was an area where ICP footprints had end points for provision of services during 2019/20.

4.2 Actions were taken to remove the immediate risk of service cessation by incorporating extensions to provision on alternate provider contracts. This has two benefits, firstly that services can continue to be provided without risk to patients across LSC, secondly that by using existing alternate contracts, alignment can take place to ensure that a consistent re-procurement can take place.

4.3 A PID is being completed to demonstrate the work required over the next 18 months to reach a consistent procurement of dermatology services across LCS recognising the limitations of some existing service provision.

5. Next Steps

5.1 The Ophthalmology PID will be concluded once patient engagement feedback has been collected and this will then form the basis of the agreed protocol for these services for commissioners.

5.2 The opportunity is then to determine whether commissioners can seek to enhance outcomes or efficiency from their existing contractual arrangements or await a common procurement opportunity in the future. (or preferably a combination of both)

5.3 MSK PID will be developed to deliver the same process as Ophthalmology but at an accelerated pace.

5.4 A Dermatology PID will allow for a re-procurement of Tier 2 services across the LSC footprint during 2020/21, and this should provide service stabilization during this period with again opportunities for efficiency and improved outcomes.

6 Conclusion / Recommendation

JCCCG is requested to:

1. Note the contents of the report;
2. Support the ongoing work of the Planned Care workstream
3. Acknowledge that the work will need to continue and expand during 2020/21

Andrew Harrison

26th February 2020

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

Title of Paper	Development of Lancashire and South Cumbria clinical commissioning policies: A decision paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	05 March 2020	Agenda Item	07

Lead Author	Rebecca Higgs, Policy Development Manager, NHS Midlands and Lancashire Commissioning Support Unit (MLCSU)	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	√
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed the development of a new commissioning policy on the use of Extracorporeal Shock Wave Therapy (ESWT) for the treatment of tendinopathies. The policy has been prepared for adoption across Lancashire and South Cumbria.This paper details the development process undertaken. The paper also outlines amendments recommended to two further clinical policies previously ratified by the JCCCGs following post-implementation feedback. Those policies re: - *Policy for breast implant replacement.* - *Policy for Assisted Conception Services*	
Recommendations	That the JCCCGs: - ratify the following new Lancashire and South Cumbria policy: ○ *Policy for Extracorporeal Shock Wave Therapy for the treatment of Tendinopathies* - ratify amendments to the following Lancashire and South Cumbria policies: ○ *Policy for breast implant replacement.* ○ *Policy for Assisted Conception Services*	
Next Steps	Following ratification arrangements will be made to implement the commissioning	

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

	policies within relevant commissioned services.		
Equality Impact & Risk Assessment Completed	**Yes**	No	Not Applicable
Patient and Public Engagement Completed	**Yes**	No	Not Applicable
Financial Implications	Yes	**No**	Not Applicable
Risk Identified	Yes		**No**
If Yes : Risk			
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Healthier Lancashire and South Cumbria		

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

The development of Lancashire and South Cumbria clinical commissioning policies:

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

1. Introduction

1.1 The purpose of this paper is to apprise the JCCCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to develop a commissioning policy on the use of Low Intensity Pulsed Ultrasound (LIPUS) Therapy and to update the commissioning policies on assisted conception services and the replacement of breast implants.

Newly developed policy- Policy for Extracorporeal Shock Wave Therapy for the treatment of Tendinopathies

2. Development rationale

2.1 None of the Clinical Commissioning Groups (CCGs) in Lancashire and South Cumbria have an existing commissioning policy on the use of Extracorporeal Shock Wave Therapy (ESWT) for the treatment of tendinopathies and the intervention does not form part of the standard treatment pathway for these conditions.

2.2 The requirement for this policy was identified as several Individual Funding Requests (IFRs) have been received for this intervention across the geography, requesting the use of ESWT as an alternative to the standard management approach for refractory tendinopathies. This has resulted in the intervention being identified as a potential service development area.

2.3 The CPDIG therefore agreed that it would be helpful to develop a commissioning policy that outlined the local commissioning position, in line with the prevailing evidence base.

