Healthier Lancashire & South Cumbria

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

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

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

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

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	weeks largely web-based consultation process where there is minimal change, to a much more extensive 12-week programme to involve focus groups. Clinical oversight and assurance is also taken from the Care Professional Board (CPB). The Committee was informed that the CPB was supportive of the policy and happy to recommend its further consideration. The following two policies had been through this process: ***a) Policy for spinal injections and radio frequency denervation for low back pain*** E Johnstone explained that this policy had been through extensive clinical engagement and a number of changes were made as a result of that engagement. The Committee was informed that the core eligibility criterion within the policy is unchanged from the existing Pennine Lancashire policy. The net impact of this policy is to bring clinical practice across L&SC in line with the prevailing national guidance. It was reported that only two CCGs had a policy in place previously. For three CCGs (Chorley and South Ribble, Greater Preston and West Lancashire) this is an entirely new policy. For two CCGs (Fylde and Wyre CCG and Morecambe Bay CCG) this is a wider policy in scope than was previously in place. Blackpool CCG's policy was not aligned to NICE guidance and had been updated and brought in line. For the two Pennine CCGs (East Lancashire and Blackburn with Darwen) the policy is essentially unchanged. E Johnstone informed the Committee that due to the different histories in various CCGs, the introduction of this policy is expected to save resources in the region of £300k per annum. Both public engagement and the equality impact assessment process had not identified any necessary changes and the policy is now ready for the Committee to endorse. The Chair asked the Committee if there were any questions or comments relating to the policy. G Jolliffe requested clarity on the transition of existing patients through the system. E Johnstone informed the Committee that the generally agreed principle across L&SC for all policies where changes are introduced is that any patient who is already in the treatment pathway carries on with the pathway and the policy in place at the point of referral. The change will be for new patients. M Youlton requested clarity on the process for communicating the information to providers once agreed. He also asked if providers are required to agree and sign a contract variation. E Johnstone responded to the question and informed the Committee that the standard NHS Contract has provision for contract variations if there is a level of potential change to provider income. There are clauses in the contract regarding the amount of notice and there is a degree of variation across L&SC about what has been negotiated with individual providers. R Higgs answered the question regarding onward communication to providers and this varied depending on the nature of the policy being introduced. In general it is communicated by a contract variation to providers. The Committee was informed that providers had been involved in consultations throughout the development of this policy and are aware that the policy is due to be implemented in-year, so there is an expectation that the policy will be implemented by CCGs. Contract teams issue formal contract variations and process these through Trusts. Work was ongoing to understand the least bureaucratic way for CCGs to vary "commissioner/provider" approach. A Doyle felt that the discussion was reverting to purist commissioners and went on to say that the whole point of developing an integrated approach to care is to look at how we prioritise the use of the total resource and agree what are the clinically appropriate things to do for the community. She added that implementation has to be around engaging the clinicians in the pathways that we have in L&SC. It was concluded that the bigger discussion is about clinical practice and how we communicate to patients and how we communicate to our clinicians on how they are expected to change their practice.

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

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

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

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

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

RESOLVED: that the Committee approved the policy.

b) Policy for assisted conception services.

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

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

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

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

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

E Johnstone reported the key changes:

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

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

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

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

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

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

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

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benefits of people being treated effectively and having less disability but the costs incurred for longer-term care. It is possible this could cost the NHS more in some aspects but may have bigger benefits within the local authority sector. Meetings were due to take place seeking input from local authority colleagues to gain fully rounded views on the costs and benefits of this particular programme.

G Stanion informed the Committee of the challenges from a clinical acute perspective/hyper acute implemented from a staffing and workforce perspective. In terms of Cumbria it was reported that a meeting took place with commissioning and provider representatives from Morecambe Bay to discuss how to make it very clear for residents in that part of the patch what we are doing to ensure they have the best possible outcomes of the pathway.

A Bennett informed the Committee that this was a detailed stocktake predicated on helping to understand where commissioning needs to come together to secure certain outcomes and to share the same with provider leaders. A Bennett asked that the Committee endorsed the collective action being taken by providers to address gaps in the current services. G Stanion agreed to convey the message, including the omission of smoking.

RESOLVED: that the Committee noted the content of the report and endorsed the programme and work going forward.

9 **Special Educational Needs and Disabilities (SEND)**

M Youlton provided a formal update on the latest position of the services across the county of Lancashire. Following a review of the service in November 2017 where the outcome was far from good, a process was put in place to submit a written statement of action to improve the services. Two reviews by the regulators had taken place in 2018. It was reported that a number of patients and carers are members of the Board overseeing this improvement plan.

A service around autism spectrum disorder (ASD) has been put in place in North Lancashire with 135 children and young people moving off the waiting list within a few months. Engagement had taken place in schools with school heads, patients and carers and one event resulted in 44 carers who want to be actively involved in this programme in Lancashire. A Power Group made up of mainly young people had produced great videos and powerful stories about people with these disabilities and this is something the group will continue to develop, along with the development of the 'local offer' website for Lancashire families to access messages of support and for that support to be consistent to lead them through the challenges they face.

Actions to date:

- Engagement workstream developing a new website
- 16 regional events attended by 190 parents and carers on what the service can offer
- 129 practitioners involved and 600 patient carers
- 368 children and young people completed surveys with 285 educators attending events across the county and this will continue through the process

Further work was ongoing following an assessment of engagement at the beginning of October 2018. Work was also ongoing with the appointment of designated clinical officers who will have a key role in assessing the quality in health and education care plans in existence for people to ensure they are of a consistent quality across the county.

A final scrutiny visit is due in December 2018.

Professor D Harrison commended on the piece of work as one of "the best pieces of work we have done all year to reduce inequalities." From a public health perspective this is one of the areas probably most critical in the health and wellbeing of vulnerable young people. He went on to say that the criminal justice system has between 40-60% of young people with an undiagnosed learning difficulty or ASD and this service will make a big different to the risk of that cohort going into the criminal justice system.

S Stevenson informed the Committee that Healthwatch, across L&SC, will support this

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

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