Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 05 September 2019, 13:00-15:00,
South Ribble Borough Council, Civic Centre,
West Paddock, Leyland, Lancashire, PR25 1DH

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 02 May 2019	Chair	Approval	Attached
	4.	Items for any other business	Chair	Information	Verbal
Improving Population Health					
13:05	5.	Lancashire and South Cumbria Urgent and Emergency Care Strategy	T Almond	Note	Attached
13:25	6.	Commissioning Policies: a. Tonsillectomy b. Surgical release of trigger finger c. Surgical management of gynaecomastia d. Management of otitis media with effusion using grommets e. Surgical treatment of carpal tunnel syndrome f. Breast reduction surgery g. Removal of benign skin lesions	E Johnstone/ R Higgs	Approval	Attached
13:45	7.	Individual Patient Activity (IPA) Interim Progress Report	J Hawker	Approval	Attached
14:10	8.	Ophthalmology Project Initiation Document	A Harrison	Approval	Attached
14:20	9.	Terms of Reference Review	J Hawker	Approval	Attached
Any Other Business					
14:55	10.	Any other business	Chair	Information	Verbal
Date and time of next meeting: Thursday 07 November 2019, 13:00-15:00, Morecambe Bay CCG, Moor Lane Mills, Moor Lane, Lancaster, LA1 1QD. Dates of future meetings 2020: 09 January 2020 05 March 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.

Healthier Lancashire & South Cumbria

Notes of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 02 May 2019 13:00-15:00
NHS Morecambe Bay CCG (Main Lecture Theatre),
Moor Lane Mils, Moore Lane, Lancaster, LA1 1AD

Present		
Phil Watson	Independent Chair	JCCCGs
Dr Richard Robinson	Clinical Chair	East Lancashire CCG
Geoffrey O'Donoghue	Lay Member	Chorley and South Ribble CCG
Dr Geoff Jolliffe	GP and Clinical Chair	Morecambe Bay CCG
Doug Soper	Lay Member	West Lancashire CCG
Dr Gora Bangi	Chair	Chorley South Ribble CCG
David Bonson	Chief Operating Officer	Blackpool CCG
Roy Fisher	Chair	Blackpool CCG
Dr Sumantra Mukerji	Chair	Greater Preston CCG
Paul Kingan	Chief Finance Officer	West Lancashire CCG
Graham Burgess	Chair	Blackburn with Darwen CCG
Louise Taylor	Executive Director for Adult Services and Health and Wellbeing	Lancashire County Council
Dr Adam Janjua	GP and Acting Chair	Fylde and Wyre CCG
In Attendance		
Andrew Bennett	Executive Lead Commissioning	Healthier Lancashire and South Cumbria ICS
Margaret Williams	Chief Nurse	Morecambe Bay CCG (attended for item 7)
Elaine Johnstone	Chair, Commissioning Policy Development and Implementation Group (CPDIG)	Midlands and Lancashire Commissioning Support Unit (attended for Items 5 and 8)
Rebecca Higgs	Individual Funding Request (IFR) Policy Development Manager	Midlands and Lancashire Commissioning Support Unit
Roger Parr	Chief Finance Officer	East Lancashire and Blackburn with Darwen CCGs
Denis Gizzi	Chief Officer	Chorley & South Ribble CCG and Greater Preston CCG
Gary Raphael	Finance Lead	Healthier Lancashire and South Cumbria ICS
Amanda Doyle	Chief Officer	Healthier Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Healthier Lancashire and South Cumbria ICS
Jane Cass	Locality Director	Healthier Lancashire and South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Healthier Lancashire and South Cumbria ICS
Linda Riley	Director of Operations	Midlands and Lancashire Commissioning Support Unit
Rachel Snow-Miller	Director of Commissioning for All Age Mental Health and Learning Disability Services	Healthier Lancashire and South Cumbria ICS (attended for Item 6)
Heather Bryan	Programme Manager/Service Redesign Team	Midlands and Lancashire Commissioning Support Unit (attended for Item 6)

Apologies		
Debbie Corcoran	Lay member	Greater Preston CCG
Harry Catherall	Chief Executive	Blackburn with Darwen Borough Council ICS
Jerry Hawker	Chief Officer	Morecambe Bay CCG
Steve Thompson	Director of Resources	Blackpool Borough Council
Julie Higgins	Chief Officer	East Lancashire and Blackburn with Darwen CCGs
Andrew Bibby	Assistant Regional Director of Specialised Commissioning (North)	NHS England/NHS Improvement
Gary Hall	Chief Executive	Chorley Borough Council
Neil Jack	Chief Executive	Blackpool Borough Council
Sakthi Karunanithi	Director of Public Health	Lancashire County Council
Angie Ridgwell	Chief Executive	Lancashire County Council
Carl Ashworth	Service Director	Midlands and Lancashire Commissioning Support Unit
Hilary Fordham	Chief Operating Officer	Morecambe Bay CCG
Talib Yaseen	Director of Transformation	Healthier Lancashire and South Cumbria ICS
Kevin Toole	Lay Member	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. Members were reminded that the business today was being live-streamed and recorded so that decisions are accessible and available to members of the public following the meeting, on the Healthier Lancashire and South Cumbria (HL&SC) YouTube channel. It was reported that in line with recent meetings, members of the public had been invited to raise any questions relating to items on the agenda prior to the start of the meeting and again at the end of the meeting. Questions were also welcomed in writing. The Chair reminded members that local elections are taking place and due to purdah, and the meeting being live-streamed, asked members to be mindful of specific restrictions on communications activity.
2.	**Declaration of Interests** G O'Donoghue, Lay Member, Chorley and South Ribble CCG, declared an interest in Item 5 (*Glucose Monitoring and Flash Glucose Monitoring to patients with Diabetes Mellitus*). The Chair determined that this was a non-financial personal interest and it was agreed that Mr O'Donoghue could stay in the room but not participate in any discussion relating to this item.
3.	**Notes of the meeting held on 07 March 2019** Following an amendment to include J Cass on the apologies and to note a new title for Dr Janjua, (GP and Acting Chair), the notes was agreed as a correct record.
4.	**Items of any other business** None reported.
5.	**Chair's action: Glucose Monitoring and Flash Glucose Monitoring to patients with Diabetes Mellitus** The Chair reminded members that during the meeting on the 07 March, the Joint

	Committee delegated responsibility to the Independent Chair, P Watson and ICS Executive Director of Commissioning, A Bennett, to sign off an amendment to the commissioning policy, in response to national guidance received that day for access to flash glucose monitoring consistently across England. In response to national guidance, the Chair invited E Johnstone, Service Director, Midlands and Lancashire Commissioning Support Unit to outline the basis for the changes made to the policy. The Joint Committee was informed that following a review of the local policy and new national criteria for access, an amendment had been made to enable more patients to benefit from this technology. The Commissioning Policy Development and Implementation Working Group (CPDIG) will continue to support CCGs to embed the policy in clinical practice. E Johnstone asked the Committee to endorse the decision of the Independent Chair and the ICS Executive Director of Commissioning to ratify the updated policy. **RESOLVED**: **that the Joint Committee endorsed the ratification of this updated policy.**
Improving Population Health	
6.	**The Children and Young People's Emotional Health and Wellbeing and Mental Health (CYPEWMH) programme: Transformation Plan and Business Plan** A Bennett informed members that the CYPEWMH is an established programme of work and the information provided is based on previous presentations to the Joint Committee. A Bennett welcomed R Snow-Miller and H Bryan to the meeting and R Snow-Miller gave an update on the CYPEWMH programme of work for 2019/20, including the refinements and developments that draw local authority, health commissioners and providers into a collaborative programme. The Collaborative Commissioning Board (CCB) had received the Lancashire and South Cumbria (L&SC) Transformation Plan in April 2019 and recommended that the same is presented to the Joint Committee for final approval. R Snow-Miller described the main achievements to date and the key challenges to meet the requirements of the Long-Term Plan (LTP), published on 07 January 2019. The following key priorities were highlighted for this financial year: • Digital THRIVE on-line platform - an evidence-based training programme that teaches people the skills and resources to overcome mental health issues and learn to thrive, ultimately becoming part of the self-referral process • Redesign of Children and Adolescent Mental Health Services (CAMHS) to be delivered in-year and in line with the THRIVE model • To define and deliver appropriate specialist in-patient community support R Snow-Miller also presented the Business Plan 2019/20. It was reported that L&SC CCGs had aligned a percentage of their budgets against the Transformation Plan objectives and from April 2020 the CCGs had agreed to a percentage of alignment and local spend. The Chair asked if there were any questions or comments. D Soper requested clarifications on the allocated spend in 2018/19. It was agreed that Mr Soper would receive a written response outside the meeting on the services available around the 7-day CAMHS response.

	Dr R Robinson inquired about the advantages of having a single point of access and whether this was part of the nationally recognised digital model, THRIVE. R Snow-Miller informed members that as part of CAMHS redesign, work was ongoing towards a single point of access, including looking at how this can be brought into the neurodevelopmental pathway that is part of the Special Educational Needs and Disability (SEND) work; the aspiration is for a single digital access point into services. Focus is currently on joining CAMHS redesign single point of access and also making sure that digital THRIVE promotes self-help and mental wellbeing. From a question raised on the challenges created by the national access target and the year-end position, R Snow-Miller confirmed that the Business Plan allows for the delivery of the access targets for children's mental health services. It was reported that later in the year the Joint Committee is to consider the clinical model coming out of the work from providers. R Snow-Miller was asked to highlight how providers are working together and to identify the biggest risks in the programme. R Snow-Miller informed members that providers are calling themselves a 'Care Partnership'. Providers are working with Northumberland Tyne and Wear Trust in making sure the ICS has an effective pathway to meet the needs of children and their families. In July, a model will be proposed and considered through a formal evaluation process, chaired by the Chief Operating Officer at Morecambe Bay CCG. Risks in the programme will continue to be monitored. **RESOLVED**: **that the Joint Committee approved the Transformation Plan refresh 2019/20 and the Business Plan.**
7.	**Individual Patient Activity (IPA) programme** M Williams, Executive Lead for the IPA programme, provided an update on IPA activity across the system to support case for change. It was reported that the paper had been endorsed in April 2019 by the Commissioning Oversight Group (COG), the Collaborative Commissioning Board (CCB) and shared with executive teams and CCG Governing Bodies. M Williams described the key objectives set against NHS England standards and the need to incorporate a system-wide collaborative approach and funding mechanism with multiple providers of IPA. The Chair asked if there were any questions or comments. A number of questions were raised around funding and patient eligibility. D Soper indicated that delays in patient assessments could result in over-provided packages of care. M Williams informed Mr Soper that one of the objectives of the L&SC IPA Programme Board is to address detailed finances and funding of services and to also review success measures of alternative IPA models outside the current system that could potentially add value. L Riley informed members that Midlands and Lancashire Commissioning Support Unit (M&L CSU) is supporting seven of the eight L&SC CCGs (excl. Blackpool) to review the costs of individual packages of care. A number of members queried the timeframe of the new ways of working and further detail was requested on the split between Continuing Health Care (CHC) standards of care and the percentage of CCG and IPA components. It was pointed out that the system needed to realise the impact and risk in the system in relation to the 28-day Out of Hospital (OOH) discharge. M Williams informed members that a future delivery

	model will be developed within the next 12 months. A Bennett asked if there is sufficient resource available to proceed as proposed. M Williams informed the Joint Committee that there is enough resource to commence the programme. Future resource may be required as the programme progresses. A Bennett asked how local authorities would play in to the IPA Programme Board. M Williams recognised that local authority colleagues need to be involved to support the commitment to future modelling and improvements and reiterated that each Integrated Care Partnership (ICP) needs to ensure that they have nominated representatives on the current IPA Programme Board, including local authority representation. P Kingan raised a question on the scope and process and if this included initial investment of patients prior to eligibility. M Williams informed members that the eligibility of patients will continue to be assessed. M Williams asked the Joint Committee to endorse the specific requirement to nominate one representative from each ICP to sit on the Lancashire and South Cumbria IPA Programme Board to strengthen the new IPA governance structure. The Chair asked the Joint Committee to: • Note and endorse the approach presented in the report • Confirm support for the proposed Governance arrangements and responsibilities of the IPA Programme Board • Note the urgent need for all CCGs to review with partners and propose nominations for ICP representatives on the board • Endorse the recommendation that the IPA programme Board will take single responsibility for overseeing and implementing a performance improvement plan with NHS England (and M&L CSU) to deliver the required improvements in National quality standards • Note the initial draft work programme set-out in section 6.0. **RESOLVED: that the Joint Committee agreed the recommendations, and endorsed the specific requirement to nominate one representative from each ICP to sit on the Lancashire and South Cumbria IPA Programme Board.**
8.	**Commissioning Policies:** A Bennett reintroduced E Johnstone to set the context for the commissioning polices. E Johnstone informed members that a decision has been made within Lancashire and South Cumbria to adopt the same clinical policies across the ICS to ensure equity of access to treatments for all patients; CCGs have been charged to set resources and to deliver maximum benefits. It was noted that CPDIG is responsible for the oversight of this process and ensuring policies are based on the best quality and clinical evidence. The financial impact of any change is also recognised and robust processes are in place with the clinical community and the public. E Johnstone informed members that CPDIG agrees the final versions of all policies that come to Joint Committee for approval and went on to explain the following two specific policies: **Policy for the treatment of varicose veins** E Johnstone reported that all patients across L&SC will have the same access for eligibility. The main difference between the historical policies and what is presented today, around the stage at which varicose veins can be treated, was explained. Evidence-based recommendation within NICE Guidance and subsequent NHS

Evidence-Based Intervention (EBI) Guidance was discussed, along with the impact of potentially widening the access criteria for patients to be treated sooner than they currently are. The ICS Finance and Investment Group (FIG) have been apprised of the implementation of the new criteria coming in line with NICE guidance and EBI guidance and how this would impact financially. At an ICS level, it is believed that this policy, when fully implemented through all vascular services, will enable the support of more patients earlier in the care pathway for less expenditure and more patients will have a faster recovery through the less invasive procedure.

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

D Soper raised a question around the feasibility of potentially harmonising effective clinical practice to achieve these expectations. E Johnstone informed Mr Soper that part of CPDIG's remit is to monitor the impact of policies. Processes are in place to monitor the results of policies and this particular policy, following extensive clinical engagement, lists the order of intervention that ought to be considered. Colleagues on the L&SC Vascular Programme Board will also be made aware of decisions and expectations.

From a number of questions raised on the interpretation of clinical policies available for patients, it was reported that appropriate literature was being considered for use in general practice. E Johnstone informed members that as with all policies, CCGs will be notified, as part of the communications and engagement process, that a policy is available and as part of that, specific literature will be signposted.

S Mukerji informed members that his CCG did have straightforward clinical policies listed on their website and suggested that the same should be listed on all CCG's websites, located in one section.

D Bonson raised a question on a potential increase in cost and demand for services where CCGs have had existing policies. E Johnstone informed members that there is an expected cost for each procedure and cost effectiveness will continue to be reviewed.

RESOLVED: that the policy for the treatment of varicose veins was agreed by the Joint Committee.

Policy for Hysteroscopy

E Johnstone explained the history of the policy that had recently been harmonised for L&SC (March 2018). E Johnstone explained that shortly after ratification, NICE updated a piece of non-mandatory NICE Guidance about the use of hysteroscopy as an investigative and treatment intervention. The final published guidance had slightly changed recommendations that moved hysteroscopy up the treatment pathway to be used as a first-line of investigation in certain circumstances. The clinical benefit is to have one appointment and one cost to achieve a diagnosis and treatment. The implementation of the policy is confirmed.

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

G O'Donoghue raised a question on the decrease in variation from one area to another when following NICE Guidance across the country and to what extent are we close to neighbouring CCGs and their policies for people outside Lancashire and South Cumbria. E Johnstone informed members that the principle is about reducing inappropriate variation in access or use of interventions. Business Intelligence colleagues within Midlands and Lancashire Commissioning Support Unit are carrying out modelling on behalf of CPDIG, to enable benchmarking with other geographical

	areas. E Johnstone was not aware of a systematic national benchmarking process. G Jolliffe thought the variation was dependent on clinician behaviour, patient expectations and demographics and raised his concern on where allotted increases in activity should be. A Doyle added that commissioners have to prioritise how we spend allocated resource for improvement in outcomes for our population. D Soper requested that the paper includes decisions on how we are prioritising resource effectively and showing the biggest improvement in outcomes for our population. The Chair asked member to vote on the policy. **RESOLVED: that the policy for the treatment of Hysteroscopy was ratified by the Joint Committee.**
9.	**Draft work programme for the Joint Committee** Following conversations with executive colleagues around the system, A Bennett presented the latest draft work programme for the Joint Committee. Members were informed that further discussions will be scheduled on the issues at the point the work comes to fruition and for this to become live, A Bennett will write to Accountable Officers to present the same through each Governing Body. Chief Officers will also receive an email requesting appropriate delegation for specific areas of work to come through Joint Committee; he restated that appropriate information would only come to Joint Committee once all the usual involvement from colleagues in CCGs had taken place. G Burgess welcomed the report and requested that a timescales of actions are included on when Joint Committee can expect policy report-backs. A Bennett agreed that the next iteration would include timescales. **RESOLVED: that the Joint Committee noted the proposed work plan for 2019/20.**
10.	**Any other business** A Bennett informed members that as part of the ICS review of governance and partnership arrangements, a questionnaire has been circulated requesting feedback on the JCCCGs. For those who have not received this information, an appropriate email will be circulated in due course.
11.	**Questions from the public** The Chair asked members of the public present if they had any questions relating to items on the agenda. There were no questions raised.

Date and time of next meeting: Thursday 04 July 2019 13:00-15:00, Blackpool Central Library, Queen Street, Blackpool, FY1 1PX
Dates of future meetings held in public:
05 September 2019
07 November 2019
02 January 2020
05 March 2020

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS MEETING

Title of Paper	Urgent & Emergency Care Strategy (2019-2023)		
Date of Meeting	5 September 2019	Agenda Item	5

Lead Author	David Bonson		
Contributors	Tim Almond Stephanie Gregory		
Purpose of the Report	Please tick as appropriate		
	For Information	✓	
	For Discussion		
	For Decision		
Executive Summary	This strategy paper is provided to Lancashire and South Cumbria (LSC) Joint Committee of Clinical Commissioning Groups (JCCCGs) and members as an update on the Urgent and Emergency Care (UEC) transformation work programme of the Integrated Care System (ICS) in Lancashire and South Cumbria.		
Recommendations	The Committee and members are requested to note the contents of the refreshed UEC Strategy as per the NHS long term plan requirements and locally agreed priorities.		
Next Steps			
Equality Impact & Risk Assessment Completed			Not Applicable
Patient and Public Engagement Completed			Not Applicable
Financial Implications			Not Applicable
Risk Identified			No
If Yes : Risk			
Report Authorised by:			

Healthier Lancashire & South Cumbria

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS MEETING

Urgent & Emergency Care Strategy (2019-2023)

1. Introduction

The Urgent and Emergency Care Programme has developed a system wide Integrated Care System (ICS) strategy that will underpin the overall Lancashire & South Cumbria ICS strategy and will support the requirements of the NHS long term plan and local agreed priorities.

There will be a more detailed project plan to accompany the overall strategy and provide the supporting detail in terms of delivery, timelines, outcomes and resources.

2. UEC Progress to Date

Following the release of the NHS Long Term Plan the UEC workstream has undertaken a full review of its project plans and identified several achievements since the publication of the Next Steps on the Forward View (2017) :-

- Enhanced NHS 111 offer, so over 50% of people calling the service now receive a clinical assessment and can be offered immediate advice or referred to the right clinician for a face-to-face consultation;

- Achieved 100% of the population now able to access urgent and emergency care advice through the NHS 111 online service, the North West was the first in the regional footprint to go live;

- Blackpool, East Lancashire and Lancashire Teaching Hospitals have been part of Every Minute Matters collaborative improvement programme, working with North West Ambulance Service, focusing on addressing ambulance handover delays. Improvements have been made across all sites with the biggest seen at LTH;

- Rolled out 10 Urgent Treatment Centre's (UTCs), offering a consistent service to patients. 8 UTCs are introducing the ability to book appointments through NHS 111, Fylde Coast were the first in the North West to implement direct booking in December 2017;

- Rolled out direct booking from NHS111 into primary medical Out of Hours services and extended access appointments;

- As of October 2018, 100% of patients in Lancashire and South Cumbria have access to extended access primary services, offering appointments at weekends and evenings;

- Introduced the new national standards for ambulance services to ensure that the sickest patients receive the fastest response, and that all patients get the response they need first time and in a clinically appropriate timeframe;

- Programme co-ordination and support for wider system working utilising external support, eg, Newton Europe, Ernst & Young and the Lancashire Intermediate Care review.

- Reduced the number of people delayed in hospital – reducing the length of stay of patients who remain in hospital for more than 21 days;

- Begun implementing Same Day Emergency Care (SDEC), increasing the proportion of people who are not admitted overnight in an emergency;

- Developed system level intelligence and escalation arrangements to manage demand and capacity to ensure consistent and standardised approach to drive improved performance, through the development of strategic and tactical information.

- Rolled out the care home capacity tracker, currently 78% of LSC providers are registered on the portal. Further work is planned in terms of integrating this work through the implementation of the escalation management systems (EMS+).

- Implementation of home 1st and alternative pathways for patients requiring a continuing health care assessment;

- Standardisation of ICS policy development through collaborative working for local implementation such as; Home of Choice, Repatriation Policy and Mental Health Standard Operating Procedure (12-hour breaches);

- Support and coordinate the development and subsequent review of winter plans and ensure that best practice from within the ICS (or from elsewhere) is shared;

- Worked with each A&E Delivery Board to identify good practice in UEC and shared and implemented across the ICS;

- Worked at North West level to develop and implement local actions for the NWAS Performance Improvement Plans for 999 and 111.

3. National Long Term Plan Requirements by 2020/21

The long term plan describes the accelerated development of out of hospital care, reforms to hospital emergency care and cutting delays in patients being able to go home. Specific requirements for UEC include:-

- Avoidable ambulance conveyances to A&E will be reduced through system-wide implementation of interventions;

- Lord Carter's recommendations implemented in all ambulance services;

- Urgent Treatment Centre's (UTCs) will have been designated by December 2019 and will be fully operational, working effectively alongside other parts of the urgent care network by autumn 2020;

- 100% of patient activity in A&E, UTCs and Same Day Emergency Care (SDEC) will be effectively recorded via Emergency Care Data set (ECDS);

- Delayed Transfers of Care (DTOCs) will be on average no more than 4,000 people per day nationally;

- Length of stay for patients in hospital for 21 days and over will be further reduced beyond the March 2020 ambition of 40%;

- There will be a reduction in delays of handover of patients from ambulances to A&E, with the aim that no one waits more than 15 minutes;

- NHS 111 will be direct booking into GP practices and other points of care across the country;

- Specialist mental health ambulance vehicles.

4. National Long Term Plan Requirements by 2023

- Clinical Assessment Services (CAS) will act as the single point of access for patients, carers and health professionals accessing integrated urgent care services, and to support admissions avoidance or facilitate discharge from hospital;

- NHS111 will be the single point of access for patients experiencing mental health crisis and will be supported by mental health CAS;

- Through SDEC the proportion of total acute admissions discharged on the same day of attendance will increase from a fifth to a third;

- Hospitals will work towards achieving clinical frailty assessment within 30 minutes of arrival;

- DTOCs will have further reduced below 4,000 people per day.