3. Development process

3.1 The development of this policy has been completed in accordance with the process approved by the CPDIG, which has been shared with the JCCCGs previously. That process includes the following key steps:

i. an evidence review by a Consultant in Public Health;
ii. clinical stakeholder engagement with both Specialist and General Practitioners;
iii. public and patient engagement;
iv. notification of local Health Overview and Scrutiny Committees;
v. consideration of any financial implications

vi. an Equality Impact Risk Assessment (EIRA);
vii. consultation with Healthier Lancashire and South Cumbria Care Professionals Board (the CPB) for clinical assurance purposes.

3.2 Clinical engagement on the policy involved GP practices, Secondary Care Trusts and the Strategic Clinical Network. The feedback received from clinicians highlighted additional information regarding the effectiveness of this intervention in specific patient cohorts. As a result, the proposed policy was amended and criteria for its use in certain patient groups were included.

3.3 Patient engagement was also undertaken. A very low level of response was received, none of which raised concerns regarding the proposed policy position. No changes were therefore made to the policy as a result of patient engagement.

3.4 The policy was presented to Healthier Lancashire and South Cumbria's Care Professionals Board in September 2019, who supported its development.

3.5 The proposed policy criteria have resulted in the existing management pathway for various tendinopathies remaining largely unchanged. As such, the CPDIG recognised that the existing activity and expenditure levels associated with the management are expected to be little affected as very few current service providers use this treatment modality.

3.5 The final draft policy and a stage one Equality Impact Risk Assessment (EIRA)[1] was presented to the CPDIG on 19 December 2019. No equality risks were identified and so the group agreed the policy should proceed to ratification.

3.6 The final draft policy is available to view via the following link https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/ET7rafIhP25MohwiCvX07G8BwhpM7rda-irv1ndwUWjV8Q?e=it2AlI

Amended Policies- Rationale for amendment

4. Policy for Assisted Conception Services

4.1 Following a patient enquiry it was identified that there was potentially some ambiguity in the policy criteria regarding eligibility for NHS funded treatment in the presence of children from a previous relationship. The patient enquiry highlighted that the policy may benefit from clarification to ensure consistent interpretation.

4.2 The issue was discussed at the CPDIG in December 2019 and January 2020 who noted that when the policy was written the CPDIG were clear that the intention of the

policy was that for couples both partners must be childless to be eligible for treatment.

4.3 Members therefore agreed that the policy should be amended to avoid any potential confusion regarding eligibility. The existing policy wording and proposed amended wording are outlined in table 1 below for ease of reference.

Table 1: An overview of the proposed amendment to the Policy for Assisted Conception Services

Existing policy wording	Proposed future policy wording
The patient/s have no living biological or adopted children from the current or any previous relationship."	"*The patient, and their partner in the case of couples, must not have a living biological or adopted child from their current or any previous relationship."*

4.4 As this amendment relates to a point of clarity, rather than a change to access criteria, no impact on cost or activity levels associated with assisted conception services are anticipated.

5. Policy for Cosmetic Procedures- Breast implant replacement

5.1 The current policy for breast implant replacement came into force in July 18, and only allows implant replacement to be undertaken if eligibility criteria are met. Those criteria include the requirement that the replacement must be done at the same time as the removal procedure. It is also of note that the criteria relating to the removal of breast implants require functional symptoms to be present for implants to be removed on the NHS.

5.2 The requirement to review this policy was identified following the receipt of several Individual Funding Requests (IFRs) requesting authorisation for either delayed re-implantation prior to implant removal, or the replacement of breast implants following previous implant removal.

5.3 Clinicians responsible for submitting those requests also highlighted that the evidence base regarding the potential impact of different approaches to re-implantation had developed.

5.4 A new review of the evidence base was therefore undertaken and the findings were discussed with the CPDIG. This concluded that there was evidence to indicate that, in some patients, the removal and immediate replacement of implants increases the risk of further capsular contraction due to biofilm formation around the initial implant. The CPDIG therefore agreed that the decision about when to replace the implants should be guided by clinical considerations; and the criteria mandating that implants be replaced in the same procedure as the removal should be removed from the policy.