5. Local Strategic Priorities

The proposed operating model for UEC services is a blended approach with ICS and ICP level integration. ICP resources come together to work on agreed priorities for system wide design and standardisation to be implemented within each local ICP consistently. The following local priorities have been identified with either plans being drafted or task and finish groups reporting back to the monthly Urgent and Emergency Care Network;

- Future model for core/modular approach for Integrated Urgent Care (IUC) being worked through considering further integration of 999, NHS 111 and out of hours provider responses and different ways of managing the category 3 and 4 ambulance activity;

- Implementation of a Lancashire & South Cumbria Falls Lifting Service supported through the Health Systems Led Investment Fund;

- Support and implement existing UTC developments and plans, to ensure consistency of service effectiveness;

- Transform clinical pathways to achieve common standards and improved outcomes for high priority and high volume UEC pathways. Continue to develop the respiratory pathway as an initial priority;

- Continue to develop the strategic and tactical dashboards and roll out the real time data Escalation Management System (EMS+) and use the intelligence to develop whole system (ICS) level tactical management of the UEC system as well as the more strategic review of UEC services to achieve service improvements by identifying the best in class pathway capability and delivery across Lancashire and South Cumbria in terms of:-

    - Clinical effectiveness
    - Clinical risk
    - Timeliness, appropriateness and expedience in delivery
    - Cost effectiveness

  With a view to:-

    - Sharing best practice and setting Lancashire and South Cumbria wide expectations
    - Understanding future needs and build fit for purpose systems
    - Look for opportunities to consolidate and strengthen service provision
    - Build class leading centres of excellence within Lancashire and South Cumbria;

- UEC Workforce plan being scoped out and will encompasses the whole of the UEC pathway.

6. Recommendations

The Committee is requested to note the contents of this report (**Appendix 1**).

David Bonson

ICS Urgent and Emergency Care Lead

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS MEETING

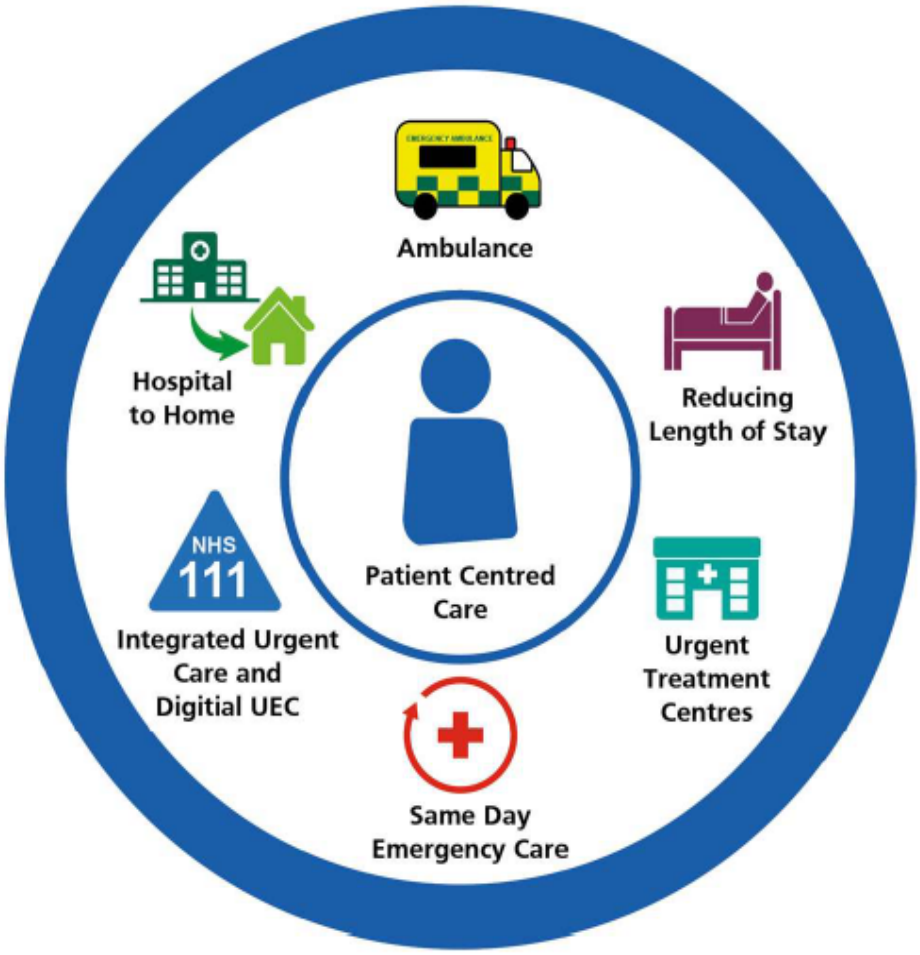
Appendices

Appendix 1 - ICS UEC Strategy

ICP Strategy v2.docx

Healthier Lancashire & South Cumbria

URGENT & EMERGENCY CARE STRATEGY 2019-2024



Healthier Lancashire & South Cumbria

Purpose

The delivery of high quality Urgent and Emergency Care (UEC) services is a critical part of the Lancashire and South Cumbria (LSC) transformation programme and remains an ongoing challenge due to increases in demand for services, an ageing population with increasingly complex conditions and developing a sustainable workforce which is fit for the future.

As we move into new models of service delivery and care provision, there needs to be a vigorous re-think in our approach to urgent and emergency care, with innovation at the heart of what we do; testing new models of care, utilising technology to efficiently connect all parts of the patient journey, enabling systems to work better, together.

This strategy paper is provided to the LSC Joint Committee of Clinical Commissioning Groups (JCCCGs) as a strategic update on the Urgent and Emergency Care (UEC) transformation work programme of the Integrated Care System (ICS) in Lancashire and South Cumbria.

The strategy document sets out and defines our vision, strategic principles and aims for urgent care across the ICS. It includes a detailed description of current achievements as well as outlines the challenges and risks we face moving forwards. The strategy describes our key drivers for change as well as the robust governance structures in place to assure local and national stakeholders of our progress.

National Context

Each year the NHS in England provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system.

They turn to A&E because it seems like the best or only option. In recent years the proportion of patients looked after within 4 hours has been falling – caused by rising demand in A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives. (Five Year Forward View: March 2017)

In the 2017 "Next Steps on the NHS Five Year Forward View (5YFV)", Urgent and Emergency Care is one of NHS' main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients.

Nationally, 4-hour waits in A&E rose to a new high in 2018/19, with 18.5% of people attending major departments experiencing long waits compared with 17.6% in 2017/18. Attendances rose by 2% - locally at an ICS we have experienced a 6% increase in ED attendances.

In 2018-19, an average of 67,991 people attended accident and emergency departments each day in England. This is 4.1% higher than in 2017-18. At 'type 1' A&E departments – major hospital emergency departments offering a 24-hour service – the increase was lower, at 2.0%. Much of the recent increase in attendance has been due to 'type 3' departments such as urgent care centres and minor injury units. Over the last five years, attendances at major A&Es have risen 10.3%, which amounts to over

4,000 extra people attending each day. Including minor departments, the increase is over 8,000 per day across England.

Four-hour wait performance has fallen over several years. 2018-19 had the lowest annual performance on record, with **12.0% of patients spending over 4 hours in A&E compared with 11.3% a year earlier and 4.3% five years ago**. The largest fall in performance was between 2015 and 2016 – since then declines have been slight and gradual. While performance tends to be worse in the winter months, waiting times in recent summers have been higher than those seen in any winter on record prior to 2014/15.

In 2018-19, an average of 13,058 people were admitted to hospital via A&E each day. This is up 6.8% on 2017-18 and 24.2% on five years ago. This amounts to an extra 2,548 emergency admissions in England each day. The table below shows patients spending 4 hours in A&E (all departments, England):

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2011	4%	3%	3%	3%	3%	3%	2%	3%	3%	3%	3%	4%
2012	4%	5%	3%	4%	3%	3%	3%	3%	3%	4%	4%	5%
2013	5%	6%	6%	7%	3%	3%	3%	4%	4%	4%	4%	5%
2014	5%	5%	4%	5%	5%	5%	5%	5%	5%	6%	7%	10%
2015	9%	8%	7%	7%	6%	5%	5%	6%	7%	8%	9%	9%
2016	11%	12%	13%	10%	10%	9%	10%	9%	9%	11%	12%	14%
2017	15%	12%	10%	10%	10%	9%	10%	10%	10%	10%	11%	15%
2018	15%	15%	15%	11%	10%	9%	11%	10%	11%	11%	12%	14%
2019	16%	16%	13%	15%								

Key
2% - 3.5%
3.5% - 5%
5% - 7%
7% - 9%
9% - 12%
12% - 16%
Over 16%

It's been reported that much of the growth in emergency admissions is due to 'zero-day admissions' i.e. those who are discharged without an overnight stay. If correct, this suggests that the change in emergency admissions doesn't simply indicate an increase in demand.

Clinical Review of NHS Access Standards

It is well documented that standards and performance targets have incentivised and encouraged improvements in care and outcomes, and provided assurance on quality and availability of care when people need it. It is also recognised that in some cases the same targets can restrict the ability to innovate or result in other unintended consequences.

The history of the National Health Service is one of evolution and innovation, with each generation using the latest technology and treatments to meet the changing needs of patients and the public. This strategy adopts the mindset of innovation for delivery as and where possible.

In June 2018, the NHS National Medical Director was asked by the Prime Minister to review the core set of NHS access standards, in the context of the model of service described in the NHS Long Term Plan, and informed by the latest clinical and operational evidence, recommend any required updates and improvements to ensure that NHS standards:

- promote safety and outcomes
- drive improvements in patients experience

- are clinically meaningful, accurate and practically achievable
- ensure the sickest and most urgent patients are given priority
- ensure patients get the right service in the right place
- are simple and easy to understand for patients and the public; and
- not worsen inequalities.

The review is being undertaken in three phases:

1. Consider what is already known about how current targets operate and influence behaviours
2. Map the current standards against the NHS Long Term Plan to examine how performance measures can help transform the health service and deliver better care and treatment
3. Test and evaluate proposals to ensure that they deliver the expected change in behaviours and experience for patients prior to making final recommendations for wider implementation

In relation to UEC, the first six-week phase of testing explored whether an average (mean) time in A&E could be implemented safely and provide clinicians with a useful measure of activity and patient experience. Findings from this phase were that the measure was introduced successfully across all sites, with no reported safety concerns linked to the testing.

The Clinical Advisory Group for this work stream, and the trusts involved, therefore support that a second phase of testing should go ahead and this phase will include:

- measuring time to initial assessment
- collecting data to examine the feasibility of measuring how fast critically ill or injured patients arriving at A&E receive a package of tests and care developed with clinical experts
- test sites to continue monitoring average (mean) total time in department and long waits from arrival, aiming for continual improvement.

As an ICS, we will monitor the review in detail and ensure all recommendations are adopted as best practice as soon as is practicable.

Our Vision

The Healthier Lancashire and South Cumbria vision for UEC is:-

“To provide highly responsive services, for adults and children with urgent care needs, which deliver care as close to home as possible and which are safe, sustainable and of a consistent high quality. We will empower people to take responsibility for their own minor health needs and will encourage them to self-care where appropriate. We will deliver health care improvements in a transformational manner and encourage the use of digital solutions to optimise healthcare delivery”.

ICS Position

Under the context of the North West and in particular Lancashire and South Cumbria needing to make significant improvements in Urgent and Emergency Care, the ICS has now been tasked with 3 clear objectives from NHSE/I and these are:

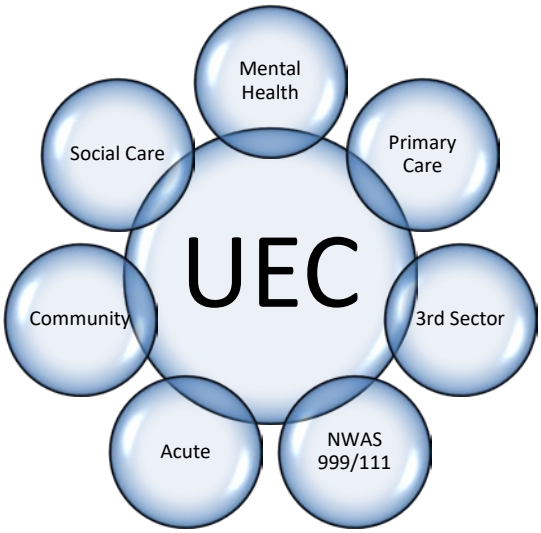
- Improved forensic analysis of breaches in the ED to facilitate a better understanding of pressures and how best to map capacity to demand.
- Work to improve flow out of the ED by bringing forward discharges to earlier in the day.
- A commitment to proactive pre-weekend planning to ensure sufficient capacity to maintain performance over the weekends.

In addition, the draft ICS Memorandum of Understanding and ICS Partnership Agreement with NHS England/Improvement sets out the following deliverables for UEC:-

- Provide system wide leadership and oversight of the UEC system across L&SC.
- Identify opportunities to 'do things once' and provide a system wide response to UEC.
- Bring together interdependent organisations across the Lancashire and South Cumbria system.
- Agree an escalation process and determine how ICPs will support each other through mutual aid during pressurised periods.

ICS Achievements

As an Integrated Care System, our approach aims to ensure we build up an urgent and emergency care system which includes and represents all key stakeholders from Health and Social Care alongside the traditional offer from our acute and community services. This partnership mind-set is fundamental in our current focus on integrated urgent and emergency care. In order to achieve our vision we need to align individual ICP level priorities with our ICS strategic vision to ensure we are developing a sustainable urgent and emergency care service for the future.



As we move forwards to look for sustainable solutions to delivering urgent and emergency care, there will be a greater reliance on 'upstream' input into patient care and in particular working more closely with community and primary care colleagues via the Primary Care Networks (PCN). PCN's were introduced into the NHS as part of the NHS Long Term Plan in 2018, and the 2019 GP contract required practices to join networks. Each network is to have between 30,000 and 50,000 patients. The stated aim is to create fully integrated community-based health services. This model will support the delivery of both preventative and admission avoidance solutions for UEC.

Recently, a range of initiatives and programmes of work have been deployed across the ICS footprint to improve performance against the 4-hour ED standard.

These activities have included specific models of care delivered at an ICP level, inclusion in transformational programmes at the cutting edge of delivery such as the recent NWAS Every Minute Matters ('Super Six') handover improvement work and also developing new programme management approaches and learning from other providers and systems.

In addition, all stakeholders in the ICS have benefitted from the commissioning of external support e.g. ECIST, Ernst and Young and the North West Utilisation Management team, to review processes and support implementation of recommendations for improvement. In all of this work the focus has been mapped around a broad strategy of developing the health and social care resource and supporting people to keep well and out of hospital and avoiding admissions where at all possible; improving in–hospital processes in ED and on the wards, and; keeping bed occupancy in the acute sector at an optimum level (85% recommended) through reducing length of stay and improving discharge.

Following the release of the NHS long term plan, the UEC work stream has undertaken a full review of the its project plans and identified key achievements that have been accomplished since the publication of the Next Steps on the Forward View (2017). To date, significant progress has been achieved at an ICS level, some examples of which are described below:-

- Enhanced the NHS 111 offer, so over 50% of people calling the service now receive a clinical assessment and can be offered immediate advice or referred to the right clinician for a face-to-face consultation.

- Achieved 100% of the population now able to access urgent and emergency care advice through the NHS 111 online service, the North West was the first in the regional footprint to go live.

- Blackpool, East Lancashire and Lancashire Teaching hospitals (LTH) have been part of Every Minute Matters collaborative improvement programme focusing on addressing ambulance handover delays. Improvements noted across all sites with the biggest seen at LTH in terms of sustainability.

- Rolled out Urgent Treatment Centres (UTCs), offering a consistent service to patients and introducing the ability to book appointments in UTCs through NHS 111, Fylde Coast were the first in the North West to implement direct booking in December 2017

- As of October 2018, 100% of patients in Lancashire and South Cumbria have access to extended access service.

- Rolled out direct booking from NHS111 into primary medical Out of Hours services and extended access appointments.

- Introduced the new national standards for ambulance services to ensure that the sickest patients receive the fastest response, and that all patients get the response they need first time and in a clinically appropriate timeframe.

- Reduced the number of people delayed in hospital – reducing the length of stay of patients who remain in hospital for than 21 days.

- Begun implementing Same Day Emergency Care (SDEC), increasing the proportion of people who are not admitted overnight in an emergency.

- Developed system level intelligence and escalation arrangements to manage demand and capacity to ensure consistent and standardised approach to drive improved performance, through the development of strategic and tactical dashboards.

- Rolled out the care home capacity tracker, currently 78% of LSC providers are registered on the portal, further work planned in terms of integrating this work through the implementation of the escalation management systems (EMS+).

- Implementation of home 1st and alternative pathways for patients requiring a continuing health care assessment.

- Standardisation of ICS policy development through collaborative working for local implementation such as; Home of Choice, Repatriation Policy and Mental Health Standard Operating Procedures (12-hour breaches).

Whilst we have seen success in our ICS over the last 12 months, there are also key areas where we have identified a need to focus on delivering better outcomes:

- Primary care streaming
- Earlier discharge in the day i.e. before 12 noon
- Achieving consistent performance in NWAS handover times
- Care home market stimulation
- Increased use of domiciliary care and reablement services
- Using digital solutions to drive transformation at an ICS level
- Providing a more robust overview of real time performance allowing decisions to be made at a 'system' level

Furthermore, the ICS has recently partnered with Carnall Farrar to review the intermediate care offer at an ICS level. This work has led to the identification of significant opportunity at an ICS level to fundamentally redesign our intermediate care offer within the ICS and this will form a key deliverable in the coming 12 months to improve community based assets and service provision which will in turn enable flow and performance through the system.

Risks

The following risks have been identified in relation to recovery of the A&E performance standard:

- Continued increase in A&E demand, including numbers of patients with mental health conditions.
- Inability to access to capital monies across the ICS to improve infrastructure and estate.
- Insufficient medical, nursing and social care workforce levels across the system to respond to service needs.
- Further reduction in local authority budgets.
- Limited capacity in the regulated care sector.

Whilst we will work with stakeholders and partners to mitigate these risks where possible, it is a rising tide which will have a potentially significant and adverse impact on the UEC agenda.

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ICP Performance

In recent months, a significant proportion of our ICP footprints have had their acute trusts subjected to the rigors of a Care Quality Commission (CQC) assessment. Already we are seeing the recommendations containing a significant focus on the Urgent Care agenda and these findings are captured in their essence through the body of the ICS strategy.

This strategy is produced at an ICS level and broadly focusses on the national agenda and those requirements mandated in the NHS Long Term Plan (2019). However, each ICP, whilst wanting to collaborate and make economies of scale across the ICS, will have within their gift the ability to deliver these outcomes as they deem appropriate.

The NHS Long Term Plan

In 2018, the government announced £20.5bn of additional funding for the NHS in England by 2023/24. The NHS Long Term Plan - launched in January 2019 - sets out priorities for how this money will be spent over the next ten years. The long-term plan describes boosting out of hospital care, reforms to hospital emergency care and cutting delays in patients being able to go home. The key recommendations and metrics in relation to UEC are set out below:

- Avoidable ambulance conveyances to A&E will be reduced through system-wide implementation of interventions.
- Lord Carter's recommendations implemented in all ambulance services.
- Urgent Treatment Centre's (UTCs) will have been designated by December 2019 and will be fully operational, working effectively alongside other parts of the urgent care network by autumn 2020.
- 100% of patient activity in A&E, UTCs and Same Day Emergency Care (SDEC) will be effectively recorded via the Emergency Care Data set (ECDS).
- Delayed Transfers of Care (DTOCs) will be on average no more than 4,000 people per day nationally.
- Length of stay for patients in hospital for 21 days and over will be further reduced beyond the March 2020 ambition of 40%.
- There will be a reduction in delays of handover of patients from ambulances to A&E, with the aim that no one waits more than 15 minutes.
- NHS 111 will be directly booking into GP practices and other points of care across the country.
- Specialist mental health ambulance vehicles

National Long-Term Plan Requirements by 2023

- Clinical Assessment Services (CAS) will act as the single point of access for patients, carers and health professionals accessing integrated urgent care services, and to support admissions avoidance or facilitate discharge from hospital.

- NHS111 will be the single point of access for patients experiencing mental health crisis and will be supported by mental health CAS

- Through SDEC the proportion of total acute admissions discharged on the same day of attendance will increase from a fifth to a third.

- Hospitals will work towards achieving clinical frailty assessment within 30 minutes of arrival.

- DTOCs will have further reduced below 4,000 people per day.

Local Strategic Priorities

We will continue to progress and deliver the various national strategies for urgent and emergency care including the Long-Term Plan requirements, in addition to that as a system we have agreed some local priority ideas for us to focus on:

- Development of an ICS level modular approach to integrated urgent care.

- Implementation of a Lancashire & South Cumbria Falls Lifting Service supported through the Health Systems Led Investment Fund.

- Transform clinical pathways to achieve common standards and improved outcomes for high priority and high volume UEC pathways. Continue to develop the respiratory pathway as an initial priority.

- Continue to develop the strategic and tactical dashboards and roll out the real time data Escalation Management System (EMS+) and use the intelligence to develop whole system (ICS) level tactical management of the UEC system as well as the more strategic review of UEC services to achieve service improvements by identifying the best in class pathway capability and delivery across Lancashire and South Cumbria in terms of:-

    - Clinical effectiveness
    - Clinical risk
    - Timeliness, appropriateness and expedience in delivery
    - Cost effectiveness

    With a view to:-

    - Sharing best practice and setting Lancashire and South Cumbria wide expectations
    - Understanding future needs and build fit for purpose systems
    - Look for opportunities to consolidate and strengthen service provision
    - Build class leading centres of excellence within Lancashire and South Cumbria;

- UEC Workforce plan being scoped out and will encompasses the whole of the UEC pathway.

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Local Priorities

In addition to the new national requirements from the Long Term Plan, there is still the need to continue to deliver on other key national strategies, including the Urgent and Emergency Care Delivery Plan – April 2017.

A number of other local priorities have been identified which form part of the UEC strategy for Lancashire and South Cumbria, namely:

- Develop the local future model for Integrated Urgent Care to ensure that patients have easier access to urgent care clinical advice on the telephone and online and enhanced triage across urgent care services with 999 and 111 services being increasingly integrated together and with other relevant services.

- Develop alternative models of delivery of the lower acuity ambulance activity (categories 3 and 4).

- Implementation of a Lancashire and South Cumbria falls and lifting response service using digital technology.

- Review existing Urgent Treatment Centre provision and plan future requirement to ensure consistency of service effectiveness.

- Transform clinical pathways to achieve common standards and improved outcomes for high priority, high volume UEC patient pathways. The initial priority for Lancashire and South Cumbria is the respiratory pathway.

- Continue to develop the strategic and tactical dashboards and roll out the real time data Escalation Management System (EMS+) and use the intelligence to develop whole system (ICS) level tactical management of the UEC system as well as the more strategic review of UEC services to achieve service improvements by identifying the best in class pathway capability and delivery across Lancashire and South Cumbria.

- Review workforce across the whole UEC pathway to identify future requirements to support new models of care.

- Review resources available at ICP and ICS levels to support system transformation.

Governance

As part of the principles of mutual accountability, the Urgent and Emergency Care Network (UECN) will, where appropriate, take on more system responsibility for both transformation and whole system performance of the UEC agenda across the ICS. The UECN provides leadership of the transformation programme across the UEC system, to support delivery of national and locally determined UEC priorities including system wide design and the sharing of good practice.

The partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation

and best practice between partners. This has no direct impact on the roles and respective responsibilities of the Partners (including Local Authorities, Trust Boards, CCG Governing Bodies and regulators) which all retain their full statutory duties and powers.

We will work with our partner organisations to ensure we harness the resources in the system for improvement capacity and expertise, together with the improvement ability provided by national bodies and programmes.

Task and Finish groups have been set up to support delivery of local priority areas of work, including:

- Workforce
- Digital
- Clinical pathways
- Integrated Urgent Care

A&E Delivery Boards (AEDBs) provide leadership for local transformation and delivery, connecting local partnerships together under an Integrated Care Partnership (ICP). Those AEDBs share any best practice or learning with the UECN.

The Lancashire and South Cumbria ICS Memorandum of Understanding with NHS E&I North West will:

- Provide system wide leadership and oversight of the UEC system across L&SC;
- Identify opportunities to 'do things once' and provide a system wide response to UEC;
- Bring together interdependent organisations across the Lancashire and South Cumbria system; and
- Agree an escalation process and determine how ICPs will support each other through mutual aid during pressurised periods.

The diagram below shows how the governance arrangements for UEC within the ICS should operate:

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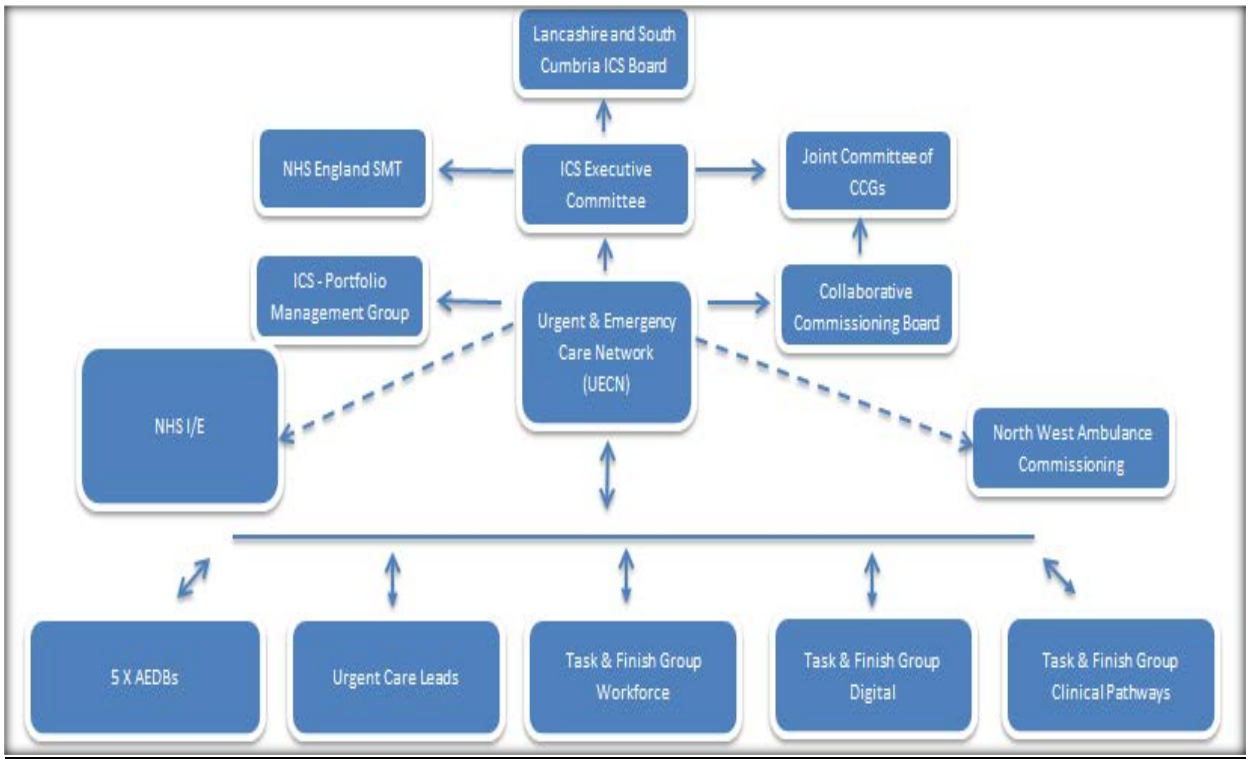

In addition to the formal governance and assurance frameworks in place, the ICS is also working with digital providers to embed a cutting edge solution to provide an ICS level overview of the pressures in the system – in real time. The EMS+ programme will allow central oversight of system pressures and the ability to make operational decisions on an ICS footprint in line with which area is under pressure and who has capacity in the system to offer support. It will also enable a feed into the regional OPEL escalation process as it will allow an ICS position to be identified and operational trigger actions to be defined which will mitigate the identified pressure. The system will be mapped to ensure it takes account of key stakeholders escalation triggers such as REAP in NWAS.

Operational Delivery

The governance principles outlined previously serve to bring structure and assurance to the key areas of operational delivery. The driver diagram below shows how we are striving towards improving outcomes and the key steps in the journey and the plan on a page which follows outlines our key priorities and expected outcomes in the coming 5 years:

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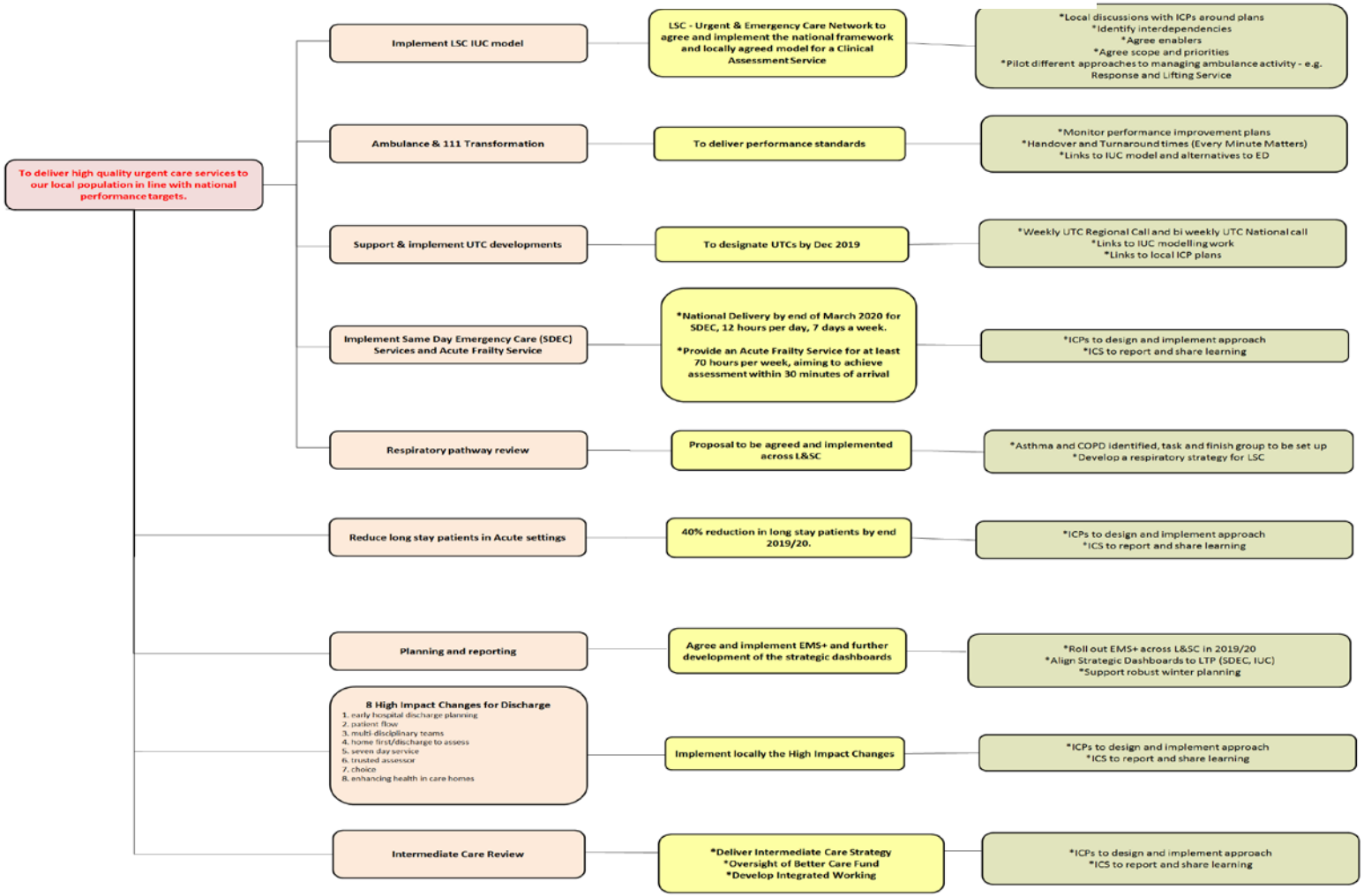
Integrated Care System – Lancashire & South Cumbria
Driver Diagram – UEC Programme 2019 - 2023



Enablers: Workforce, Estates, Communicatons & Engagement, Digital, Govervance, HR & OD, Finance

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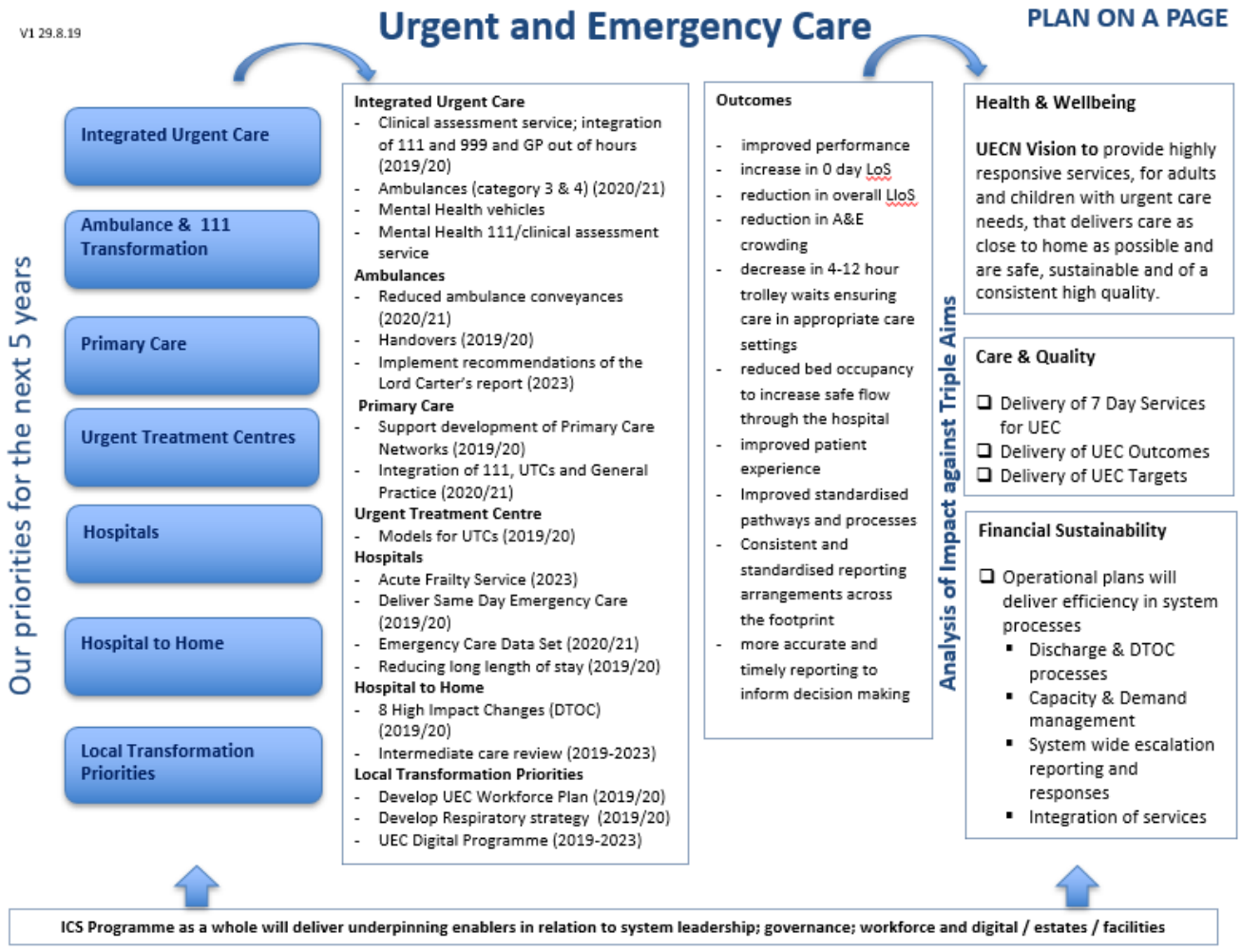

As the ICS develops and the systems needs change and become more defined in response to both the local and national agenda, the ICS UECN will ensure there is continued scrutiny and assurance in delivery to ensure sustained performance improvement.

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Useful Resources & Documents

The NHS Long term plan
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
NHS operation planning and contracting guidance
https://www.england.nhs.uk/wp-content/uploads/2019/01/Errata-to-operational-planning-and-contracting-guidance-2019.20.pdf
A five year framework for GP contract reform to implement the nhs long term plan https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf
Next steps on 5YFV and GP 5yFV
https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
UEC Delivery plan
https://medicashealth.com/media/1008/urgent-and-emergency-care-delivery-plan.pdf
8 high impact actions for reducing discharges
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model
IUC specification August 2017
https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf
999 specification 2018
https://www.england.nhs.uk/wp-content/uploads/2018/09/commissioning-framework-and-national-urgent-and-emergency-ambulance-services-specification.pdf
Reducing long hospitals stays
https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf

North West Collaborative Commissioning Intentions 2019/2021

(Item 5-1) NW Commissioning Inte

2018-19 Annual ICS Programme Evaluation

UECN ICS 201819 Annual Programme

Commissioning Development – Operating Model for UEC

190621 Operating Model for UEC.pptx

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UEC – Driver Diagram

UEC Driver Diagram v0.2.xlsm

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 September 2019	Agenda Item	6

Lead Author	Rebecca Higgs, Policy Development Manager, NHS Midlands and Lancashire CSU		
Purpose of the Report	Please tick as appropriate		
	For Information		
	For Discussion		
	For Decision	X	
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed a review of seven intervention specific commissioning policies. Revised and updated policies have been prepared for adoption across Lancashire and South Cumbria.		
Recommendations	That the JCCCGs ratify Lancashire and South Cumbria policies on the following interventions: - *Tonsillectomy* - *Surgical release of trigger finger* - *Surgical management of gynaecomastia* - *Management of otitis media with effusion using grommets* - *Surgical treatment of carpal tunnel syndrome* - *Breast reduction surgery* - *Removal of benign skin lesions*		
Next Steps	Subject to approval by the JCCCGs, the policies will proceed to implementation.		
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 ICS		

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 work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to review the Lancashire and South Cumbria commissioning policies for the interventions listed below against NHS England's (NHSE's) Evidence Based Interventions (EBI) guidance:

1.2
- *Tonsillectomy*
- *Surgical release of trigger finger*
- *Surgical management of gynaecomastia*
- *Management of otitis media with effusion using grommets*
- *Surgical treatment of carpal tunnel syndrome*
- *Breast reduction surgery*
- *Removal of benign skin lesions*

2. Development process

2.1 The eight Lancashire and South Cumbria Clinical Commissioning Groups (CCGs) have existing collaborative commissioning policies in place for all the interventions listed at section 1.2 above.

2.2 Following the publication of NHSE's EBI guidance, the CPDIG undertook a review of the evidence relied on by the national programme, to identify any points of variation between the eligibility criteria within the local harmonised commissioning policies and the eligibility criteria in the EBI guidance.

2.3 It was agreed that the existing policies required revision to ensure the EBI guidance had been considered and to provide further clarity to clinicians on the circumstances in which these procedures will be commissioned.

2.4 The revised policies have been subject to the following key steps of the development process which has been shared with the JCCCGs previously:

I. clinical stakeholder engagement;
II. public and patient engagement;
III. notification of local Health, Overview and Scrutiny Committee;
IV. consideration of any financial implications
V. an Equality Impact Risk Assessment (EIA)
VI. consultation with Healthier Lancashire and South Cumbria's Care Professionals Board (CPB) for clinical assurance purposes.

2.5 Further information regarding the amendments made to each policy are outlined below and the final policies are available to view via the following links:

Policy for Tonsillectomy
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/EeygCzJdGG5MujZgjVhDFQAB15Rih8pzO1a_j_5mH6X0fQ?e=1wRe8d

Policy for the Surgical Release of Trigger Finger
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/EWZwtd3GMrNDlGdd0X8t-0cBjHpciLB-Le5R6YR_STOyxw?e=cjSrgQ

Policy for the Surgical Management of Gynaecomastia
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/EWHGev0eJwZJkxA5VVIq54EB7e_ksWilkSHVyIaFIrpmYw?e=E50AWM

Policy for the Management of Otitis Media with Effusion (OME) using grommets.
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/ERGbadXhFbVJq20u3mI_My4BYjT0x6GLRE3J6cSVxKkkzw?e=GJHFTP

Policy for the Surgical Treatment of Carpal Tunnel Syndrome
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/EbFkzAi1iwFEtTp0GuJ3MEYBcIskFCCpfWuyzEcSS8ax7A?e=genU44

Policy for Breast Reduction Surgery
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/ETE2D5idVhJIim63gquw8QsBlbvkkGBoFRkiKQiX9toqmw?e=qxLRxC

Policy for the Removal of Benign Skin Lesions
https://csucloudservices.sharepoint.com/:w:/s/CSU/IFR/Eb_Dbd_hzWtIusfOFnFns5sBd5OifnNXU8XC628sjKuw_w?e=PbIE1e

3. Key changes

3.1 The findings of the review comparing the EBI guidance and the local policy criteria were considered in conjunction with the feedback received during clinical and patient engagement.

3.2 When determining what amendments should be made to these policies, the CPDIG ensured that changes to align local policies with NHSE's EBI guidance would only be made if they allow current access thresholds to be maintained, help facilitate objectivity, are consistent with local principles and improve clarity. Table 1 below provides an overview of the key changes made to each policy.

3.3 Currently the circumstances in which breast reduction surgery, surgical reduction of gynaecomastia and the removal of benign skin lesions will be commissioned by the CCGs in Lancashire and South Cumbria are outlined in the Policy for Cosmetic Procedures. Feedback has been received that stakeholders find individual intervention specific policies easier to locate and utilise than policies that cover multiple interventions.

3.4 Therefore, in addition to the key changes outlined below, the CPDIG agreed that these three interventions should be removed from the scope of the Policy for Cosmetic Procedures and individual policies should be produced.

Table 1: *Summary of the key changes made to the existing Lancashire and South Cumbria policies*

Policy	Key changes
Policy for Tonsillectomy	• The following criteria have been added to the policy: a) Acute and chronic renal disease resulting from acute bacterial tonsillitis OR b) Metabolic disorders where a period of reduced oral intake could be dangerous to health OR c) PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis) OR d) Severe immune deficiency that would make episode of recurrent tonsillitis dangerous.
Policy for the Surgical Release of Trigger Finger	• The scope of the policy has been clarified to reflect that applies only to children. • The range of acceptable conservative management options and the patient cohorts who must undergo conservative management prior to surgery have been clarified. • Surgery will now be funded surgery will now be available as the first-line intervention for patients who have previously not had successful results from conservative management on two other digits.
Policy for the Surgical Management of Gynaecomastia	• Previously this procedure wasn't routinely commissioned. The new policy allows surgery to be commissioned when the gynaecomastia has occurred as a result of medical treatment.
Policy for the Management of Otitis Media with Effusion (OME) using grommets.	• The policy has been clarified to make it clear the procedure will be commissioned where children are unable to undergo standard hearing assessments for clinical reasons. • The structure of the policy has been improved to aid understanding and consistency.
Policy for the Surgical Treatment of Carpal Tunnel Syndrome	• The criteria have been updated to ensure all circumstances in which surgery is indicated without the need for conservative management, such as permanent reduction in sensation/muscle wasting, etc, are reflected. • The period of conservative management required has been reduced from 3 months to 2 months. • The criteria related to the management of pregnant women has been clarified to improve its reflection of the evidence base and ensure consistent application.
Policy for Breast Reduction Surgery	• The BMI requirements regarding the period of stability required and the upper threshold have been brought in line with the EBI criteria. • The criteria related to the presence of intertrigo has been simplified to aid understanding.
Policy for the Removal of Benign Skin Lesions	• The scope of the policy has been clarified to reflect that it addresses benign skin lesions only. • The criteria have been updated to ensure they are consistent with criteria for the provision of other cosmetic procedures, e.g. the inclusion of explicit confirmation that lesions obstructing an orifice or impairing visual fields fulfil the definition of functional impairment.

3.4 An assessment of the likely financial impact of the changes was undertaken. This concluded that the overall impact of the changes are likely to be minimal as the majority of changes made are changes to wording to add clarification.

3.5 The policies were presented to Healthier Lancashire and South Cumbria's Care Professionals Board in June 2019, who supported their development.

3.6 An EIA[1-7] has been undertaken on each of the policies. These were presented to the CPDIG on 18 July 2019. No equality risks were identified, and so the group agreed that the policies should proceed to ratification.