5.5 The existing policy wording and proposed amended wording are outlined in table 2 below for ease of reference.

Table 2: An overview of the proposed amendment to the Policy Breast implant replacement

Existing policy wording	Proposed future policy wording
The CCG will commission the supply and insertion of a replacement breast implant under the following circumstances: *a) the original implant was supplied and inserted by the NHS;* AND *b) the removal of the implant is in accordance with this policy;* AND *c) the replacement can be carried out as part of the same procedure as the removal of the previous implant.* *When the CCG funds a replacement implant it is the expectation that the surgeon will explain the implications and risks in relation to breast screening and clinical detection of breast cancer and will record in the notes that the patient is aware of such risks and takes responsibility for them.*	*The CCG will commission the supply and insertion of a replacement breast implant under the following circumstances:* *a) the original implant was supplied and inserted by the NHS;* AND *b) the removal of the implant is in accordance with this policy;* *When the CCG funds a replacement implant it is the expectation that the surgeon will explain the implications and risks in relation to breast screening and clinical detection of breast cancer and will record in the notes that the patient is aware of such risks and takes responsibility for them.*

6. Recommendations

6.1 The JCCCGs is asked to:

- ratify the following collaborative commissioning policy *Policy for Extracorporeal Shock Wave Therapy for the treatment of Tendinopathies.*
- ratify the proposed amendment to the *Policy for Assisted Conception Services.*
- ratify the proposed amendment to the Policy for Breast Implant Replacement.

Elaine Johnstone

Chair of the CPDIG

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

27.02.2020

References

1. Equality Impact Risk Assessment on Policy for Extracorporeal Shock Wave Therapy for the treatment of Tendinopathies

   https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EVt9mhxu7jNPt41VthiFcxsBjYvTa6wfRx0XyNgZ5wP5sw?e=eSlw5N

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Title of Paper	**2020/21 Work Plan**		
Date of Meeting	5th March 2020	Agenda Item	08

Lead Author	Andrew Bennett	
Contributors	Commissioning and Programme Leads	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X
Executive Summary	This paper sets out the proposed work plan for the Joint Committee of CCGs for 2020/21. The work plan is designed to address specific issues requiring collective decision making by the eight CCGs in Lancashire and South Cumbria. These commissioning decisions arise from several of the existing workstreams operating under the partnership of organisations known as the Lancashire and South Cumbria Integrated Care System.	
Recommendations	The Joint Committee is asked to: 1. Review and endorse the work programme for 2020/21. 2. Arrange for the work programme to be presented to each CCG Governing Body to receive the required delegation of authority to take decisions through the Joint Committee	
Next Steps	Arrange for the work programme to be presented to each CCG Governing Body to receive the required delegation of authority to take decisions through the Joint Committee.	

Is this a level 1 or Level 2 decision?	Level 1		Level 2	x

Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable

Risk Identified		No
If Yes : Risk		
Report Authorised by:	Andrew Bennett	

Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)
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Level 1: *where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs.*

Level 2: *where health and social care commissioning areas and operational functions affect/impact on the population of Lancashire & South Cumbria (or wider) are considered by the Committee and any decision(s) undertaken by the Committee from the basis of endorsements and recommendations to the governing bodies of each member CCG, and other decision making bodies.*

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

2020/21 Work Plan

Introduction

This paper sets out the proposed work plan for the Joint Committee of CCGs for 2020/21. The work plan is designed to address specific issues requiring collective decision making by the eight CCGs in Lancashire and South Cumbria. These commissioning decisions arise from several of the existing workstreams operating under the partnership of organisations known as the Lancashire and South Cumbria Integrated Care System.

The work programme has been developed by commissioning and other workstream leads in recent weeks. Each workstream has been asked to be as specific as possible at this stage in the year as to the nature of the decision being requested from the Joint Committee.

The Joint Committee is asked to review and endorse the work programme. The work programme will then be presented to individual Governing Bodies in order to receive the required delegation of authority which enables each CCG to take decisions through the Joint Committee of CCGs.

Context

1. The Joint Committee of CCGs was established in 2016/17 to enable the eight CCGs in Lancashire and South Cumbria to exercise jointly an agreed number of commissioning functions in line with current legislation. The primary purpose of the Joint Committee is to take decisions on commissioning issues which are pertinent to the whole of Lancashire and South Cumbria and which arise from the Lancashire and South Cumbria ICS programmes of work.