4. Recommendations

4.1 The JCCCGs is asked to ratify the following collaborative commissioning policies, which will replace any existing CCG policies:

- Policy for Tonsillectomy
- Policy for the Surgical Release of Trigger Finger
- Policy for the Surgical Management of Gynaecomastia
- Policy for the Management of Otitis Media with Effusion (OME) using grommets.
- Policy for the Surgical Treatment of Carpal Tunnel Syndrome
- Policy for Breast Reduction Surgery
- Policy for the Removal of Benign Skin Lesions

Elaine Johnstone, Chair of the CPDIG

23 August 2019

References

1. Equality Impact Risk Assessment Policy on Tonsillectomy https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EaVL-Ek6yOZIqSuCO72EUggBveu16QQmu4QQTdzaFAIhjQ?e=NUbxcd
2. Equality Impact Risk Assessment Policy for the Surgical Release of Trigger Finger https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EbO83zoD9h1OsLJNCW8KEKABeV_O4MABSUe2UHKVrvw0nQ?e=7jpRgF
3. Equality Impact Risk Assessment Policy for the Surgical Management of Gynaecomastia https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EV5-A2F65otFpQvgBx33DuoB59WaOQ6ke1vIW_BZCWuUWg?e=dPI5qF
4. Equality Impact Risk Assessment Policy for the Management of Otitis Media with Effusion (OME) using grommets. https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/ETLgmNkaVfZCrx8W4SueGE4B_ulwwu2lcouacjVQabLaUA?e=Vbw23U
5. Equality Impact Risk Assessment Policy for the Surgical Treatment of Carpal Tunnel Syndrome https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EfuHXxk7erlJov6WS9uCW68BUy0C885OUEmcqeN3u-s8ZA?e=zIMzbF

6. Equality Impact Risk Assessment Policy for Breast Reduction Surgery https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EbZ2Arxns9pGiS8XtfnXnU8Bshnzu4tKigw6rNlD4BNa7Q?e=h2nm63
7. Equality Impact Risk Assessment Policy for the Removal of Benign Skin Lesions https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EbujW7fxuk1Iv9nw-EjRAB4BAn8dttXRbrxnCP0AsaRT6w?e=NfgIvU

Title of Paper	Individual Patient Activity (IPA) Programme Board Update		
Date of Meeting	5th September 2019	Agenda Item	7

Lead Author	Margaret Williams – IPA Programme Director (Executive Nurse – Morecambe Bay CCG)	
Contributors	Jerry Hawker – Accountable Officer Morecambe Bay CCG Iain Fletcher – NHS Blackburn with Darwin CCG, Jackie Hadwen MLCSU	
Purpose of the Report	Please tick as appropriate	
	For Information	X
	For Discussion	
	For Decision	X
Executive Summary	The JCCCGs at its May 2019 meeting acknowledged the current level of Individual Patient Activity services provided across Lancashire and South Cumbria (with the exception of Blackpool) was providing standards of care that fall well below an acceptable standard and should be of concern to all CCG Governing Bodies. This was articulated through an earlier independent review which highlighted 7 specific thematic areas where sustained improvement was required. The Committee endorsed the establishment of a new IPA programme Board to act as a single point of coordination on behalf of the Lancashire & South Cumbria CCGs and Integrated Care System. In addition to addressing the thematic areas of improvement, two broad objectives were agreed for the IPA Programme Board: • Develop and make formal proposals on the future arrangements for commissioning and operational delivery of IPA services by the end December 2019. • Deliver the explicit ambition to try to stabilise the current system, accelerate improvement in current performance and provide a more stable platform for future transformation. These two broad objectives have been translated into a detailed programme plan which has been expanded to include a focus on delivery of the National Personal Health Budgets guidance and more recently a review of the current CHC procurement framework/market management. This update provides an overview of progress to date in addressing the thematic areas for improvement and progress against delivering the programme plan developed by the IPA Board.	

	Whilst outside the delegated authority of the Joint Committee, this report includes a number of recommendations from the IPA programme board that would benefit being endorsed by the Joint Committee prior to final approval through individual CCGs.		
Recommendations	•		
Next Steps	• Specific recommendations contained in this report will be presented to each CCG for decision. • A further report will be presented to the Joint Committee on the two objectives in-line with the agreed work programme and in time for inclusion in the 2020/21 planning process.		
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	With the exception of Blackpool CCG, the Lancashire & South Cumbria CCG's (and collectively as an ICS) are failing to comply with the NHS Continuing Healthcare framework and the quality standards expected by all CCG's.		
Report Authorised by:	Jerry Hawker – Chair and SRO for the IPA Programme Board (Accountable Officer Morecambe Bay CCG)		

Individual Patient Activity (IPA) Programme Board Update

1. Introduction

1.1 The JCCCGs in May 2019 acknowledged that the current level of services provided across Lancashire and South Cumbria (with the exception of Blackpool) was providing standards of care that fell well below an acceptable standard and should be of concern to all CCG Governing Bodies and Integrated Care Partnerships (ICPs).

Additionally, a thematic review presented in November 2019 identified a number of areas for improvement.

- Leadership
- Relationships
- Governance
- Finance
- Operational Model
- Access and Quality Variability
- Performance

In May 2019 the Committee endorsed a single point of coordination through the IPA Programme Board. The IPA Programme Board was established and has been working together collectively, listening and engaging the views of partners in order to agree areas of improvement focus, actions and timeframes.

The IPA Programme Board has representation from across the Integrated Care System (ICS) and is made up of the 5 Lancashire and South Cumbria ICPs, including representation from the 4 Local Authorities and 8 Clinical Commissioning Groups.

The Committee endorsed the establishment of a new IPA programme Board to act as a single point of coordination on behalf of the Lancashire & South Cumbria CCGs and Integrated Care System.

In addition to addressing the thematic areas of improvement, two broad objectives were agreed for the IPA Programme Board:

- Develop and make formal proposals on the future arrangements for commissioning and operational delivery of IPA services by the end December 2019.

- Deliver the explicit ambition to try to stabilise the current system, accelerate improvement in current performance and provide a more stable platform for future transformation.

These two broad objectives have been translated into a detailed programme plan which has been expanded to include a focus on delivery of the National guidance on the introduction of Personal Health Budgets and more recently a review of the current CHC procurement framework/market management.

2. **Progress against the thematic areas of improvement.**

2.1 **Leadership-** there is now clear executive leadership, a clear mandate, direction and strategy at ICS level, with a maturing ICP and developing ICC level leadership. *Capacity and resource constraints remain a concern and will continue to limit the speed and spread of the programme improvements.*

2.2 **Relationships**-there is improving organisational transparency with relationships continuing to mature. The IPA Board has strong representation from the Local Authorities and the move to ICP representation has been an important step in balancing ICS system leadership whilst retaining local place leadership. *A lack of system knowledge about IPA remains a risk to relationships as does the overall level of poor operational performance which requires collective system leadership but inevitably results in undermining relationships.*

2.3 **Governance -** Significant progress has been made in strengthening the governance arrangements. The IPA Board as now well established, with appropriate sub-groups established to deliver a robust work plan (Appendix A). Delegation Authority means that all decisions continue to be made through individual statutory bodies, but the IPA Board is active in using the Collaborative Commissioning Board, Joint Committee of CCGs and the emerging ICP's to support collaborative development of recommendations. *Formal proposals on the future arrangements for commissioning and operational delivery (including governance arrangements) of IPA services will be developed by the end December 2019.*

2.4 **Finance –** The IPA Board has an increased confidence in our understanding of financial and resource allocation across the Lancashire & South Cumbria service. This is an area where we are continuing to strengthen our understanding and particularly use of benchmarking data to compare the cost of providing the service verses the cost of delivering IPA Care. *Forecasting continues to be a challenge due to the lack of clear and consistent commissioning, contracting and financial management. Significant variability in funding levels and approaches remain. Overview of financial information is provided in at Appendix B.*

2.5 **Operational Model –** The outline business modelling is progressing well. Best practice models from across the country (including Blackpool locally) have been evaluated against the national CHC Maturity Framework. The IPA Board is applying a robust business modelling process to assess benefits and risks enabling a long list of 8 options to be reduced to 2 preferred options for full business case work up. Both options will include proposals regarding future commissioning arrangements. Feasibility, Acceptability, Clinical Quality, Performance and Affordability were the key considerations applied to the modelling work.

There continues to be multiple providers delivering variable aspects of the IPA pathway. This continues to contribute to the unacceptable delays in referral management, assessment and care co-ordination.

The Health and Social Care System is not accessing core services as it should. Core services are raising burden of CHC process on their ability to deliver front line Core services. There continues to be a lack of ownership of case co-ordination.

2.6 **Access & Quality variability –** The IPA Programme Board has invested significant time and resource to establishing a clear understanding of the variability in service delivery (quality and performance) and can now describe the detail and root causes of the underlying issues. This has enabled a robust improvement programme and actions to be developed (Appendix C).

The improvement programme has focused on improving efficiency and productivity within current resources and by sharing best practice. This has included a focus on improving policies, referral behaviours, training and development. However it is a strong view of the IPA Board (supported by wide benchmarking) that sustained improvement will require increased investment in the service (new service model), if the ICS partners are to address the embedded structure weaknesses and poor performance/quality. *There continues to be significant variability in referral rates, eligibility rates, and conversion rates. A significant delay in reviews represents poor patient care and is a responsibility of all partners.*

2.7 Performance - Across Lancashire & South Cumbria there is a significant level of poor performance and variability against National KPI's, Access standards, and Quality Indicators. Appendix D provides information against Minimum Quality Premium Standards and Appendix E compares 17/18 –18/19 – CCG/ICP/England

Progress has been made with establishing improvement trajectories in-line with recently introduced National requirements. Each ICP have agreed its Quarter on Quarter Improvement projection with the aim to be meeting standards by April 2020.

3.0 Key Messages

3.1 **Performance against Quality premium Standards (**Appendix D)

2 of the 5 ICP's and 4 of the 8 CCG have not met the national target of ensuring less than 15% of all NHS CHC assessments take place in an acute hospital setting.

This means that individuals are not at their optimum when being assessed for CHC; this can lead to a number of issues including delays in discharging patients from acute care settings, setting an expectation that individuals/patients will continue to meet. It can lead to placing individuals into inappropriate long term care settings.

The reason for this is mainly attributable to the variable way each ICP have implemented Discharge to Assessment models, resourced the models and sourced market capacity for complex care.

None of the 5 ICPs and only 1 of the 8 CCGs met the more than 80% of all NHS CHC assessments are completed within 28 days.

This means that individuals are waiting too long for decisions of access to care cost causing undue distress, difficult dialogue between care providers, health and social care teams, Core services and families. It puts additional work burden onto front line

health and social care teams and causes unhealthy working relationships between colleagues and families.

The reason for this is multifactorial, but mainly aligned to CSU and Community provider team capacity and need to prioritise clinical front line care, and the growing number of disputes between health and social care that take time to process.

3.2 **Overdue Reviews**

As at 31st July 2019, Lancashire and South Cumbria report 1644 open care packages across CHC Standard and Fast Track funding care stream. Of these 547 standard CHC care packages and 362 Fast Track Care Packages are overdue by 12 weeks or more. This reflects one of the worst performances in England and represents poor management and care for those accessing the service.

The IPA Programme Board have been working through a number of Strategic options that could be implemented to address the number of overdue reviews in the most equitable, inclusive way. A final proposal will be submitted to the IPA Programme Board at its September Meeting, and will then be presented to the individual CCGs for consideration/approval. For avoidance of doubt, addressing the scale of outstanding reviews will require a level of resources that is significantly beyond the current service capability. Any improvement action is likely to require non-recurrent investment to address the outstanding reviews and ensure that any future service model is implemented on a sustainable basis. To maximise the return on investment any proposal will strongly support a single ICS approach.

3.3 **Personal Health Budgets**

The NHS Long Term Plan and implementation framework set-out a clear commitment and expectation with regard to giving people more control over their own health and more personalised care.

For CCG this increases specific responsibilities and duties to increase significantly the scale and scope of Personalised Health Budgets (PHBs).

A report on the progress in ensuring all CCGs in Lancashire & South Cumbria are complying with the requirements to offer PHBs is presented in Appendix F

The paper sets-out the options available to CCG's to either stop the existing interim funding arrangements, maintain the current interim funding or expand the service/funding in-line with the growing service requirement and CCG duties.

The IPA Programme Board has considered carefully the National guidance and the need to embedded PHB's within the future IPA model of care. It is therefore the strong recommendation of the IPA Board that CCG's should support a non-recurrent level of funding of £154K from 1st October 2019 to 30th April 2020. Long term

recurrent funding would be dependent on the the response of all CCGs to the proposed business case on the future provision of IPA services.

3.4 **Joint Disputes Resolution Protocol**

As part of the approach to improving efficiency and productivity within the existing service a new Joint Disputes Resolution Protocol has been developed with the involvement of all statutory partners. A copy of the full proposal and policy is attached in Appendix G.

CCGs and Local Authorities in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them. This protocol will also apply to managing disputes raised about joint packages of care also referred to as integrated funding. This protocol will ensure a clear process that allows disputes to be addressed in a professional and timely manner and within clearly defined agreed responsibilities.

The IPA Programme Board has overseen the development of this protocol and recommends that it is approved by the Joint Committee of CCG's.

4.0 Conclusion

4.1 Since May 2019 the IPA Programme Board has been able to secure a collectively view of the performance, financial and quality issues impacting IPA Service Delivery and the consequence on care to many of our most vulnerable individuals in our communities. Governance arrangements are established and a full programme management approach implemented.

4.2 Good progress has been made against the broad objectives of the IPA Programme Board and it remains on-track to produce formal proposals on the future of the service by the end of the year.

4.3 Whilst good progress has been made in many areas, underlying delivery of the National standards for CHC remain of very significant concern. Whilst the board is committed to progressing the improvement plan there is growing evidence that financial resource will be required in order to sustain the level of service delivery we aim to achieve for our populations.

4.4 A report on the progress in ensuring all CCGs in Lancashire & South Cumbria are complying with the requirements to offer PHBs is presented in Appendix F. The report calls on an additional non-recurrent funding of £154K through to the end of April 2020 to ensure all CCGs continue to meet their duties with respect to offering PHB's. The recommendation is full supported by the IPA Programme Board.

5.0 Recommendations

The joint committee is asked to:

- Note the ongoing performance position and current level of improvement action and ensure individual CCG Governing Bodies are full sighted on the current risks associated including potential additional investment requirements to address.
- Note progress and actions to develop proposals on both new commissioning and operational delivery models for IPA services due to be presented before end of the year.
- Endorse the recommendation of the IPA Programme Board to continue and increase the level of non-recurrent funding to ensure CCGs continue to comply with the duties to promote and provide PHB's. *Note: The decision whether to extend the PHB investment remains under the statutory duty of individual CCGs.*
- Approve the proposed Joint Disputes Resolution Protocol set-out in appendix F and delegate authority to the IPA Programme Board to sign-off any minor non-material amendments at the September board meeting. This is to allow parallel approval processes with the Local Authorities.

Jerry Hawker & Margaret Williams

On behalf of the IPA Programme Board

28th August 2019

ICS Individual Patient Activity Programme: Plan on a Page 2019/20

Integrated Care System IPA vision for our population....	**Our objectives:**
• A set of services that support patients, carers and families in a caring, responsive way, placing the individual at the centre of care. • Empowering individuals with better information and choice to manage their care through NHS support services or Personal Health Budgets(PHB) • A 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.	To achieve our vision we will deliver "triple aim" **Better Health, Better Care, Delivered Sustainably.** • We will be align to ICS Priorities supporting Communities and Staff, building partnerships and relationships and planning & resourcing. • We will agree a single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICPs and neighbourhoods. • We will deliver an improvement programme to achieve all National framework standards and quality metrics by October 2019

Workstream 1:
Develop and make formal proposals to the JCCGs on the future arrangements for commissioning and operational delivery of IPA services by the end December 2019.

Priority	Initiative/Task	Metrics	Timeframe	Leads
1. Develop the outline business case for IPA service across the ICS that improves outcomes and efficiency in line with the triple aim objectives	Redesign 1. follows the patient's journey and pathway of care 2. is clinically led with facilitation and help from all clinical support services 3. promotes effective integrated delivery/ team working, with right skill 4. focus on improving the patient's experience and outcomes of care 5. based on best practice and follows a structured methodology	I. complete demographic needs assessment II. workforce modelling, capability capacity mapping III. capacity and demand review IV. develop plan to progress CHC maturity V. have outline business case ready by November IPA Board VI. outline business case to JCCGs December 2019 VII. full Business Case January 2020	October 2019 (Full options to JCCCGs Dec)	**Jackie Hadwen (Responsible Lead)** Iain Fletcher Paul Jones Jackie Hadwen David Storry
2. To achieve the PHB & Integrated Personal Commissioning National Expansion Plan	1. Simplifying and securing the delivery model 2. Increasing the uptake 3. Increasing the breadth of areas and services in which PHBs are offered 4. Stimulate demand for PHBs 5. Value added appraisal of PHB 6. Ensuring integral part of future model delivery	I. Produce outline/full business case II. Increase notional, 3rd party and Direct PHB uptake III. Deliver associated personalisation outcomes IV. Improve timeframe from decision to implementation of PHB	August 2019	**Iain Fletcher (Responsible Lead)** Judith Johnston Emma Orton Ian Smith
3. Minimise use of Fast Track, Maximise End of Life care offer	4. Integrate fast track funding model into EoL 5. Demonstrate value added care 6. Work towards a Zero tolerance of overdue reviews in this co-hort of individuals	I. Reduce fast track cases open beyond 6 month II. Maintain 100% conversion rate III. Improve experience outcomes for these individuals	October 2019	**Emma Orton (Responsible Lead)** Kim Crabtree Andrea Isherwood
4. Understand and evaluate the current position of IPA service provision in relation to best practice and identify areas and means of performance improvement.	1. Identify leading best practice models 2. Determine superior performance levels 3. Quantify performance gaps in other models/ key business areas 4. Evaluate reasons for superior performance. 5. Share knowledge of working practices that enable superior performance. 6. Enable learning to build foundations for performance improvement	I. Agree benchmarking modelling criteria (use maturity matrix) II. Determine best practice visit sights III. Capture workforce and digital enablers in options model IV. Deploy visits (ensure voice of users views/independent lay view) V. Evaluate, write up ready for option appraisal	September 2019	**Judith Johnston (Responsible Lead)** Margaret Williams Joanna Livingstone Alison Small Jayne Mello (TBC)
Complete a IPA Financial Assessment that supports to articulate current and future model delivery (	1. Understanding the Financial Baseline for Individual Patient Activity (IPA) 2. Move to having a joint Health and Local Authority Financial baseline for IPA 3. Understand total cost of current service delivery (all provision) 4. Move to having a joint Health and Local Authority Financial baseline for IPA service cost 5. Projected population care costs 6. Support and appraisal cost of model options 7. Support Workstream task groups	i. Determine baseline, cost of care, service cost ii. Project future cost in line with population demographics iii. Outline cost of model options iv. Appraise financial impact of overdue review and PHB project	September 2019	**Paul Jones (Responsible Lead)** Ian Smith Charlotte Macke Gill Nixon –Smith Mike Banks

Workstream 2:
Performance Improvement – Provide tactical leadership in the development and implementation of an LSC ICS wide improvement programme and demonstrate delivery against improvement plan of all National framework standards and quality metrics by October 2019

Priority	Initiative/Task	Metrics	Timeframe	Leads
1. Deliver IPA Services in line with national best practice standards; facilitate transparency for improvement celebrating where services are doing well, and being open where there need to improve. Allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.	1. Improve the ICS baseline position 2. Cumulatively worst performing ICS/STP in the North of England against *% of CHC assessments in hospital* (<15% target) 3. Cumulatively worst performing ICS/STP in North against *28 Standard for completing assessments* (only BCCG meeting) 4. Over 3000 *overdue assessments*. 5. 300% variation in DST's per weighted population between CCGs 6. 80% variation in CHC cases per weighted population between CCGs 7. *Low checklist to DST conversation rates* across Standard CHC 8. Consistent *Policy* application, SoPs and Guidance 9. *Referral Management* process and *audit* programme	I. ICS progresses improvement journey as per NHSE projected plan II. ICPs report less than 15% of all NHS CHC assessments take place in an acute hospital setting. III. ICPs at least 80% of all NHS CHC assessments are completed within 28 days IV. Reduce the number of Appeal and Local Resolution open cases in terms of number of cases received and remaining for the and confirm the an estimated trajectory V. Reduce number of cases into NHSE Independent Review panels VI. Reduce number of open fast track reviews over 6 month VII. Reduce number of overdue reviews	November 2019	**Margaret Williams (Responsible Lead)** Jane Brennan Alison Small Gill Nixon- Smith Andrea Isherwood Charlotte Macke Angela Clarke
1. Develop a process of engagement patients, users, family and associated groups to improve all aspects of the CHC care pathway, including experience and outcomes – giving people the power to shape the programme.	1. Agree approach to encourage patient/user and family and associated involvement in the design, planning and delivery of redesign of the service. 2. Improve written information 3. Apply learning from complaints 4. Celebrate good stories 5. Review the ICS approach to User and staff satisfaction survey 6. Visioning event	I. Representative voice clarified at different points across the programme II. Improve staff experience of engaging with and delivering CHC III. Improve communications, leaflets, web sites use of pod cast/audio IV. Visioning events outputs	November 2019	**Margaret Williams (Responsible Lead)** Lesley Anderton-Hadley Kim Crabtree Harinder Sanghera (IFR) Alison Small Gill Nixon-Smith

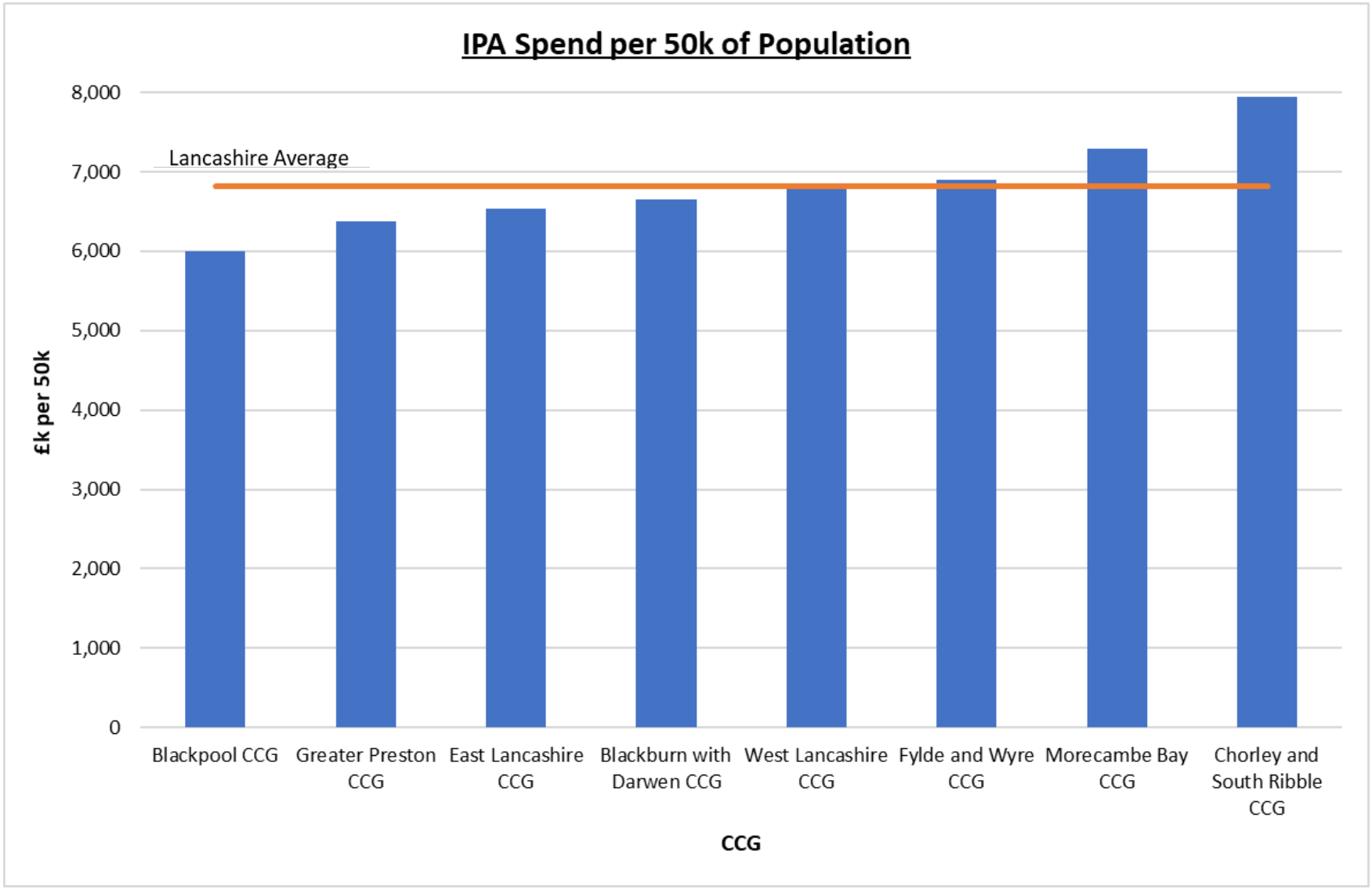
Lancashire & South Cumbria ICS

Understanding the Financial Baseline for Individual Patient Activity (IPA)