2. The Joint Committee continues to operate with an Independent Chair and for 2020/21 will be holding its meetings in public on a bi-monthly basis.

3. The work programme shown below has been developed by commissioning and other workstream leads in recent weeks. Each workstream has been asked to be as specific as possible at this stage in the year as to the nature of the decision being requested for collective decision making. Members will note therefore that the Joint Committee will be asked to review for example: clinical models, business cases, cases for change and option appraisals. In certain cases, these proposals may lead towards public consultation if plans for significant service change are developed.

4. The work programme has also been developed in the light of the Joint Committee's review of Terms of Reference which took place during 2019/20. This identified two levels of decision-making as follows:

    - Level 1 – where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs.
    - Level 2 – where health and social care commissioning areas and operational functions affect/impact on the population of Lancashire and South Cumbria (or

wider) are considered by the Committee and any decision(s) undertaken by the Committee form the basis of endorsements and recommendations to the Governing Bodies of each member CCG and other decision making bodies.

5. It is vital to emphasise that prior to any decisions coming to the Joint Committee, clinical, commissioning, finance and other colleagues from the CCG will have been involved by each workstream in the necessary development work. In recent months, system leaders have also discussed a clearer process of decision-making using gateways at a number of key stages to oversee these collective programmes of work. Each programme also has an agreed programme governance structure through which the ICS's partners can review progress.

6. Once the work programme is agreed, a more detailed timetable will be developed for the Joint Committee to indicate when decisions on this work programme are anticipated during 2020/21. This will enable local Governing Bodies and CCG executive teams to plan more clearly for involvement on the issues under review.

7. Given the breadth of the agenda for commissioners in Lancashire and South Cumbria, it is possible that the work programme may need to be updated later in 2020. This will obviously be undertaken in line with expected governance arrangements involving CCG Governing Bodies.

Recommendation

The Joint Committee is asked to:

3. Review and endorse the work programme for 2020/21.

4. Arrange for the work programme to be presented to each CCG Governing Body to receive the required delegation of authority to take decisions through the Joint Committee.

Andrew Bennett

Executive Director of Commissioning – Lancashire and South Cumbria ICS

Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)
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Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)
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Joint Committee of the Lancashire & South Cumbria Clinical Commissioning Groups

2020/21 Work Programme

Area 1: Committee Administration & Operation				
Service/ Subject	**Executive Sponsor**	**Description**	**Key Output**	**Level of Decision making**
Committee Administration	Andrew Bennett	Holding of Committee meetings Committee Agendas and papers Committee minutes Publication of notice of meetings Approval and publication of Committee Agendas and papers Approval of Committee minutes and ensure publication of minutes on each CCG website Approval of progress against Workplan and ensure publication within each CCG annual report of progress Approval of Quarterly and Annual Committee Reports to each CCG Governing Body Review of self-assessment. Review of progress against Annual Workplan Committee Self-assessment.	Delivery of the statutory role, responsibilities and Accountabilities as set-out in the TOR's. Annual Committee report to CCG Governing Bodies	Level 1
Committee Administration	Andrew Bennett	Review annual work plan and submit amendment recommendations for adoption to each CCG Governing Body / GP memberships Review Committee TOR and submit amendment recommendations for adoption to each CCG Governing Body / GP Memberships.	Annual Committee Work plan Committee TOR	Level 2

Decision making authority level definition:

Level 1: *where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs*

Level 2: *where health and social care commissioning areas and operational functions affect / impact on the population of Lancashire & South Cumbria(or wider) are considered by the Committee and any decision(s) undertaken by the Committee form the basis of endorsements and recommendations to the Governing Bodies of each member CCG, and other decision making bodies.*

Area 3: Lancashire & South Cumbria ICS Priority Programmes of work				
Service/ Subject	**Executive Sponsor**	**Description**	**Key Output**	**Level of Decision making**
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs	Policy Documents	Level 1
Medicines Management Policies	Andy Curran	Agree updated medicines management policies developed collectively for all CCGs	Commissioning Policies Commissioning Pathways Ratification of NICE Technology Appraisals	Level 1
Commissioning Standards		Agree key clinical standards to be consistently met across Lancashire & South Cumbria, so that all people receive the highest possible care and best outcomes.	Standards Documentation	Level 1