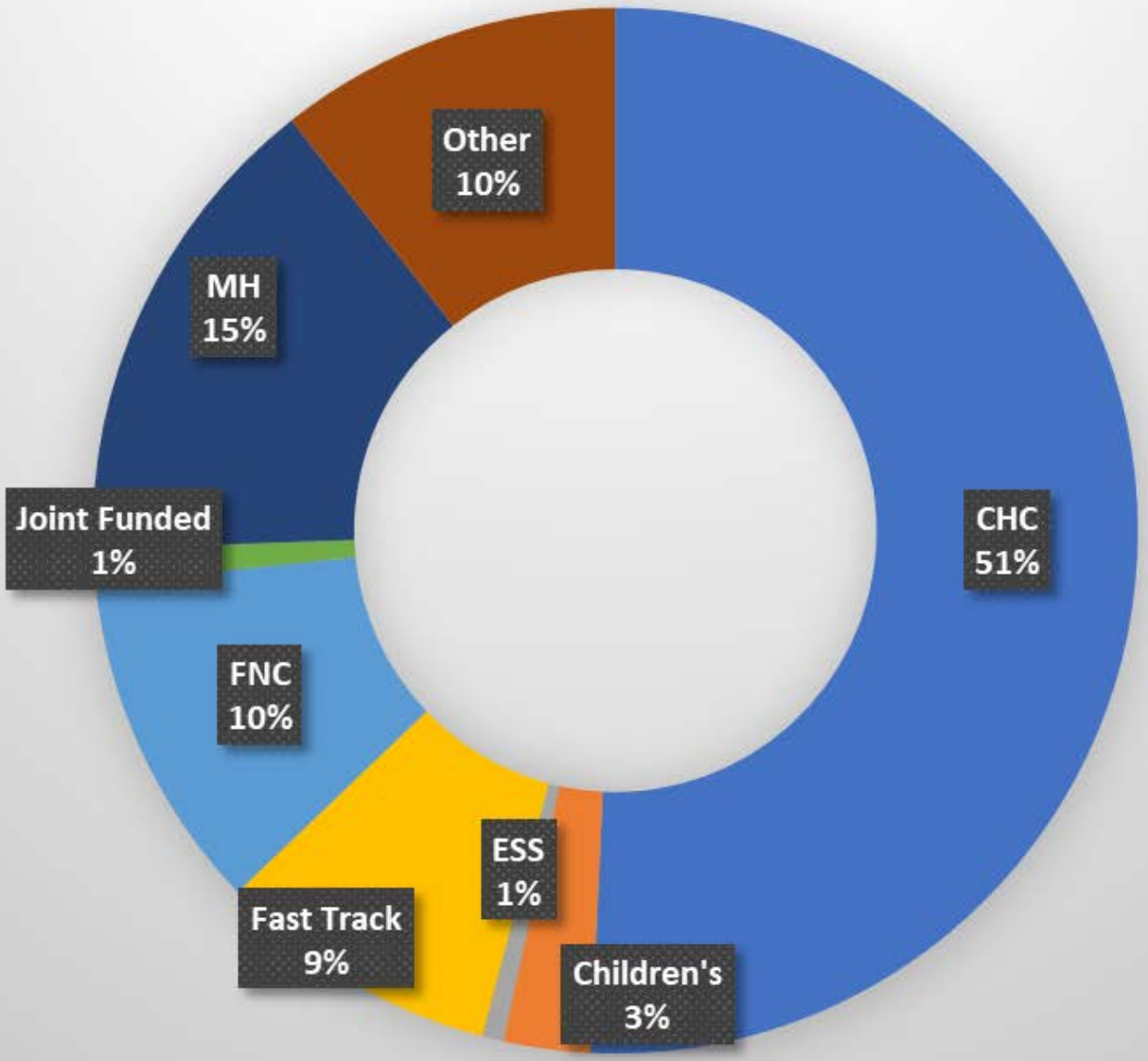
Lancashire & South Cumbria 18-19 IPA Spend

CCG	£m
Blackburn with Darwen CCG	17.758
Chorley and South Ribble CCG	23.477
East Lancashire CCG	39.205
Fylde and Wyre CCG	20.333
Greater Preston CCG	21.315
Morecambe Bay CCG	41.972
West Lancashire CCG	12.635
Blackpool CCG	16.931
Total	**193.626**

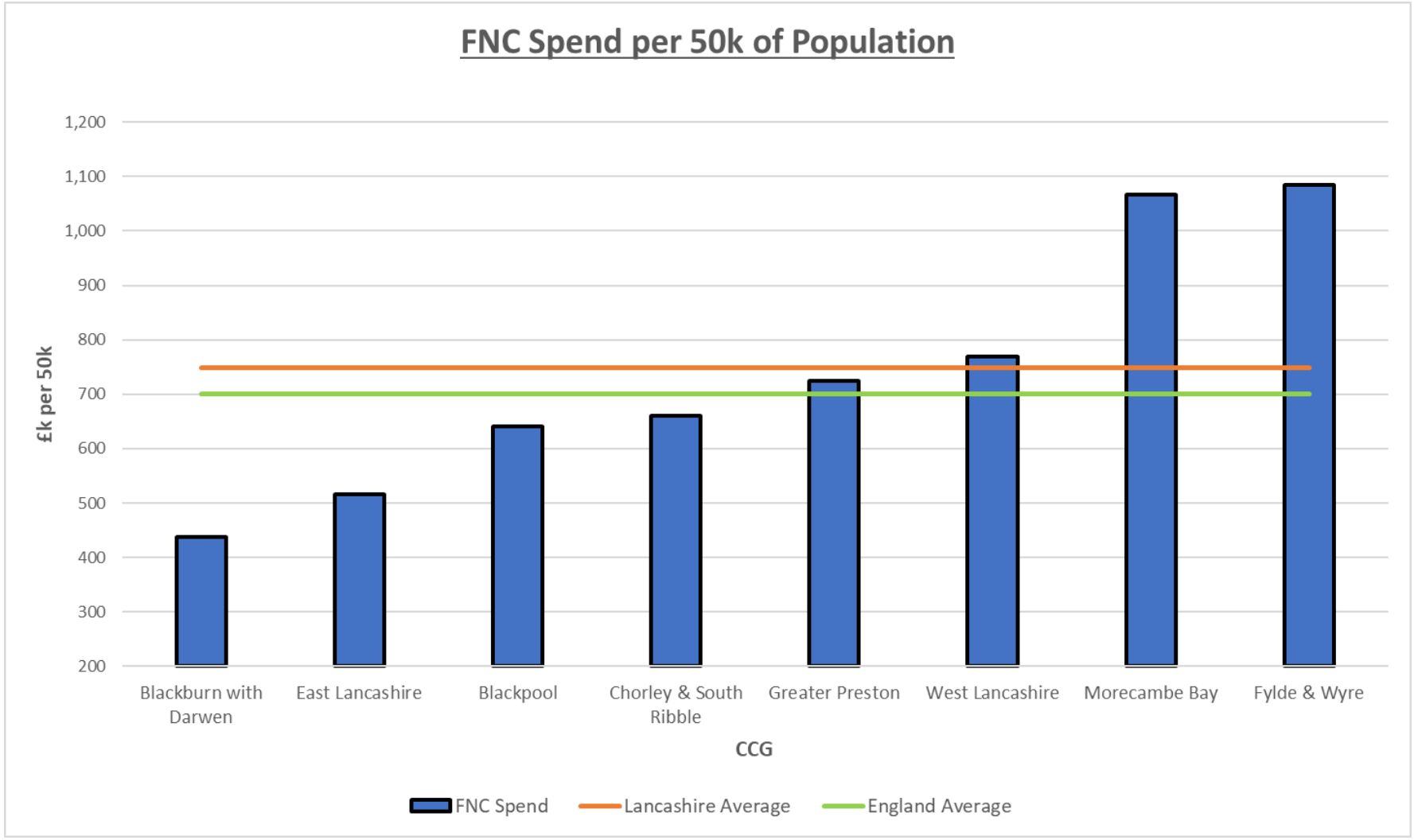
Expenditure per Head of Population



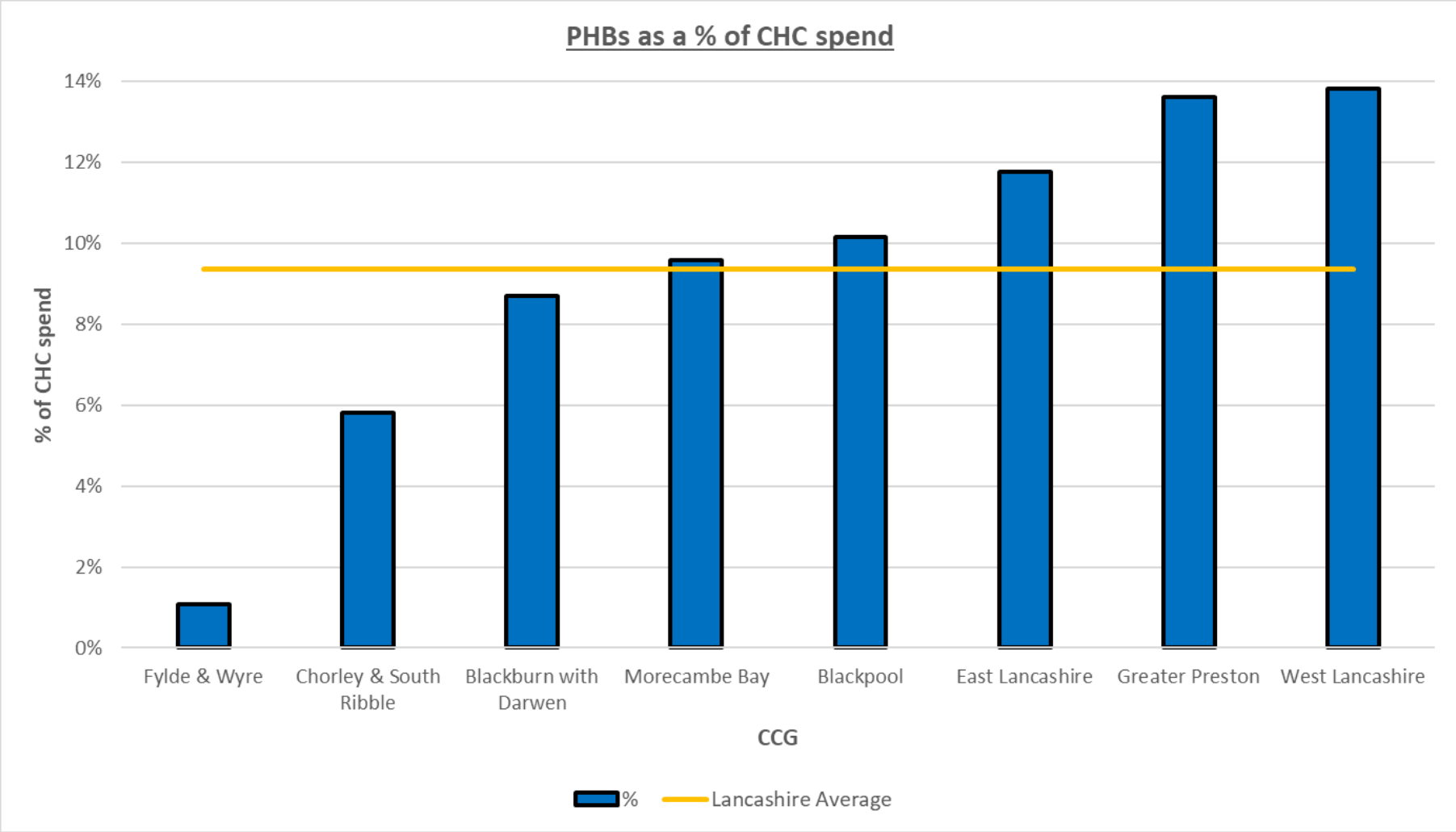
Breakdown of IPA Expenditure by Category



FNC Spend


FNC Spend per 50k of Population
£k per 50k
1,200
1,100
1,000
900
800
700
600
500
400
300
200
Blackburn with Darwen
East Lancashire
Blackpool
Chorley & South Ribble
Greater Preston
West Lancashire
Morecambe Bay
Fylde & Wyre
CCG
FNC Spend
Lancashire Average
England Average

Personal Health Budgets



- Variation could be explained by a small number of high cost packages

Observations/Conclusions

- Significant degree of variation across ICS footprint:
  - 32% for overall IPA expenditure (Blackpool to C&SR)
  - 148% for FNC expenditure (BwD to Fylde & Wyre)
- PHBs still form a low proportion of expenditure (9% of CHC in 18/19)
- National data does not demonstrate a relationship between investment in IPA service and reduced expenditure (but Blackpool has lowest IPA cost in Lancashire….)
- This analysis does not imply causality but hopefully informs and potentially offers leads for further investigation of savings opportunities
- NB: Not yet included local authority costs

KEY

On track	
Progressing but delivery issues identified	
Not started/Not reported	

Appendix C- The table below details the **Quality Improvement Outcomes and Improvement Actions**

Workstream 1				Overall Amber	
Develop and make formal proposals to the JCCGs on the future arrangements for commissioning and operational delivery of IPA services by the end December 2019					
Deliverable	By When	Successes	Constraints & Issues	Plan to Manage	Outcome to be achieved	RAG
1. Develop the outline Business Case for IPA Services across the ICS that improve outcomes and efficiency in line with the triple aim objectives.	Oct 2019	Time line on track	Financial detail required	Agreed leads and times frames	Model options	
2. To achieve the PHB and Integrated Personal Commissioning National Expansion Plan	Aug 2019	Solution for Direct Payment found	Financial pressure to maintain current delivery Financial forecast at year 2-3 not yet known	Agreed options to be presented to CCG AOs	PHB integrated into Model options	
3. Minimise use of Fast Track, maximise End of Life Care offer	Oct 2019		Need to address overdue Fast Track reviews 1st Need to align to future commissioning EoL service offer	Commence later in year. Align to EoL pathway activity	Fast track funds used to support continuum of EoL pathway	
4. Understand and evaluate the current position of IPA service provision in relation to best practice and identify areas and means of performance improvement	Sept 2019	Long list to short List completed	End to end service offer not yet agreed Need to agree what is in what is out i.e. case management, care co-ordination, fast track	Best practice mapping completed. Sight Visits planned	Model developed against the best	
5. Complete an IPA Financial Assessment that supports to	Sept	Initial high level overview	Additional financial detail required	Forecasting being developed via	Model developed against	

KEY

On track	
Progressing but delivery issues identified	
Not started/Not reported	

articulate current and future model delivery	2019	completed		agreed Lead	the best value added	
Workstream 2					**Overall RED**	
Performance Improvement- Provide tactical leadership in the development and implementation of an LSC ICS wide improvement programme to delivery against all National framework standards and quality metrics by October 2019						
2.1 Deliver IPA Services in line with National best practice standards. Allow quality improvement to take place where it will be most useful- January 2020						
Deliverable	By When	Successes	Constraints & Issues	Plan to Manage	Outcomes to be achieved	RAG
Improvement Area 1						
Implementation of Referral Management System- This is a tool that keeps a track of the individuals/patient referrals throughout the care continuum.	Jan 2020	Programme of rolling out agreed Manual roll out for CSR and GrP CCGs has improved the control of referrals. This is evidenced by the reduction in open referrals over 28 days. (121 – 16 over a six month period)	Capacity means rolling out across each ICP will take time. Excludes services delivered by Community South Cumbria Strata System not yet got referral management built in	ICP level of improvement action and resource being mapped Meetings set up to talk through what is needed	Reduce number of poor quality Checklists Improve 28 days DST Decision timescales	
Improvement Area 2						
Training – This will focus on training the workforce at specific points of the path way to aid continuity of	Jan 2020	Local teams requested to gather local referrer logs	Anecdotally ELearning not sufficient	Start with mapping log of referees and target focussed training Expand to DST	Improve Standardisation Reduce burden of inappropriate referrals	

KEY

On track	
Progressing but delivery issues identified	
Not started/Not reported	

application. The starting point will be training to those Health and Social Care Staff who refer				training, competence	Increase Conversion Rates Build agency relationships	
Improvement Area 3						
Scheduling – This process supports to take administrative tasks off clinical front line staff. It is about lean ways of working, scheduling meetings and activity that meets needs of Individuals/patients, staff, organisations and teams.	Jan 2020	Programme of rolling out agreed. Additional administrator recruited for CSR and GrP CCGs, their role is to schedule the MDTs utilising a tracker to manage the 28 day process. QP hasn't improved due to the initial number of long term open referrals and staffing issues. There has been the reduction in open referrals over 28 days. (121 – 16 over a six month period)	Capacity means rolling out across each ICP will take time Excludes services delivered by Community South Cumbria Strata System not yet got scheduling built in	ICP level of improvement action and resource being mapped Meetings set up to talk through what is needed	Reduce number of poor quality Checklists Support team efficiency Support families offer to attend DST Reduce short notice cancellations Improve 28 days DST Decision timescales	
Improvement Area 4						
Processes & Policies This aims to standardise across the ICs working practices and policy standards. Initially focussing on Local Health and Social Care Disputes and Appeal processes with Individuals/Patients	Sept 2019	Key Doc in Draft	Time it will take for each Org CCG and LA to ratify within their Orgs	Recommendation into JCCCGs re resolution for this	Standardised processes across ICS for dealing with family appeals and LA/Health Disputes. Reduce burden appeals and disputes cause	

KEY

On track	
Progressing but delivery issues identified	
Not started/Not reported	

Improvement Area 5						
Focus of Rapid Improvement This aim to put additional focus and improvement activity into Pennine. Pennine continually is unable to meet standards or demonstrate any level of improvement	Dec 2019	Pennine ICP to be the focus for rapid improvement	Methodology to be agreed. Series of improvement meetings yet to be set	Stakeholder mapping to be completed alongside invite letter, KPIs for deliverable. Letter to ICP leads, AOs inviting offer. Will need to secure Improvement Expert	ICS demonstrate overall improvement Populations receive and improved level of quality NHSE see that L&SC co-ordinated approach is working	
Improvement Area 5						
Local Authority Triage (BWD) This is a peer review referral management project. It is hoped this pilot will complement the Training action. Colleagues within BWD CC will triage all referrals before they are submitted	Dec 2019	BwD LA model of triage evidencing good quality check listing referrals	For Pennine to implement require support and input from LCC	Hold a joint meeting between LCC, BWD, CCC and BWD to discuss	Reduce inappropriate referrals, support front line staff, improve conversion rates	
2.2 Develop an engagement process for patients, users and families to improve all aspects of the patient pathway. January 2020						
Appraisal of NHSE individual and family information resources, including family video, information leaflets. We have a huge variation in how we communicate information, we collectively do not utilise NHSE establish resources	Nov 2019	Request gone out across MB before cascading across ICS including family representative groups	Resource published by NHSE 6 month ago, no evidence of use of video being used by health or SC. Video resource only	Process of gaining feedback and communicating use in development	That we maximise standardised NHSE resources that have had significant users friendly input when being made. That we ensure staff	

KEY

On track	
Progressing but delivery issues identified	
Not started/Not reported	

and we need to understand why			available on line		value their use, that family are aware that they exists	
Key learning themes from Complaints across CHC/IPA and IFR are collectively reviewed and plans for improvement action developed. This is to ensure we do not lose sight of the individuals/patients experience, and that we continue to learn throughout.	Jan 2020	IFR learning themes and changes mapped into an action plan	Various models across the ICS for managing complaints including tracking of MP and legal team queries	Group to be identified and tasked to review. Likely to be an October start date	Understand impact of poor experience and take collective action to reduce frequency and complexity of issues being raised into Complaints team	

Healthier Lancashire & South Cumbria

Quality Improvement Projections

Quality Premium - CCGs must ensure that less than 15% of all NHS CHC assessments take place in an acute hospital setting.

CCG	Q4	National	Q1 ICP predicted range	Q1 performance against ICP predicated
NHS BLACKBURN WITH DARWEN CCG	21%	21%	>=20% to 24.9%	31%
NHS BLACKPOOL CCG	6%		<15%	1%
NHS CHORLEY AND SOUTH RIBBLE CCG	20%	20%	>=17% to 19.9%	15%
NHS EAST LANCASHIRE CCG	17%	17%	>=20% to 24.9%	19%
NHS FYLDE AND WYRE CCG	6%		<15%	6%
NHS GREATER PRESTON CCG	13%		<15%	16%
NHS MORECAMBE BAY CCG	8%		>=25% to 29.9%	16%
NHS WEST LANCASHIRE CCG	0%		<15%	0%

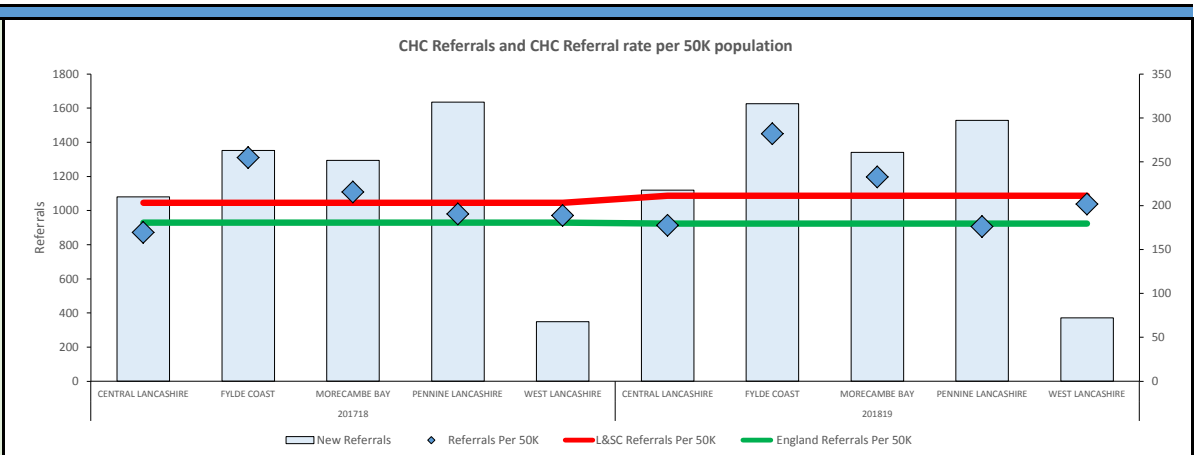
Quality Premium - CCGs must ensure that less that no less than 80% of all NHS CHC assessments are completed within 28 days.