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SEND	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to delivery the 2020/21 SEND partnership improvement plan. This includes specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental pathway, therapy service review and transition to adult services.	2020/21 Lancashire SEND partnership improvement plan	Level 2
Advancing Integration	Julie Higgins	Collaborative work between CCGs and Local Authorities in Lancashire and South Cumbria to agree a commissioning strategy and financial strategy for Intermediate Care Services.	Commissioning strategy Finance strategy	Level 2
Stroke	Aaron Cummins/ Talib Yaseen	Review and approve Outline Business Case for the optimum configuration of Hyperacute Stroke Units (HASUs) Review and approve Pre-consultation Business Case (PCBC) Decide on requirement and readiness to consult with the public on options for HASU configuration Review outcomes of HASU public consultation (if required) Approve full business case Approve commissioning approach and delivery plan	Outline Business Case Pre-Consultation Business Case Full Business Case Delivery Plan	Level 1
Vascular	Karen Partington/ Talib Yaseen	Review and approve Pre-consultation Business Case. Decide on requirement and readiness to consult with the public on options for operating model. Review outcomes of public consultation (if required) Approve full business case Approve commissioning approach and delivery plan	Pre-Consultation Business Case Full Business Case Delivery Plan	Level 1

Head & Neck/Oral Maxillo-facial services	Aaron Cummins/ Talib Yaseen	Review and approve Pre-consultation Business Case (PCBC) Decide on requirement and readiness to consult with the public on options for operating model. Approve full business case Approve commissioning approach and delivery plan	Pre-Consultation Business Case Full business case Delivery Plan	Level 1
Diagnostics – Interventional Radiology, Endoscopy and Endoscopic Ultrasound	Kevin McGee/ Talib Yaseen	Approve case for change to the operating model for interventional radiology services across Lancashire and South Cumbria Review options appraisal for the operating model for interventional radiology services across Lancashire and South Cumbria Approve case for change to the operating model for endoscopic ultrasound (EUS) services across Lancashire and South Cumbria Review options appraisal for the operating model for endoscopic ultrasound (EUS) services across Lancashire and South Cumbria Approve case for change to the operating model for endoscopy services across Lancashire and South Cumbria Review options appraisal for the operating model for endoscopy services across Lancashire and South Cumbria	Case for Change Options appraisal Case for Change Options appraisal Case for change Options appraisal	Level 1
Adult Mental Health	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in March 2020 for implementation from April 2020. Model will describe governance arrangements, including JCCCG responsibilities.	Operating Model and Financial Framework	Level 1

		Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process.	Operational Plan	
Children's Mental Health	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in April 2020 for implementation from May 2020. Model will describe governance arrangements, including JCCCG responsibilities. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process. Approve the annual refresh of the CYPEWMH Local Transformation Plan Approve the end of year position for 2019/20 and the financial allocations for 2020/21 as detailed within the annual CYPEWMH Business Plan Approve the Clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve transition and implementation plan for the Clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve the Financial Modelling Template to underpin the Clinical model for CYP Mental Health services across Lancashire and South Cumbria	Operating Model and Financial Framework Operational Plan Transformation Plan 2020/21 Business Plan 2020/21 Clinical Model Transition and Implementation Plan Financial Modelling Template	Level 1
Learning Disabilities and Autism	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in May 2020 for implementation from June	Operating Model and Financial Framework	Level 1

		2020. Model will describe governance arrangements, including JCCCG commissioning. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process.	Operational Plan	
Ambulance Commissioning – Paramedic emergency service (PES). NHS 111 and Patent Transport Services (PTS)	David Bonson	Responsibility for all commissioning functions in accordance with the agreed North West Collaborative Governance Arrangements. Approve integrated future operating model across 999, NHS 111 and PTS services which will include a collective financial and contractual framework for Lancashire and South Cumbria (to be mobilised by April 2021) Agree strategic direction for Patient Transport Services across Lancashire and South Cumbria	Operating Model, Finance and Contractual Framework Strategic Plan Procurement Plan	Level 1
Cancer	Denis Gizzi	E	Report and Recommendations	Level 1
Planned Care	Andrew Harrison	Agree prioritised list of pathways and timeline for development of outcome based consistent clinical pathways across Lancashire & South Cumbria	Clinical Pathways	Level 1
Falls Lifting Service	Louise Taylor (Executive Director – LCC)	Receive recommendations for further opportunities for joint commissioning of this service.	Report and recommendations	Level 2
Telecare	Louise Taylor (Executive Director – LCC)	Review recommendations for further opportunities for joint commissioning of these services.	Report and recommendations	Level 2

Health Infrastructure Plan	Talib Yaseen	Periodic updates on the planning process to respond to this national initiative	Updates	Level 2
Digital Health	Gary Raphael	Recommendations which support: a) the commissioning of services from providers who are willing to collaborate towards a single electronic patient record across Lancashire and South Cumbria. b) The commissioning of services from providers who adopt a "digital first" approach to service design and delivery	Report and recommendations	Level 2

Decision making authority level definition:

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Area 4: Commissioning Leadership in developing new ways of working as set-out in the NHS Plan				
Service/ Subject	**Executive Sponsor**	**Description**	**Key Output**	**Level of Decision making**
Commissioning reform	Andrew Bennett	Oversight of Commissioning reform process based on agreed roadmap (via Commissioning Reform Group)	Progress reports Proposed CCG constitution	Level 2
Commissioning reform	Andrew Bennett	Following engagement process with member practices and partner organisations, progress proposals to establish a single CCG and five locality commissioning teams across LSC. This is subject to a vote of member practices to take place in May 2020.	CCG merger submission to NHS England/Improvement Due Diligence Plans required by NHS England and CCGs as part of an agreed transition process.	Level 1
Transformation Funding	Gary Raphael	Opportunity to develop proposals for risk/gain share arrangements for the use of local transformation funding as part of financial strategy development.	Risk/gain share proposals	Level 2

Decision making authority level definition:

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Level 2: *where health and social care commissioning areas and operational functions affect / impact on the population of Lancashire & South Cumbria(or wider) are considered by the Committee and any decision(s) undertaken by the Committee form the basis of endorsements and recommendations to the*

Governing Bodies of each member CCG, and other decision making bodies.

Note: this section of the work programme may be updated later in 2020/21 to reflect any emerging requirements as a consequence of the Commissioning Reform process.

Joint Committee of Clinical Commissioning Groups

Title of Paper	Lancashire and South Cumbria Medicines Management Group Recommendations: A briefing paper for the Healthier Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	05.03.2020	Agenda Item	10

Lead Author:	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for medicine reviews and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria.	
Recommendations	That the JCCCGs ratify the collaborative LSMMG recommendations on the following: - *Agomelatine for the treatment of major depressive episodes in adults.* - *NICE Technology Appraisals (December 2019 and January 2020).* - *Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome.* - *Melatonin (Colonis tablets and liquid) for all indications.* - *Nortriptyline for chronic neuropathic pain.* - *Octreotide and lanreotide in secretory gastrointestinal disorders.* - *Octreotide and lanreotide in orthostatic intolerance disorders.* - *Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis.*	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	No	
Financial Implications	Yes	
Risk Identified	No	
If Yes: Risk	N/A	
Report Authorised by:	XXXX	

Midlands and Lancashire
Commissioning Support Unit

DEVELOPMENT OF LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP RECOMMENDATIONS:

1. INTRODUCTION

1.1 The purpose of this paper is to apprise the JCCCGs of the work undertaken by the Lancashire and South Cumbria Medicines Management Group (LSCMMG) to develop commissioning recommendations on the following:

- *Agomelatine for the treatment of major depressive episodes in adults.*
- *NICE Technology Appraisals (December 2019 and January 2020).*
- *Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome.*
- *Melatonin (Colonis tablets and liquid) for all indications.*
- *Nortriptyline for chronic neuropathic pain.*
- *Octreotide and lanreotide in secretory gastrointestinal disorders.*
- *Octreotide and lanreotide in orthostatic intolerance disorders.*
- *Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis.*

2. DEVELOPMENT PROCESS

2.1 LMMG produces a number of different documents to support the safe, effective and cost-effective usage of medicines. The development of recommendations has been completed in accordance with the process approved by the LSCMMG, which has been shared with the JCCCGs previously.