CCG	Q4	National	Q1 ICP predicted range	Q1 performance against ICP predicated
NHS BLACKBURN WITH DARWEN CCG	56%		>=60% to 64.9%	68%
NHS BLACKPOOL CCG	86%	86%	>80%	85%
NHS CHORLEY AND SOUTH RIBBLE CCG	35%		>=30% to 39.9%	30%
NHS EAST LANCASHIRE CCG	57%		>=50% to 59.9%	53%
NHS FYLDE AND WYRE CCG	56%		>=50% to 59.9%	60%
NHS GREATER PRESTON CCG	39%		>=30% to 39.9%	29%
NHS MORECAMBE BAY CCG	65%		>=50% to 59.9%	59%
NHS WEST LANCASHIRE CCG	43%		>=40% to 49.9%	56%

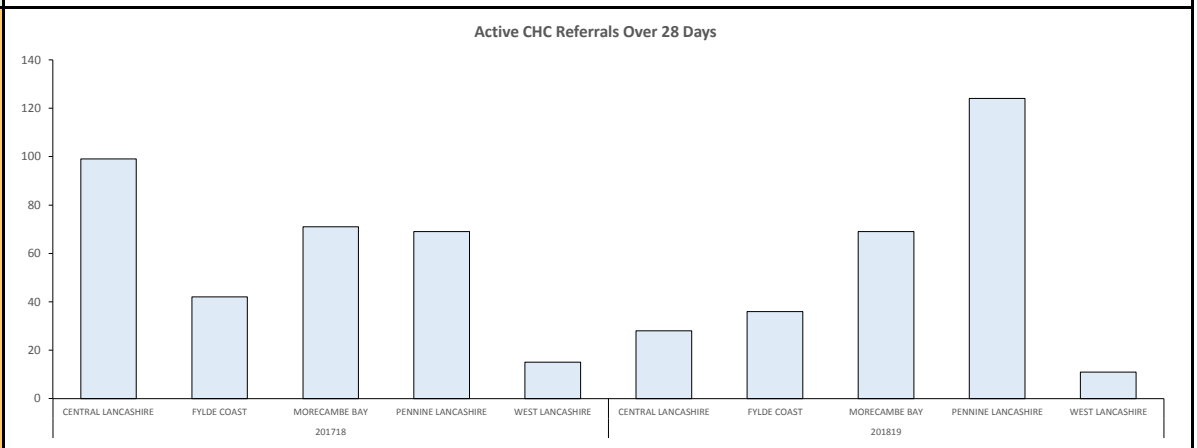
CHC & FNC Activity Summary 2017-18 to 2018-19

Note: All charts are presented in the same format. All bars are measured against the axis on the left-hand side of the chart. The diamond markers and lines are all measured against hand side of the chart. Each chart shows the Lancashire & South Cumbria (ICS) and all England averages as lines by way of a benchmark. Use slicers on the right-hand side of each gr between CCG and ICP views.

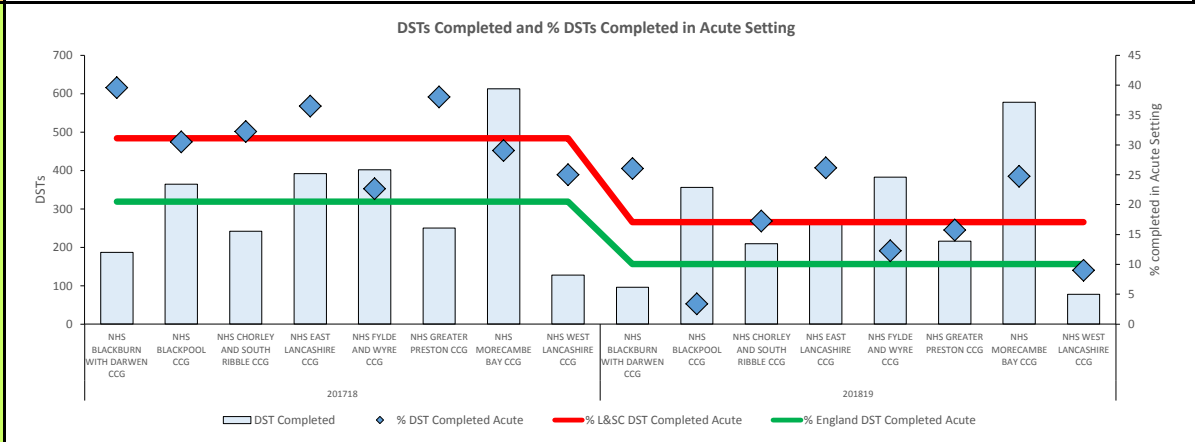
New CHC Referrals



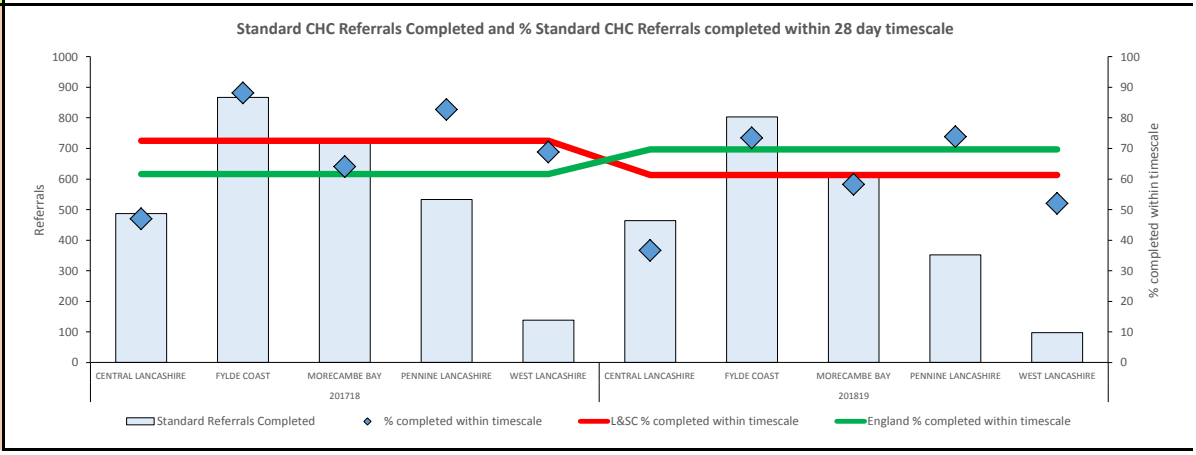
Active CHC Referrals Over 28 Days



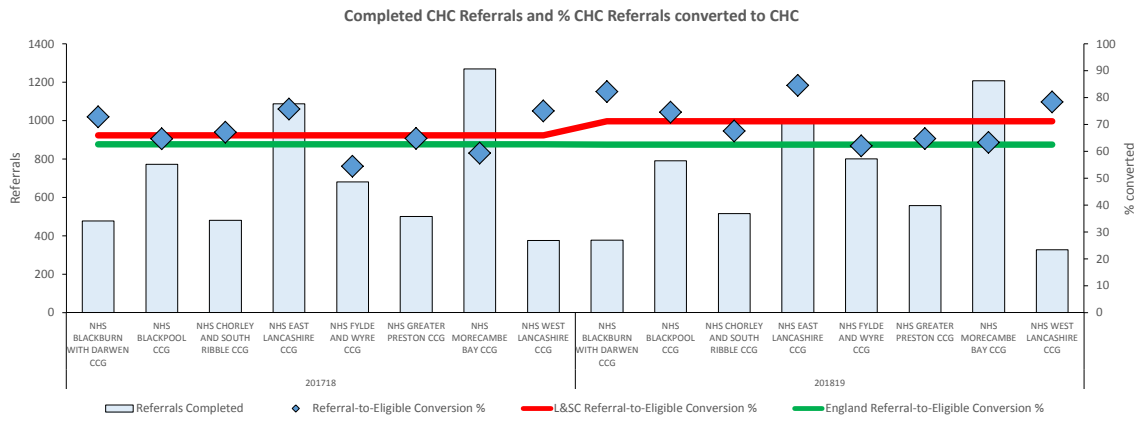
Decision Support Tools (DSTs)



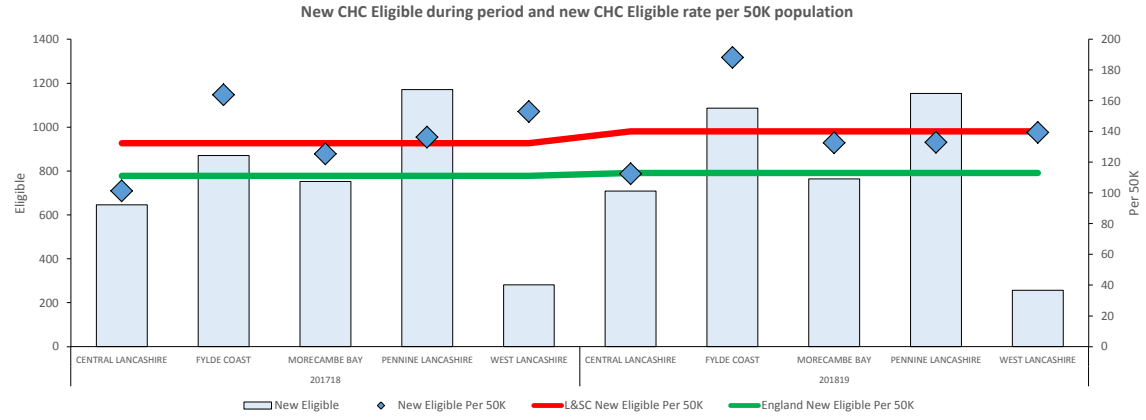
ted Referrals



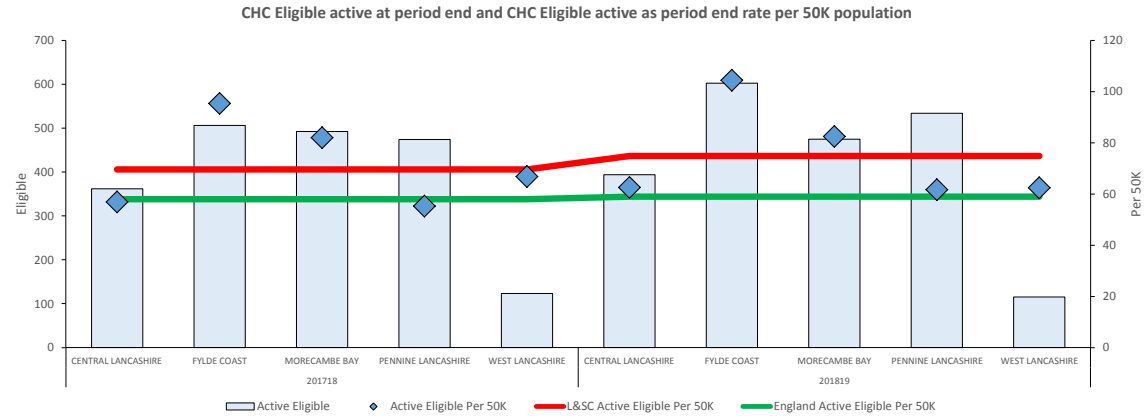
CHC Comple



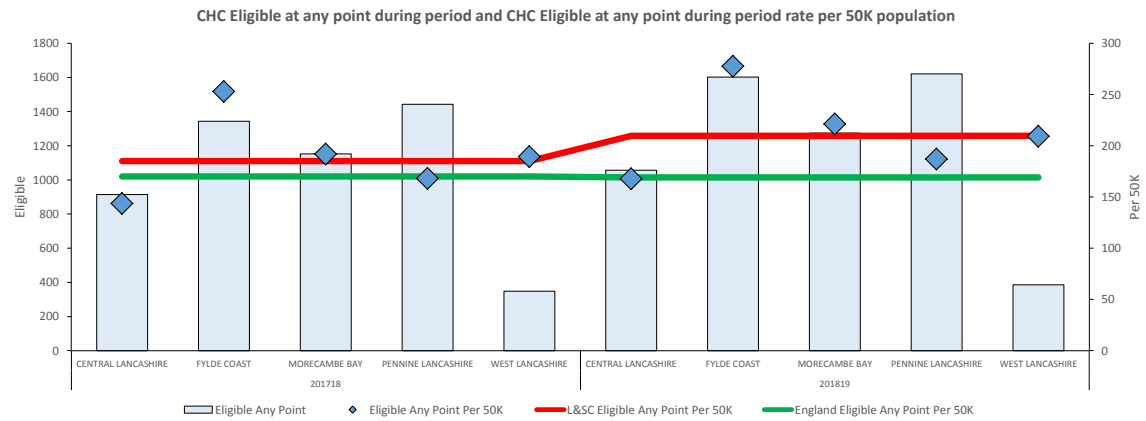
CHC New Eligible

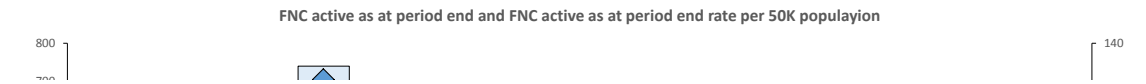


CHC Eligible Active

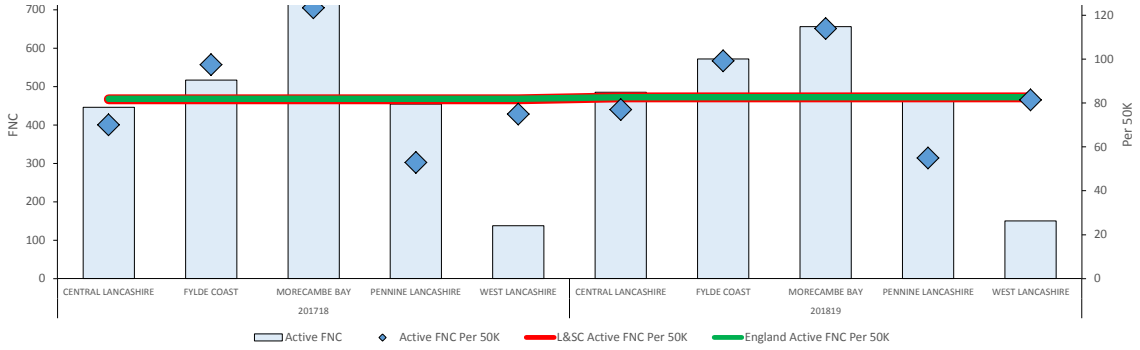


CHC Eligible Any Point

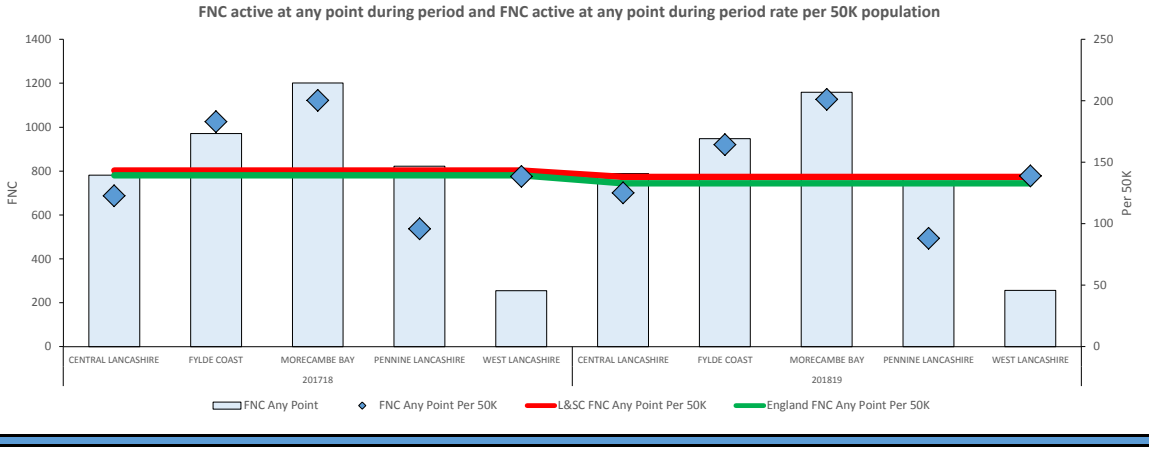




FNC Active



FNC Any Point



Healthier Lancashire & South Cumbria

Title of Paper	Personal Health Budget Development		
Date of Meeting	5th September 2019	Agenda Item	Appendix F

Lead Author: Jackie Hadwen		
Contributors: Margaret Williams, Tracey Hebblewaite, Emma Orton, Judith Johnston, Iain Fletcher,		
Purpose of the Report To provide progress update on the last 6 month of the PHB service delivered via CSU Midland and Lancashire and to recommend actions to continue.	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X
Executive Summary The NHS Long Term Plan and implementation framework set-out a clear commitment and expectation with regard to giving people more control over their own health and more personalised care. For CCG this increases specific responsibilities and duties to increase significantly the scale and scope of Personalised Health Budgets (PHBs). There are a number of fundamental steps we need to progress to secure a future delivery model for CHC including PHBs. This paper aims to explain what activity and improvement have been made with the last 6 months investment in PHBs and what needs to continue.		
Recommendations The JCCCG is asked to support the recommendation to:- • Maintain the current service offer. • Expand the team capacity in order to respond to the expected growth by appointing an additional Band 7 PHB Nurse and a Band 4 Clinical Support Officer. • Support a move to securing funds via the CCGs before presenting the outcome position into JCCCGs within its September update.		
Next Steps		

The recommendation is supported by the IPA Programme Board. Letters have been sent to CCG AO's to gaining sign off from CCGs before JCCCGs meets on the 5th September

Equality Impact & Risk Assessment Completed	Yes		Level 1
Patient and Public Engagement Completed		No	Not formally at this stage but learning taken form complaints
Financial Implications	Yes	No	Yes, additional funds required by each CCG dependant on % of overall open cases

Risk Identified	Yes	
If Yes : Risk	Hinders ICS role out of the personalisation and choice agenda	
Report Authorised by:	IPA Programme Board	

Personal Health Budget Development within IPA (MLCSU)

1 Current Position

1.1 The IPA PHB service provided by MLCSU for seven CCG's with a registered population of 1.4 million was funded for 6 months at £98k commencing in April 2019. This level of resource provides the following service:

- Offer of a personal health budget as part of the CHC/IPA process for new CHC eligible domiciliary cases.
- Conversion of new CHC eligible domiciliary care packages to notional PHB.
- Management of existing case load of non-notional cases (3rd party, Direct Payment).
- Direct payment process for cases within scope of the service offer.

1.2 PHB delivery from the IPA/CHC team for notional cases has been incorporated within the core service as per the requirement for a PHB default position in the revised CHC Framework (2018) and includes some complex packages of care and domiciliary care CHC eligible patients. Delivery of non-notional PHBs is the element of the service described in this paper which is commissioned by the CCGs to the end of September 2019.

1.3 This service has been mobilised and is staffed with two WTE PHB Nurses, one WTE PHB Administrator and oversight from the Personalisation Lead. This teamwork Lancashire and South Cumbria wide with the exception of NHS Blackpool CCG. However, please note teams are starting to provide peer support and talk through approaches with Blackpool CCG. In addition, Blackpool CCG is a member of the PHB Task and Finish Group/workstream of the LSC IPA Programme.

1.4 The Service exclusions are the conversion of legacy CHC eligible domiciliary cases into PHBs, this offer would require managed account funding the current figure of 193 legacy cases. This means that at present a full PHB service is not being commissioned or provided in Lancashire and South Cumbria with the exception of NHS Blackpool CCG.

1.5 The PHB caseload at the end of Q1 2019 is 161 cases. MLCSU are finding that the majority of these cases are highly complex and demanding to manage. A direct payment process has been introduced and is operational. The service is able to offer notional, 3rd party and direct payment PHBs.

Live IPA PHB Cases (does not include wheel chairs)				
CCG	**End of Q4 2018/19**	**End of Q1 2019/20**	**July Open**	**Protected Growth target All PHB By March 2020**
NHS Blackburn with Darwen	8	7	7	8
NHS Chorley and South Ribble	17	17	17	20
NHS East Lancashire	28	31	31	36
NHS Fylde and Wyre	14	14	14	16
NHS Greater Preston	15	19	19	22
NHS Morecambe Bay	60	59	59	68
NHS West Lancashire	11	14	14	16
Total	**153**	**161 (5% growth)**	**161**	**186**

NB –the protected growth target is calculated on a 5% increase on total cases each quarter, CCG will be charged % of overall open cases

1.4 Successes to date include:

- Mobilisation of PHB offer to new domiciliary care CHC eligible patients.
- Mobilisation of direct payment offer.
- PHB Hub Team development and skill mix supporting retention of PHB nurses – building expertise/ retaining learning.
- Renegotiation and agreement of a 3rd party pricing tariff **saving £123k** per annum across 14 cases from 01/07/19.
- Ability to undertake audit 'at scale' using finance team in Midland.
- Transfer of direct payment processing for SBS Choices to CCGs own ledgers **saving 2%** per transaction. More work needs to be done to follow this through to ensure that the saving is picked up by CCGs.
- The whole system has been learning in regard to CHC/IPA PHB and as a result there is more sharing of information and practice between providers. Blackpool have shared with MLCSU some of their processes as they have more developed service offer than MLCSU and were a demonstrator site in 2018/19. MLCSU have shared market intelligence re 3rd party providers with Blackpool.

- Evidence that the timeframe for implementing PHBs has reduced from 4-7 month to 12 weeks during this 6-month period.
- Evidence from the Personalisation Lead working in other areas that standard CHC care package cost has reduced when placed onto a PHB care package see Appendix 1 (it is noted that this information isn't from Lancashire but in time we feel we can replicate this in Lancashire)

2 Learning to Date

2.1 The service to date has been learning via both direct experience and mentoring with Blackpool CCG PHB service. In particular findings are:

- The existing non-notional caseload with complex needs is taking up the vast majority of the PHB nurses time and they are beginning to struggle to manage that caseload as it grows.
- Incorporation of PHB into general nurse assessor workload has been difficult to do due to workload demands. MLCSU are providing more training and support going forward and looking to reduce the burden of non-clinical work on clinicians to create more capacity.
- MLCSU are engaged in a mentoring programme with Blackpool in regard to PHB.
- MLCSU are undertaking an audit of support planning as MLCSU are not seeing the numbers coming through the process as expected yet.
- MLCSU have initiated an internal PHB development programme to continue development of internal processes to ensure provision of efficient service delivery of PHBs to the local population.
- MLCSU are experiencing demands to provide a PHB service for Children and Young People in receipt of IPA funding and S117.

2.2 The personalisation agenda is expanding and we expect:

- Increased awareness and therefore demand for PHB's from individuals and families to increase.
- A need to provide PHB's for all new cases across the totality of the service in due course.
- Fast Track PHB's expected 2021.
- The conversion of legacy home care CHC to PHB on review to be explored. The expectation from NHSE is that all CHC homecare packages are converted to PHB by 2020.
- A need for the regular review and audit of all PHB's to control costs.
- Need to have an appropriate level of workforce expertise to respond to the personalisation agenda in preparation for how our populations will interact with it.

3 Proposed Service Development Approach

3.1 Traditionally the CCGs have individually asked MLCSU what is required to meet service demand. The answer in this case is that demand is too fast moving to delivery of a comprehensive CHC/IPA service that includes the offering of PHBs in line with NHS England's guidance, and maintaining certainty that full control of costs can be established and maintained for all parties. Instead a phased approach working transparently with commissioners is proposed in order to ensure that we can do all of the basics well across the system before moving onto to further development.

In order to do this the ask for the remainder of 2019/20 is:

- £98k funding to continue with current provision from 01/10/19 until 31/03/20 as stated at 1.1. This is to deliver Standard CHC only, if an expansion of current provision is required to include Children and Young People and S177 PHB we would need to look again at this.
- Funding for an additional band 7 PHB Nurse/Co-ordinator to create more capacity for the PHB nurses to support CHC nurse assessors to develop their PHB practice as well managing the non-notional caseload. This would mean we can restore a PHB nurse to each locality. Please note workforce profiling and an OD plan for core CHC service delivery is underway. Skill mix and realigning work plans of more senior grades is underway, the PHB aspect of the service will be included in this.
- Funding for an additional band 4 PHB administrator to trial the movement of non-clinical PHB work in a locality from clinicians to free up clinical capacity. This is a fundamental step we need to test for future delivery model. This will also support us to assess the impact on existing Clinical Support Officer roles for the future model.
- MLCSU will supply dedicated project management resource from within existing resources.

3.2 Total funding for 6 months is approximately £154k. This will deliver:

- Service as stated at 1.2
- Tracking the impact of the investment on activity and package costs. I.e. Movement between Standard CHC to PHB.
- Impact assessment of general nurse assessors staffing capacity (MLCSU only) and role development within the service.
- Continuing to learn about what is required to provide a comprehensive and quality PHB service within IPA working with Blackpool.
- Developing robust PHB processes to provide a strong foundation for any future development requirements.
- Informing the transition planning to a new model of care associated with the ICS IPA Programme.

4 Conclusion

4.1 The outline service proposal signals a move to a more mature development model whereby MLCSU and ICS IPA Programme partners run this as a programme of work with a defined budget for the remainder of 2019/20, any slippage returns to the CCG's.

5 CCG Options

5.1 The above service proposal is one of three options for the CCGs, as tabled below:

Nos	Option	Possible Outcome
1	Cease funding for the PHB Service with Midlands and Lancashire CSU	• CCGs do not meet statutory right for delivery PHBs. • NHE England defined trajectories are not met. • Deprive the patients right to

		have a PHB is as within the National Framework
2	Agree to extend existing level of funding of £98k to continue with current service provision from 01/10/19 until 31/03/20	• CCGs don't continue to develop and not meet the NHSE trajectories.
3	Agree with the recommendation below supported by the IPA Programme Board to fund £154k to move to a more mature development model as detailed in this paper	Details given in section 3.2.

6 Recommendation

6.1 The JCCCG is asked to support the recommendation of **Option 3** to:-

- Maintain the current service offer.
- Expand the team capacity in order to respond to the expected growth by appointing an additional Band 7 PHB Nurse and a Band 4 Clinical Support Officer.
- Support a move to securing funds via the CCGs .

Service Offer Costings - 01/10/2019 - 31/03/2020					
Role	***Band***	***wte***	***Top Band Including on-costs***	***Annual Cost***	***6 months***
PHB Nurses	7	3.00	54,916	164,748	82,374
PHB Administrator	4	2.00	29,266	58,532	29,266
Personalisation Lead	8b	-	63,949	38,369	19,185
				261,649	130,825
MLCSU - on-costs				18%	23,175
Request from MLCSU for CCGs to Fund					**154,000**

Iain Fletcher
Margaret Williams
Jackie Hadwen
16/08/19

Healthier Lancashire & South Cumbria

Appendix 1 – OUT of Lancashire and South Cumbria example of changes in cost when placed in a PHB package of care

Care Package hours	Weekly Cost traditional package (unit cost £14.50)	Annual (weekly x 52.143)	Contingency (1 weeks care)	Enhancement (bank holidays)	Extras (Respite, Daycare, Travel)	Current Annual (from PHB Support Plan)	Total	Difference from the PHB/ savings/ loss from using PHB
48.0	696.00	36,291.53	696.00	795.43	1,564.29	41,903.68	39,347.25	-2,556.43
50.0	725.00	37,803.68	725.00	828.57		34,414.38	39,357.25	4,942.87
39.0	565.50	29,486.87	565.50	646.29	29,587.92	47,053.84	60,286.57	13,232.73
40.0	580.00	30,242.94	580.00	662.86	1,904.00	24,667.81	33,389.80	8,721.99
273.0	3,958.50	206,408.07	3,958.50	4,524.00	34,135.92	217,784.84	249,026.49	31,241.65
51.5	746.75	38,937.79	746.75	853.43		38,950.82	40,537.96	1,587.14
54.0	783.00	40,827.97	783.00	894.86		73,150.37	42,505.83	-30,644.54
160.0	2,320.00	120,971.76	2,320.00	2,651.43		98,614.32	125,943.19	27,328.87
72.5	1,051.25	54,815.33	1,051.25	1,201.43		54,815.33	57,068.01	2,252.68
185.5	2,689.75	140,251.63	2,689.75	3,074.00		136,607.12	146,015.38	9,408.26
40.0	580.00	30,242.94	580.00	662.86		37,542.96	31,485.80	-6,057.16
115.0	1,667.50	86,948.45	1,667.50	1,905.71		78,083.10	90,521.67	12,438.57
30.5	442.25	23,060.24	442.25	505.43	4,266.00	29,289.24	28,273.92	-1,015.32
168.0	2,436.00	127,020.35	2,436.00	2,784.00		150,350.20	132,240.35	-18,109.85
58.0	841.00	43,852.26	841.00	961.14		45,150.62	45,654.41	503.79
168.0	2,436.00	127,020.35	2,436.00	2,784.00	8,012.00	104,624.00	140,252.35	35,628.35
175.0	2,537.50	132,312.86	2,537.50	2,900.00		141,052.79	137,750.36	-3,302.43
154.0	2,233.00	116,435.32	2,233.00	2,552.00		72,423.50	121,220.32	48,796.82
175.0	2,537.50	132,312.86	2,537.50	2,900.00		125,469.62	137,750.36	12,280.74
168.0	2,436.00	127,020.35	2,436.00	2,784.00		120,000.00	132,240.35	12,240.35
65.0	942.50	49,144.78	942.50	1,077.14		35,054.00	51,164.42	16,110.42
50.5	732.25	38,181.71	732.25	836.86		37,440.00	39,750.82	2,310.82
132.0	1,914.00	99,801.70	1,914.00	2,187.43		61,900.00	103,903.13	42,003.13
8.0	116.00	6,048.59	116.00	132.57	6,184.50	12,374.96	12,481.66	106.70
45.0	652.50	34,023.31	652.50	745.71	21,896.00	58,936.71	57,317.52	-1,619.19
25.0	362.50	18,901.84	362.50	414.29	11,020.00	36,871.00	30,698.62	-6,172.38
91.0	1,319.50	68,802.69	1,319.50	1,508.00	21,980.00	87,650.00	93,610.19	5,960.19
30.0	435.00	22,682.21	435.00	497.14	4,980.00	24,943.22	28,594.35	3,651.13
25.5	369.75	19,279.87	369.75	422.57		35,700.00	20,072.20	-15,627.80
	0.00	0.00	0.00	0.00			0.00	0.00
	39,106.50	1,935,548.16	39,106.50	44,693.14	114,378.42	1,939,446.53	2,268,460.50	205,642.07

Summary

Number of Packages	Previous Package Costing	PHB Package Costings	Savings

29	**2,268,460.50**	**1,939,446.53**	**329,013.97**

NB - it is noted that this information isn't from Lancashire but in time we feel we can replicate this in Lancashire and South Cumbria)

Title of Paper	Individual Patient Activity Joint Disputes Resolution Protocol		
Date of Meeting	23rd August 2019	Agenda Item	Appendix G

Lead Author	Margaret Williams, Jackie Hanson & Judith Johnston	
Contributors	IPA Programme Board IPA Delivery Group	
Purpose of the Report To ensure that all Local Authority (LA) and CCG Integrated Care Partners (ICP) across Lancashire & South Cumbria Integrated Care System (ICS) including Blackpool CCG and LA have a standardized approach to management of disputes associated with CHC eligibility.	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X

Executive Summary

The IPA Programme Board has reviewed and supports this protocol.
This dispute protocol states how NHS organisations and Local Authorities from across the ICS of Lancashire and South Cumbria work through and agree Disputes relating to eligibility following the ratification of the Multidisciplinary Team/Decision Support Tool Assessment and Recommendation.

Recommendations

IPA Programme Board is seeking the approval from the JCCCGs and recommend:

1. JCCCGs delegate the IPA Programme Board at its September meeting to ratify following any final amends from Partners.

Next Steps

Once ratified this document will be available to staff and placed on websites along a suite of other related information available to the public a number of which are currently in the process of review

Equality Impact & Risk Assessment Completed	**Yes**		First stage only
Patient and Public Engagement Completed		**No**	Recognising some members of the public may be interested in the process followed, this is a procedure followed between Health & Local Authorities
Financial Implications	**Yes**		Without a standardized process, disputes are often protracted in timescale which impacts funding forecasting for both Health and Local Authority organisations
Risk Identified	**Yes**		
If Yes : Risk	Poor experience for individuals and families awaiting the outcome of disputes. Current variation leading to projected timeframes for dispute conclusion.		
Report Authorised by:	IPA Programme Board		

Joint Disputes Resolution Protocol

Blackburn with Darwen CCG
Blackpool CCG
Chorley South Ribble CCG
East Lancashire CCG
Fylde and Wyre CCG
Greater Preston CCG
Morecambe Bay CCG
West Lancashire CCG
Blackburn with Darwen Council
Blackpool County Council
Cumbria County Council
Lancashire County Council

NHS Continuing Healthcare, NHS Funded Nursing Care Jointly Funded Packages of Care (excluding Section 117)

Title:	**Joint Disputes Resolution Protocol** NHS CCG and Local Authority: NHS Continuing Healthcare, NHS Funded Nursing Care and Joint Funded Packages of Care (excluding section 117)
Version:	V2.0 22nd August 2019
Ratified by:	To be ratified at IPA Programme Board 27th September 2019
Date ratified:	As above
Name of originator/author:	Midlands & Lancashire Commissioning Support Unit.
Name of Lead:	Sandra Cooper Head of IPA Operations Jubilee House Leyland PR26 6RT
Date issued:	TBC
Review date:	6 month from ratification – March 2020

In the event of any changes to relevant legislation or statutory procedures this protocol will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change
1.1	Initial Draft 1.1	30/07/19	
1.2	Version 1.2	14/08/19	ICP Leads comments actioned where they do not contradict each other and/or are controversial and most appendices added
1.3	Version 2	22/08/19	Following review at IPA Programme Board

Signed by and duly authorised representatives on behalf of the parties:

NHS Blackburn With Darwen CCG

Signed by_____Designation …… Date ……

NHS Blackpool CCG

Signed by_____Designation …… Date ……

NHS East Lancashire CCG

Signed by_____Designation …… Date ……

NHS West Lancashire CCG

Signed by_____Designation …… Date ……

NHS Morecambe Bay CCG

Signed by_____Designation …… Date ……

NHS Fylde and Wyre CCG

Signed by_____Designation …… Date ……

NHS Chorley and South Ribble CCG

Signed by_____Designation …… Date ……

NHS Greater Preston CCG

Signed by_____Designation …… Date ……

Blackburn With Darwen Council

Signed by_____ Designation …… Date …….

Blackpool County Council

Signed by_____ Designation …… Date …….

Lancashire County Council

Signed by_____ Designation ……Date ……

Cumbria County Council

Signed by_____ Designation ……Date ……

NHS Midlands and Lancashire Commissioning Support Unit

Signed by_____ Designation ……Date ……

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1.0 Introduction

1.1 This protocol relates to the following CCGs and Local Authorities:

- Blackburn with Darwen CCG
- Blackpool CCG
- Chorley South Ribble CCG
- East Lancashire CCG
- Fylde and Wyre CCG
- Greater Preston CCG
- Morecambe Bay CCG
- West Lancashire CCG
- Blackburn with Darwen Council
- Blackpool County Council
- Cumbria County Council
- Lancashire County Council

1.2 CCGs and Local Authorities in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about:

- a decision as to eligibility for NHS Continuing Healthcare;
  Or
- where an individual is not eligible for NHS Continuing Healthcare, the contribution of a CCG or Local Authority to a joint package of care for that person;
  Or
- the operation of refunds guidance (please see Annex E of the CHC National Framework)[1].

1.3 This protocol will also apply to managing disputes raised about joint packages of care also referred to as integrated funding. This protocol will ensure a clear process that allows disputes to be addressed in a professional and timely manner and within clearly defined agreed responsibilities.

1.4 The protocol is not for use for appeals between individuals applying for NHS Continuing Healthcare and the CCGs. A separate appeals and review process exist to resolve these cases.

2.0 Purpose and Scope

2.1 The CCGs and LAs have in place a system for multi-disciplinary assessment and decision-making relating to NHS CHC, NHS FNC and joint funding packages of care.

2.2 The protocol will apply to all NHS health care eligibility funding decisions for the identified CCGs and LAs where disputes exist. The reasons for the dispute must be clearly stated, and if the multi-disciplinary recommendation is challenged, this must be identified and supported by evidence when the dispute is raised.

2.3 Where disputes relate to another CCG in a different geographical or Local Authority area the regulations make it clear that it is the responsibility of the relevant Local

[1] CHC National Framework October 2018 pt. 209/ page 59

Authority and CCG in the area to agree a Dispute Resolution Process and ensure resolution in a robust and timely manner. It is expected that in all cases this should include agreement on how funding will be provided during the dispute and arrangements for reimbursement to the agencies involved once the dispute is resolved.

2.4 The disputes protocol is a mechanism to resolve disputes between CCGs and LAs regarding NHS CHC eligibility and subsequent funding of care, or the apportionment of funding joint packages of care. The Dispute Resolution Protocol applies to disputes between the parties as to:

- the outcome of an assessment of needs or eligibility for services to be provided by the CCG or the Council or those with delegated functions;
  Or
- funding responsibility including the respective contributions of the parties in the case of joint packages of care for services provided (or to be provided) to any individual, who is the responsibility of either or both of the parties;
  Or
- the package of services to be offered to an individual following an assessment by both of the parties in each case a “dispute” for the purposes of this agreement.

2.5 The Dispute Resolution Protocol does **not** cover disputes relating to:

- Ordinary Residence,
- Complaints by individuals or carers
- Appeals or about NHS services or services provided under the Care Act 2014
- Packages of care under Section 117 aftercare.

2.6 Providers act within delegated responsibility and contractual arrangements for their respective CCGs and Local Authorities. For the purposes of this protocol MLCSU and other NHS Health providers will be referred to within the same scope of responsibilities as the CCGs. Some Local Authorities have delegated various assessment and care management functions under a Section 75 agreement to NHS partners.

3.0 Consultation

3.1 This protocol was developed in consultation with:

- Blackburn with Darwen CCG
- Blackpool CCG
- Chorley South Ribble CCG
- East Lancashire CCG
- Fylde and Wyre CCG
- Greater Preston CCG
- Morecambe Bay CCG
- West Lancashire CCG
- Blackburn with Darwen Council
- Blackpool County Council
- Cumbria County Council
- Lancashire County Council

4.0 Background

4.1 The CCGs and LAs are committed to working together to ensure the continuity of care in the interests of individuals, resolving difficulties at the earliest opportunity, and using this protocol only as a last resort ensuring that individuals and family members are not drawn into any dispute which may arise between the parties.

5.0 Principles

5.1 Decisions regarding eligibility for NHS Continuing Healthcare are the responsibility of the CCG to make their decision before an inter-agency disagreement has been resolved. In such cases it is possible that the formal dispute resolution process will have to be concluded after the individual has been given a decision by the CCG.[2]

5.2 The CCGs and LAs agree to work towards the following principles and agree to use the formal dispute process as a last resort, a decision to invoke the formal disputes procedure should only be made after all informal steps have been exhausted.

- To develop a culture of problem solving and partnership working within the national guidance for NHS Continuing Healthcare October 2018.
- Dealing with genuine disagreements between practitioners in a professional manner, without drawing the individual/representative concerned into the discussion, in order to gain support for one professionals' position or the other.
- To follow the agreed process within the timescales identified.
- Front line staff (practitioners who have delegated authority) should be empowered to resolve issues within agreed policies and procedures.
- Individuals must never be left without appropriate support whilst disputes between statutory bodies about funding responsibilities are resolved.[3]
- Arrangements to keep the individual and/or their representative informed throughout the Dispute Resolution process, by the current funding authority.[4]

6.0 NHS Continuing Healthcare Process

6.1 Assessment for CHC is initiated by the completion of an initial screening assessment using the NHS CHC Checklist. [5] If a checklist is initiated it can be completed by any health or social care professional who has been trained to complete a checklist.

6.2 Where the outcome of the checklist is positive and indicates referral for NHS CHC assessment, a full professional Multi-disciplinary Team (MDT) assessment using the Decision Support Tool (DST) will take place. The MDT means a team consisting of at least:

[2] CHC National Framework October 2018 page 60 Pt. 211
[3] CHC National Framework October 2018 Page 59 Pt. 208
[4] CHC National Framework October 2018 Page 60 Pt. 210
[5] CHC National Framework October 2018 Page 30 Pt. 88-89

- Two professionals who are from different healthcare professions (RGN and or Registered Mental Health Nurse and or Learning Disability Nurse and or Social Worker)
  Or
- One Professional from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014. [6]

6.3 Please also see Multi-Disciplinary Terms of Reference at Appendix B. On completion, the DST will be submitted to the appropriate team member in Provider Services and or the Continuing Healthcare with an MDT recommendation as to CHC eligibility and this will be subject to verification by the CCG as to an eligibility decision.

6.4 If the outcome at MDT is deemed that the individual does not have a primary health need, consideration will be given to other entitlement such as funded nursing care and/or joint funding.

6.5 If the individual resides in their own home and needs can be identified that are over and above the involvement of core community services and the LA, then a submission may be considered for a joint package of care between the CCG and the LA.

6.6 It is expected that professional standards of practice and behaviour for professionals as per the relevant professional registration will be upheld at all times. The highest standards of professional conduct are required when dealing with service users and families and also between professionals. Poor conduct will not be tolerated.

7.0 Dispute Resolution

7.1 Introduction

7.1.1 The parties recognise that, as well as having a statutory duty to collaborate with each other they also have statutory duties which are distinct from each other. Each party has a responsibility to carry out their own assessments according to criteria which are set nationally and / or locally agreed as the case may be.

7.1.2 In considering whether an individual is eligible for NHS Continuing Healthcare, the parties agree that eligibility will be assessed in accordance with the 'National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018)' criteria ('the Criteria').

7.1.3 It is expected that MDT's can make a unanimous recommendation with a clearly written rationale for eligibility, demonstrating primary need characteristics. If MDT's are unable to agree levels of need in the domains, then the higher level is applied with a rationale by each practitioner that explains the differences of opinion and will

[6] CHC National Framework October 2018 Page 38 120

be recorded on the DST. Any Disputes should be resolved quickly in the interests of individual.

7.1.4 There is a chart detailing the disputes protocol at Appendix A.

7.2 Preliminary Practitioner Stage

7.2.1 All attempts should be made to resolve inter-agency disagreements at an early and preferably informal stage.

- If there are differing views at MDT on the recommendation, it is the principle aim for resolution of the disagreement at this stage.
- The assessing practitioners will need to demonstrate that the CHC assessment has been revisited and evidence will need providing. The practitioners who are disputing the recommendation will need to provide a rationale to this effect and be clear what they are disagreeing.

7.2.2 If unresolved after all attempts, then a formal Disputes Process will be initiated and will be escalated to Stage 1.

7.2.3 All copies (electronic) of relevant information will be provided to the Service Manager.

7.2.4 Verification and decision will be made by the CCG on CHC eligibility.

7.3 Stage 1 – Escalation to Nominated Service Manager of the Contributing Professionals

7.3.1 Where any dispute cannot be resolved by the decision-making practitioners, either party can request that a Nominated Service Manager in the respective parties decision-making teams, will review the decision. The Nominated Service Manger can be any manager in a more senior capacity than the decision-making practitioners.

7.3.2 The discussion between the Nominated Service Managers can be facilitated by either a meeting or use of current technology e.g. Skype etc. From being notified of the existence of a dispute the discussion needs to be concluded within **5 working days.** The aim at this stage is for discussion and review of the disagreement of eligibility and is to reach a negotiated resolution and record the outcome on the template provided. Decisions made will be a binding decision and upheld by both parties.

7.3.2 Where the process set out in Stage 1 does not result in a consensus decision being reached, as to the agreed outcome of the decision-making process, the matter must be referred to a designated Senior Service Mangers and escalated to Stage 2 of the Disputes process. All relevant information including the DST is forwarded at each stage alongside the Template, which will show the process being followed.

7.4 Stage 2 – Escalation to Designated Senior Service Managers of the Contributing Professionals

7.4.1 From being notified of the existence of the dispute being unresolved and despite previous attempts at resolution, a further discussion between Senior Service Managers in the respective parties needs to be concluded within **5 working days**,

the aim at this stage is for discussion and review of the disagreement of eligibility and is for the parties to aim to resolve the dispute by reaching a consensus decision.

7.5 Stage 3 – Independent Review Consultant / Joint Funded by LA & CCG

7.5.1 This stage should only be invoked as a **last resort** and should only be utilised when all other stages have failed to reach a mutual agreement. This stage can only be triggered by Senior Service Managers in agreement from the respective organisations regarding the next steps.

- The parties shall submit the dispute to an independent consultant specialist, appointed by agreement between the parties to assist them in resolving the dispute. The funding of the consultant will be on a joint basis.

- The parties shall, with the assistance of the independent consultant appointed seek to resolve the dispute by using an alternative dispute resolution (ADR) procedure agreed between the parties or, in default of such agreement, established by the consultant.

7.5.2 The parties should accept any recommendations made by the Independent Consultant, or otherwise reach agreement as to the resolution of the dispute, such agreement shall be recorded in writing and signed by the parties (and, if applicable, the consultant) whereupon it shall become binding upon the parties.

7.6 Funding Individual Cases during the Dispute Resolution Process

7.6.1 If the funding of the care of any individual becomes the subject of a dispute to which this Dispute Resolution Protocol applies, the parties agree that **unless otherwise agreed between them in any individual case:**

7.6.2 Where one party was funding the care of that individual prior to the dispute arising, that party will continue to fund the care until such time as the dispute is resolved;

7.6.3 Where the parties had each been funding a proportion of the care of any individual prior to the dispute arising, the parties will continue to fund that care in the same proportions as they were funding it prior to the dispute arising until such time as the dispute is resolved;

7.6.4 All other cases will be funded without prejudice on a joint funded basis of 50/50 until such time as the dispute is resolved.

7.6.5 The parties expressly agree that no dispute between them as to the funding of the care of any individual should prevent or delay the essential provision of a care package.

7.7 Transfer of Responsibility for Funding

7.7.1 If a dispute between the parties is resolved (whether as a result of this protocol or otherwise) and leads to a change in responsibility for funding an individual's care or in the contributions of parties, it is agreed that the effective date for the change will be the date of the most recently disputed DST.