2.2 The review process includes the following key steps:

- an evidence review by an allocated lead author.
- clinical stakeholder engagement;
- consideration of any financial implications
- an Equality Impact Risk (EIRA) Assessment screen
- public and patient engagement (where applicable).

2.3 The final documents are available to view via the following links:

- *Agomelatine for the treatment of major depressive episodes in adults.*

Agomelatine New Medicine Assessment JCCCG.docx

- *NICE Technology Appraisals (December 2019 and January 2020).*

Available at https://www.nice.org.uk/guidance/published?type=ta

- *Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome.*

Use of Melatonin in Children and Adolescents JCCCG.docx

- *Melatonin (Colonis tablets and liquid) for all indications.*

Use of Melatonin in Children and Adolescents JCCCG.docx

- *Nortriptyline for chronic neuropathic pain.*

Nortriptyline JCCCG.docx

- *Octreotide and lanreotide in secretory gastrointestinal disorders.*

Octreotide and Lanreotide for GI secretory disorders JCCCG.docx

- *Octreotide and lanreotide in orthostatic intolerance disorders.*

Octreotide POTS New Medicine Assessment JCCCG.docx

- *Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis.*

Oscillating PEP devices JCCCG.docx

3. RECOMMENDATIONS WITH NO ANTICIPATED RISK TO THE LANCASHIRE AND SOUTH CUMBRIA HEALTH ECONOMY

Octreotide and lanreotide in orthostatic intolerance disorders

3.1 Octreotide and Lanreotide were prioritised for review following receipt of individual funding requests for unlicensed use in orthostatic intolerance conditions such as postural orthostatic tachycardia syndrome.

3.2 The LSCMMG agreed a Black RAG rating (not to be prescribed on the NHS in Lancashire and South Cumbria) due to insufficient evidence of effectiveness, recognising that the IFR route would remain available for patients with exceptional clinical circumstances.

3.3 No significant risks were identified as a result of allocating a Black RAG status to octreotide and lanreotide.

Melatonin (Colonis tablets and liquid) for all indications

3.4 The LSCMMG considered the use of two newly licensed melatonin preparations: 1mg/ml oral solution and 3mg tablets, both products only licensed for short-term treatment of jet-lag in adults.

3.5 The LSCMMG agreed a Black RAG rating for both preparations (not to be prescribed on the NHS in Lancashire and South Cumbria). The basis for the RAG position for Colonis melatonin liquid 1mg/ml was due to safety concerns relating to the product's high propylene glycol and alcohol content. The basis for Colonis 3mg tablets was that more cost-effective alternatives are available. The Black RAG classification covers all indications including jet lag and insomnia (off-label)

3.6 No significant risks were identified as alternative melatonin preparations are available.

NICE Technology Appraisals (December 2019 and January 2020)

3.7 After consideration at LSCMMG, NICE TA recommendations will be automatically adopted and added to the LSCMMG website unless significant issues are identified by LSCMMG which require further discussion at JCCCGs.

3.8 One CCG commissioned NICE TA was identified - Lusutrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure (TA617). NICE concluded that if the benefits for patients and service delivery benefits were taken into consideration in the economic modelling it is likely that Lusutrombopag would save the NHS money.

3.9 No significant risks were identified.

Nortriptyline for chronic neuropathic pain.

3.10 Nortriptyline was prioritised for review following a request from the Lancashire Community Pain Team for Nortriptyline to be considered as a 3rd line option for treating chronic neuropathic pain.

3.11 The LSCMMG agreed a Green (restricted) RAG rating as a 3rd line agent (Appropriate for initiation and ongoing prescribing in both primary and secondary care provided additional specific criteria are met or as part of a locally agreed treatment pathway).

3.12 No significant risks were identified as the resulting net budget impact of this treatment would be minimal or cost neutral.

4. RECOMMENDATIONS WITH A LOW ANTICIPATED RISK TO THE LANCASHIRE AND SOUTH CUMBRIA HEALTH ECONOMY

Agomelatine for the treatment of major depressive episodes in adults

4.1 Agomelatine was identified for review following a request from Lancashire and South Cumbria Foundation Trust (formerly Lancashire Care NHS Foundation Trust).

4.2 The LSCMMG agreed to a Red RAG status (supplied by hospital/specialist service only) in line with a prior approval process as a last line pharmacological agent.

4.3 Agomelatine is more expensive than comparator antidepressants, however the estimated cost burden is expected to be low due to the small anticipated patient numbers and the requirement for prior approval at Lancashire and South Cumbria Foundation Trust.

Octreotide and lanreotide in secretory gastrointestinal disorders

4.4 Octreotide and Lanreotide were prioritised for review following a number of individual funding requests for unlicensed use of the products in gastrointestinal secretory disorders.

4.5 The LSCMMG agreed a Red RAG rating (supplied by hospital/specialist service only) for octreotide and lanreotide as they are not licensed for this indication and there is not a large body of evidence to support this unlicensed use.

4.6 The LSCMMG identified possible financial implications for the approval of octreotide and lanreotide in gastrointestinal secretory disorders. For this reason, it was agreed that uptake would be assessed at 6 months. Due to the small anticipated patient numbers and planned monitoring of prescribing levels, the financial risk associated with approving the use of octreotide/lanreotide in secretory gastrointestinal disorders was estimated to be low.

Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis

4.7 Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis was prioritised for review following a request to consider the devices from Greater Preston and Chorley South Ribble CCGs where queries about the devices had been received.

4.8 The LSCMMG supported a Black RAG status (not to be prescribed on the NHS in Lancashire and South Cumbria). The basis for the RAG rating was that there is insufficient, good quality evidence short term evidence and no long-term evidence.

4.9 Assigning a Black RAG status to oscillating positive expiratory pressure devices may represent a low risk for inequality in the West Lancashire health economy as the Pan Mersey Area Prescribing Committee list this device in their formulary.

5. RECOMMENDATIONS WITH A HIGH ANTICIPATED RISK TO THE LANCASHIRE AND SOUTH CUMBRIA HEALTH ECONOMY

Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome

5.1 Slenyto is the only licensed preparation of melatonin indicated for the treatment of insomnia in children and adolescents aged 2-18 with Autism Spectrum Disorder (ASD) and / or Smith-Magenis syndrome, where sleep hygiene measures have been insufficient.

5.2 Circadin® has a licence as monotherapy for the short-term treatment of primary insomnia characterised by poor quality of sleep in patients who are aged 55 or over. However, it has been used for various off label indications including the treatment of children and adolescents and has a significantly lower acquisition cost than the licensed Slenyto preparation.

5.3 The LSCMMG agreed not to restrict access to the licensed preparation and recommend both Slenyto and Circadin for this indication.

5.4 A financial risk has been identified as follows:

£436,000 was spent on tablet/capsule formulations of melatonin for children over a 12-month period in Lancashire and South Cumbria. If there was a 20% switch from all tab/cap formulations for children to Slenyto the cost would be £565,000 [additional spend of £129,000])

5.5 It was agreed that prescribing data will be monitored at 3- and 6-months following ratification to assess uptake levels for Slenyto. The LSCMMG will be informed and discuss/agree actions to mitigate the financial risk if the cost burden is greater than the predicted levels above.

6. Conclusion

6.1 The JCCCGs is asked to ratify the following LSCMMG recommendations:

- *Agomelatine for the treatment of major depressive episodes in adults.*
- *NICE Technology Appraisals (December 2019 and January 2020).*
- *Melatonin (Slenyto and Circadin tablets) for Autism Spectrum Disorder and Smith-Magenis syndrome.*
- *Melatonin (Colonis tablets and liquid) for all indications.*
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- *Octreotide and lanreotide in secretory gastrointestinal disorders.*
- *Octreotide and lanreotide in orthostatic intolerance disorders.*
- *Oscillating Positive Expiratory Pressure Device for non-cystic fibrosis bronchiectasis.*

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