- If the change is from Local Authority to CHC funding, and vice-versa then the funding responsibility date should be the date of the DST.
  Or
- Date of commencement of care package post-discharge from hospital.

7.8 Retrospective Reimbursement of Care Costs

7.8.1 Once a decision has been made in any change of CHC eligibility or Joint Funding arrangements, and either party has been funding the individual, both parties agree that any reimbursement of costs will be from the date of the original disputed DST and will be transferred within 28 days, and/or the date of the commencement of the care package. The CSU will send a letter to the respective parties confirming the decision and outcome.

7.9 Legal Obligations, Rights and Duties

7.9.1 Nothing in this Agreement shall limit or constrain the legal obligations, rights or duties of either of the parties and the respective parties must comply with all the relevant legislation.

7.10 Review Date

7.10.1 This protocol will be reviewed annually from the date of the agreed version and will be reviewed and updated sooner at the request of the CCGs or LAs or earlier in light of any changes to legislation or National Guidance.

8 References

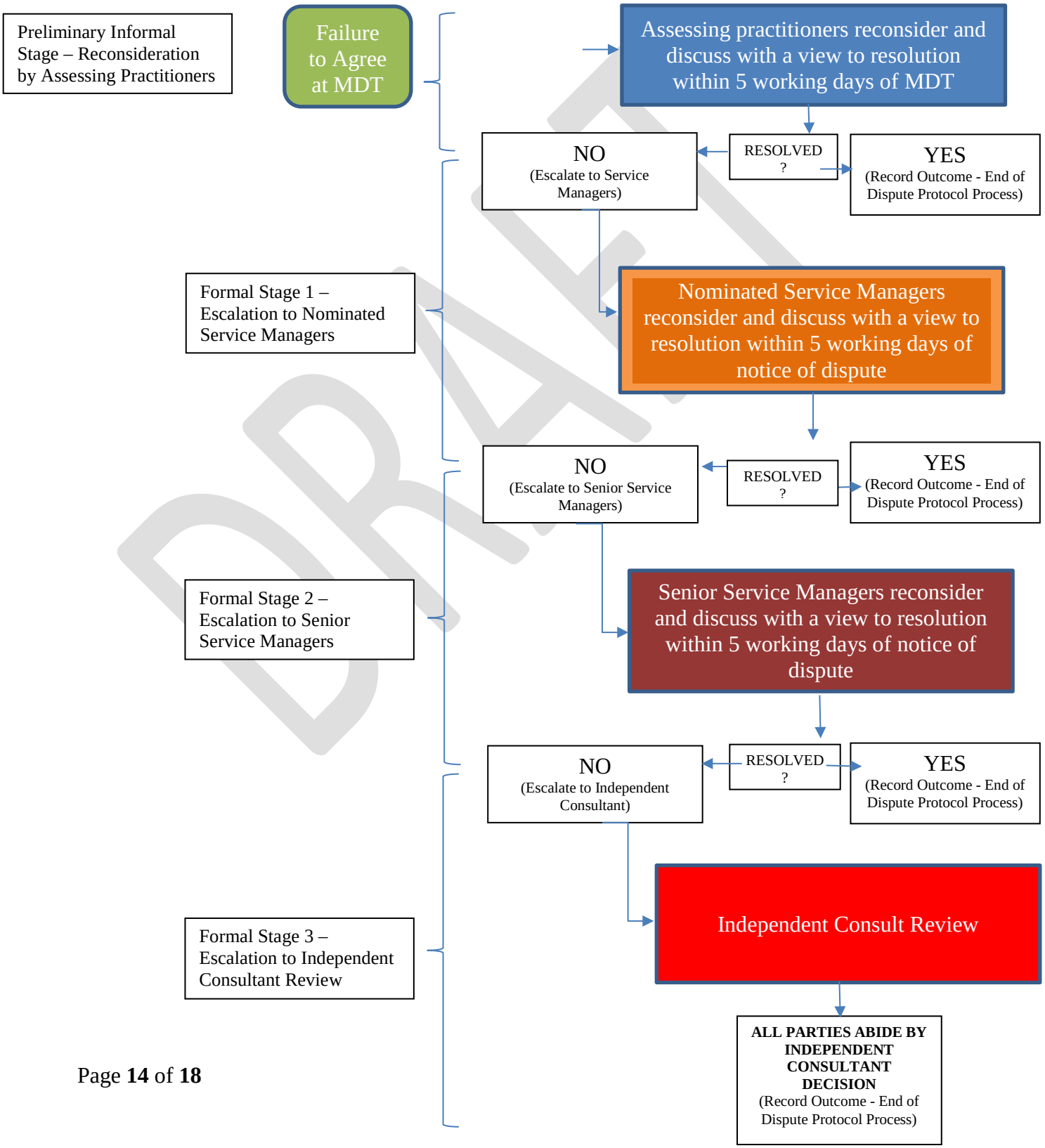
Department of Health: National Framework for NHS Continuing Healthcare and NHS-Funded Care October 2018 (Revised)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

The Care Act (2014)
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Who Pays Guidance (2016)
https://www.adass.org.uk/media/5173/updated-s117-who-pays-guidance-applicable-from-1st-april-2016.pdf

Mental Health Act (1983 – 2007 amendments)
https://www.legislation.gov.uk/ukpga/2007/12/contents

APPENDIX A – Dispute Protocol Flow Chart



APPENDIX B – MDT Terms of Reference

NB: these will be reviewed by the IPA Delivery Group Members in September ahead of IPA Programme Board 27th September 2019

Will include –ref to MDT management and meeting conduct

APPENDIX C – DISPUTE PROTOCOL TEMPLATE

Case Reference	
Referring Party	
Dispute Summary	
Dispute Reference Number	
Assessing Practitioners at MDT	
Date of MDT	

Dispute Stage		**Date of Dispute Meeting**	**In Attendance:**
Preliminary	Informal – Assessing Practitioners		
Stage 1	Formal – Nominated Service Managers		
Stage 2	Formal - Senior Service Managers		
Stage 3	Formal - Independent Review Consultant		

Minutes of the Meeting:

DISPUTE OUTOME	RESOLVED/ ESCALATE TO NEXT STAGE

APPENDIX D – GLOSSARY OF TERMS

Term	Description
NHS Continuing Healthcare (CHC)	NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness.
Standard NHS CHC (Non-Fast Track)	NHS CHC cases which are not Fast Track.
Fast Track	The Fast Track tool is used where an appropriate clinician considers that a person should be fast tracked for NHS CHC because that person has a rapidly deteriorating condition which may be entering a terminal phase. The person may need NHS CHC funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting).
Assessor	An individual with responsibility for completion of the Decision Support Tool and/or Social Work Report
Nominated Service Manager	An individual who works for the same service as the Assessor in a more senior capacity.
Senior Service Manager	An individual who works for the same service as the Assessor in a more senior capacity than both the Assessor and the Nominated Service Manager.
Primary Health Need	– this phrase is the key determination used by the Department of Health when deciding if a patient is eligible for NHS continuing healthcare. If an individual's needs are assessed to be healthcare based, rather than social care, then they have a primary health need and should receive NHS continuing healthcare funding.
Independent Review Panel	the NHS England appeals process which consists of an independent Chair, a health professional and a social care professional (they can't be from the same CCG who made the original funding decision). The team of three must work together to determine if the correct CHC outcome was reached in the first instance or if the patient should, in fact, be eligible for continuing healthcare.
Multi-disciplinary Team	A group of health and social care specialists who work

Term	Description
	together to decide if a patient meets the primary health need criteria set out in the DST and is therefore eligible for continuing healthcare funding**.**
Decision Support Tool	The DST is a document published by the Department of Health which helps health and social care professionals apply the National Framework for NHS continuing healthcare and helps to identify evidence of an individual's care needs to determine if they qualify for continuing healthcare funding.
NHS CHC Checklist	The NHS continuing healthcare checklist document is used to help identify people who may qualify for a full NHS continuing healthcare assessment.
Clinical Commissioning Group (CCG)	A clinical commissioning group (CCG) brings together local GPs and experienced health professionals to undertake commissioning responsibilities for local health services.
NHS-funded Nursing Care (FNC)	NHS-funded Nursing Care (FNC) is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for FNC.

Healthier Lancashire & South Cumbria

5th September JCCCGs

Title of Paper	Planned Care Commissioning Workstream - Ophthalmology PID		
Date of Meeting	5th September 2019	Agenda Item	8

Lead Author	Andrew Harrison (FCCCGs) – ICS Planned Care Workstream Lead	
Contributors	Cathy Gardener (BwD CCG), Donna Parker (BwD CCG)	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	√
Executive Summary	Eye health services are becoming more and more important as the population ages. An ageing population means there are more and more incidences of age-related diseases of the eye, such as age-related macular degeneration (AMD) or cataracts, leading to increasing demand on services. In Lancashire and South Cumbria, there are considerable variations in service models, their cost effectiveness and importantly in the outcomes that they deliver for patients both in terms of patient safety and quality of service. If we are to deliver safe and sustainable ophthalmology services across Lancashire and South Cumbria, clear and consistent standards, outcomes and measures are needed to underpin the redesign of pathways alongside learning from best practice to support the introduction of more innovative approaches to the management of acute and chronic eye disease. There may also be opportunities to deliver economies of scale through collaborative commissioning across and between ICP footprints. This project will produce a consistent set of standards and outcomes for the ophthalmology pathway across Lancashire and South Cumbria which will • Drive improved patient outcomes • Drive cost effectiveness • Respond to workforce challenges These standards will then form the basis for ICPs and PCNs to locally redesign pathways and develop delivery models. The attached PID is endorsed by CCG commissioning leads and CCB to be approved by JCCCGs	
Recommendations	JCCCGs are requested to Approve the PID to support the ICS wide creation of standards, measures and outcomes for Ophthalmology care pathways across the CCGs	

Healthier Lancashire & South Cumbria

5th September JCCCGs

Next Steps	Clinical Engagement Event, Public Engagement Event, Standards Confirmation, Procurement and Adoption		
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:	ICS Planned Care Workstream Lead		

Lancashire and South Cumbria Integrated Care System (ICS)

Planned Care Workstream

Ophthalmology Project Initiation Document

Project Title:	Ophthalmology – Setting Standards & Outcomes
Responsible Lead:	Cathy Gardener – Head of Commissioning, Pennine CCGs SME: Donna Parker, Service Redesign Support Manager, Pennine CCGs
Executive Sponsor:	Andrew Harrison, CFO, Fylde Coast CCGs
Month:	August 2019
Version:	0.8

1. Vision Statement

The project will produce a consistent set of standards and outcomes for the ophthalmology pathway across Lancashire and South Cumbria which

- Drive improved patient outcomes
- Drive cost effectiveness
- Respond to workforce challenges

These standards will then form the basis for ICPs and PCNs to locally redesign pathways and develop delivery models.

The objectives of the project are:

1. To produce a consistent set of standards for ophthalmology services throughout the pathway
2. To produce a consistent set of outcomes for ophthalmology patients
3. To produce a consistent set of measures to underpin the standards and outcomes
4. To establish an online knowledge base of best practice that can be drawn upon by ICPs and PCNs to support local pathway redesign and development of delivery models
5. To identify opportunities and make recommendations for collaborative pathway redesign and development of delivery models across and between ICP footprints.

2. Case for Change

In January 2018, the Joint Committee of Lancashire & South Cumbria CCGs (JCCCGs) approved the Commissioning Development Framework. The framework set out the future development of commissioning on a place-based model which works at three levels:

- Integrated Care System (ICS) - Lancashire and South Cumbria
- Integrated Care Partnerships (ICPs) (Pennine Lancashire, West Lancashire, Central Lancashire, Fylde Coast and Morecambe Bay) and;
- Neighbourhoods.

Following approval of the framework, CCG commissioning colleagues across the system were nominated to work together to apply the Lancashire and South Cumbria (L&SC) Commissioning Framework to their workstreams and develop recommendations for place based future commissioning activity.

In April 2019, JCCCGs approved recommendations for future place-based commissioning from a number of workstreams. For Planned Care, JCCCGs agreed that

- Setting standards and outcomes should be undertaken once at ICS level across all service areas by a collective commissioning team made up of CCG commissioning leads.
- Commissioning of specialist services, including specialist diagnostics, specialist surgery, specialist medicine and specialist weight management, will be undertaken

once at ICS level by a collective commissioning team made up of CCG commissioning leads. What this means in practice is that CCG commissioning leads will lead on specific projects and workstreams within the programme on behalf of each other whilst retaining local links and relationships

- Commissioning of general medicine such as pain management, trauma and orthopaedics, dermatology, general surgery, respiratory medicine and general diagnostics will be undertaken at ICP level reflecting the need to ensure that elements of service delivery are aligned and integrated with neighbourhood care teams.

Following the JCCCGs decision, the Planned Care Workstream group undertook a prioritisation exercise to identify which of the 36 pathways in scope for the workstream should be prioritised. The group identified Ophthalmology as the highest priority

In relation to ophthalmology services, JCCCGs had agreed that commissioning activity would largely be undertaken on an ICP footprint with work to set standards and outcomes being undertaken collectively on an ICS footprint.

Ophthalmology is the branch of medicine which deals with the diagnosis, treatment and prevention of diseases of the eye and visual system. There are a number of clinical conditions that can affect the eye, its surrounding structures and the visual system. Ophthalmology involves the diagnosis and therapy of such conditions, along with microsurgery.

Eye health services are becoming more and more important as the population ages. An ageing population means there are more and more incidences of age-related diseases of the eye, such as age-related macular degeneration or cataracts, leading to increasing demand on services. In England and Wales it is estimated that around 2.5 million people aged 65 or older have some degree of visual impairment caused by cataracts. Cataract surgery is the second most common operation performed in the NHS in England – over 300,000 procedures are performed each year[1]. Many eye diseases can be successfully treated if caught early and managed effectively with existing treatments and medicines.

In Lancashire and South Cumbria, there are considerable variations in service models, their cost effectiveness and importantly in the outcomes that they deliver for patients both in terms of patient safety and quality of service.

[1] https://www.rcophth.ac.uk/about/what-is-ophthalmology/

The recently published Eye Health Joint Strategic Needs Assessment (JSNA) for Lancashire and South Cumbria describes the needs and gaps currently in situ. Key messages from the report are presented below:

- There were an estimated 61,620 people of all ages in the Lancashire and South Cumbria area living with sight loss in 2018.
- By 2030 this is expected to rise to 76,410
- The projected increase in the number with sight loss across the ICS is largely, but not entirely due to an increase in the older population. Projected increases in risk factors such as diabetes also come into play so the continued drive to increase diabetes diagnosis rates will play a part in the prevention of sight loss.

Recommendations include:

- NHS and public health teams to expand existing health checks to include eye health
- Health and social care teams to plan ahead to ensure information about individual eye health conditions or risk factors are passed on when children transition to adults' services.
- Conduct service mapping across the eye health and sight loss pathway to identify gaps in current and future provision and capacity.

If we are to respond to increasing demand and deliver safe and sustainable ophthalmology services across Lancashire and South Cumbria, clear and consistent standards and outcomes are needed. These will then underpin the redesign of pathways alongside learning from best practice and support the introduction of more innovative approaches to the management of acute and chronic eye disease. There may also be opportunities to deliver economies of scale through collaborative commissioning across and between ICP footprints.

In addition, there are currently two business critical matters, which are live issues relating to the plans to seek to deliver ICS solutions to aspects of commissioning which need to be considered alongside an in line with the development of consistent standards and outcomes.

Matter One – Market Management

At this stage of the process the setting of standards, measures and outcomes does not involve procurement processes, at the point procurement is undertaken by one or more of the CCGs, the CCGs will need to engage appropriate legal advice to confirm their responsibilities for Market Management and the role they play in procurement. As different CCGs will be at different points in their existing contractual obligations, approaches may involve incremental adoption of the agreed standards, measures and outcomes

Matter Two – RTT Managing Waiting Times

Current workforce and efficiency challenges are generating scenarios which are counter to best care for patients as measured by National Standards. As a result, there is likely to be a requirement to implement further sub-optimal solutions to resolve 52-week breaches across Ophthalmology pathways whilst the changed clinical model to deliver standards and outcomes is agreed, commissioned and contracted. During this time, it will be important to recognise that one or more ICPs will require additional commissioning activity to reduce the likelihood of National Standard breaches in relation to 52 week waits.

Much work on existing capacity and efficiency suggests that Ophthalmology is the only specialty in which Theatre Efficiency work across HLSC would not fully resolve demand requirements. It is essential therefore that the needs of the population, now and in the future are resolved for the short, medium and long term in our deliberations. This links to the national High Impact Intervention programme and Getting It Right First Time.

The Planned Care group have confirmed the need to provide supportive responses to colleagues in ICPs where these challenges may exist; recognising that resolution of these business-critical matters will be required at the same time as our drive to standardise, to improve overall outcomes for patients. Thus, it may be preferable to resolve these matters at the same time, but it may also be easier to allow inconsistency on a temporary basis in order to meet National Standards for access but then fulfil the longer-term aspirations for access and outcomes via the adopted model.

Whilst there are variations in the durations of existing contracts for ophthalmology services (see appendix A), these need not prevent progression of redesign work on a collaborative basis where this is expected to deliver earlier and /or greater benefits. Recommendations for collaborative commissioning will take account of these timelines and set out options for change through for example use of contract variations, where appropriate.

3. Scope

The scope of the project will be the end-to-end ophthalmology pathway in Lancashire and South Cumbria. In scope are the following services and conditions:

Services in Scope		Conditions in Scope
Planned Eye Care Pathways		Glaucoma
NHSE Ophthalmic Enhanced Services		Cataracts
		Age Related Macular Degeneration

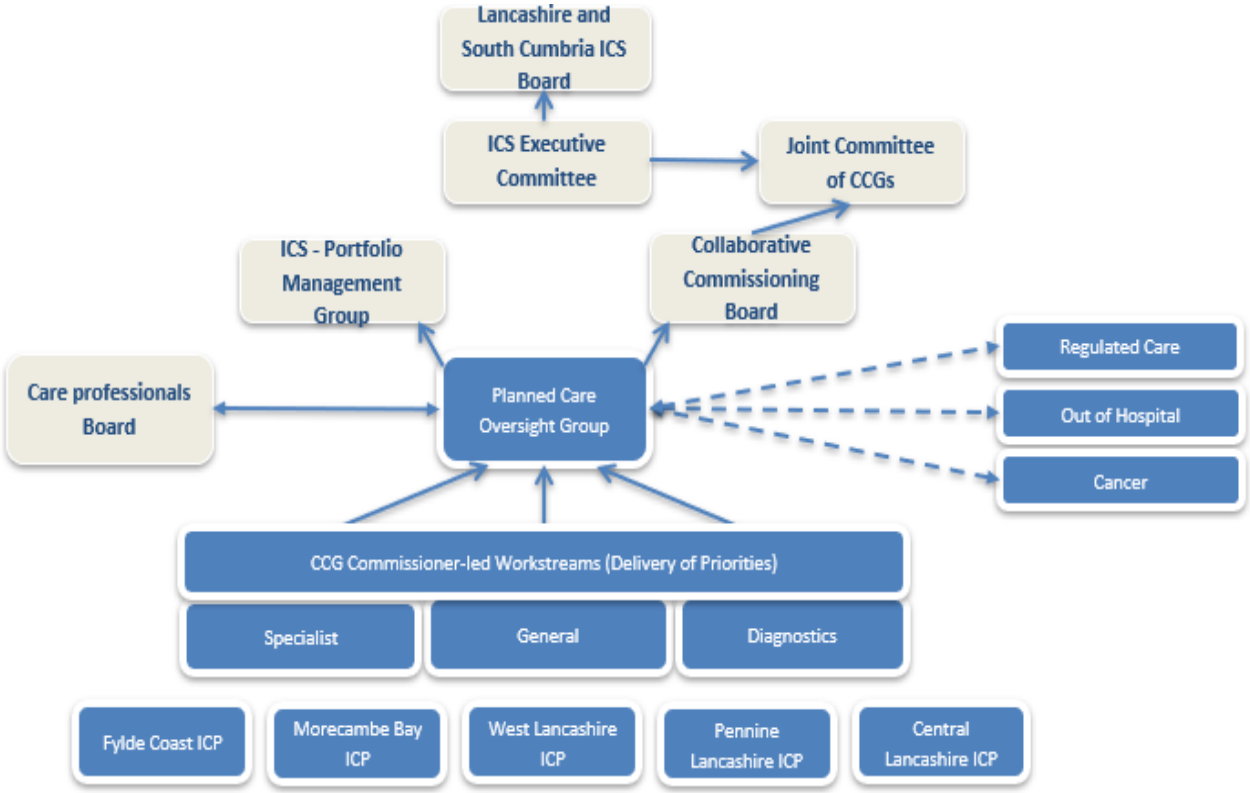
Out of scope is the prevention of ophthalmology conditions, low visual aids services.

4. Deliverables

Deliverable	Benefit	Impact Type
Ophthalmology Standards	Consistency Reducing variation Patient confidence Market management	Quality, financial, performance, workforce, alignment to policy or guidance
Ophthalmology Outcomes	Consistency Right care, right time, right place Triple aim Patient experience Shared decision making Promotion of self-management and independence Appropriate use of services	Quality, performance, alignment to policy or guidance
Ophthalmology Measures including reporting arrangements	Leverage to drive performance Efficiencies Accountability Learning Early response to poor performance	Quality, financial, performance, workforce, alignment to policy or guidance
Online knowledge base of best practice to inform ophthalmology pathway redesign	Leverage to drive performance Learning Empowering CCGs, ICPs and Neighbourhoods	Quality, financial, performance, workforce, alignment to policy or guidance
Recommendations for collaborative pathway redesign and development of delivery models across and between ICP footprints	Economies of scale Contribution to establishment of group models for services	Financial, performance, workforce.

5. Programme Structure

The Planned Care Workstream forms part of the Lancashire & South Cumbria Commissioning Framework Portfolio and as such reports to the ICS Executive Lead for Commissioning, Andrew Bennett through the Collaborative Commissioning Board and to the JCCCGs as set out in the diagram below:



ICPs are integral to all elements of the Planned Care governance structure

Andrew Harrison, Chief Finance Officer, Fylde Coast CCGs leads the Planned Care Workstream which is overseeing the Ophthalmology Project. The Planned Care Workstream Group have agreed that Cathy Gardener, Head of Commissioning will lead this Ophthalmology Project on behalf of the 8 CCGs and 5 ICPs, in line with commissioning recommendations agreed at JCCCGs in April 2019.

Other members of the project team are as follows:

- Donna Parker, Service Redesign, Pennine CCGs
- Kirsty Eyre, Scheduled Care Commissioning Manager, Pennine CCGs
- Beth Goodman, Head of Acute Commissioning, Fylde Coast CCGs
- Katie Rimmer, Commissioning Manager, Fylde Coast CCGs
- Steve Flynn, Commissioning Delivery Manager, Central Lancashire CCGs
- Liz Crossland, Transformation Manager, Central Lancashire CCGs
- Gary O'Neill, Senior Manager, Morecambe Bay CCG
- Jackie Forshaw, NHSE Commissioning Manager

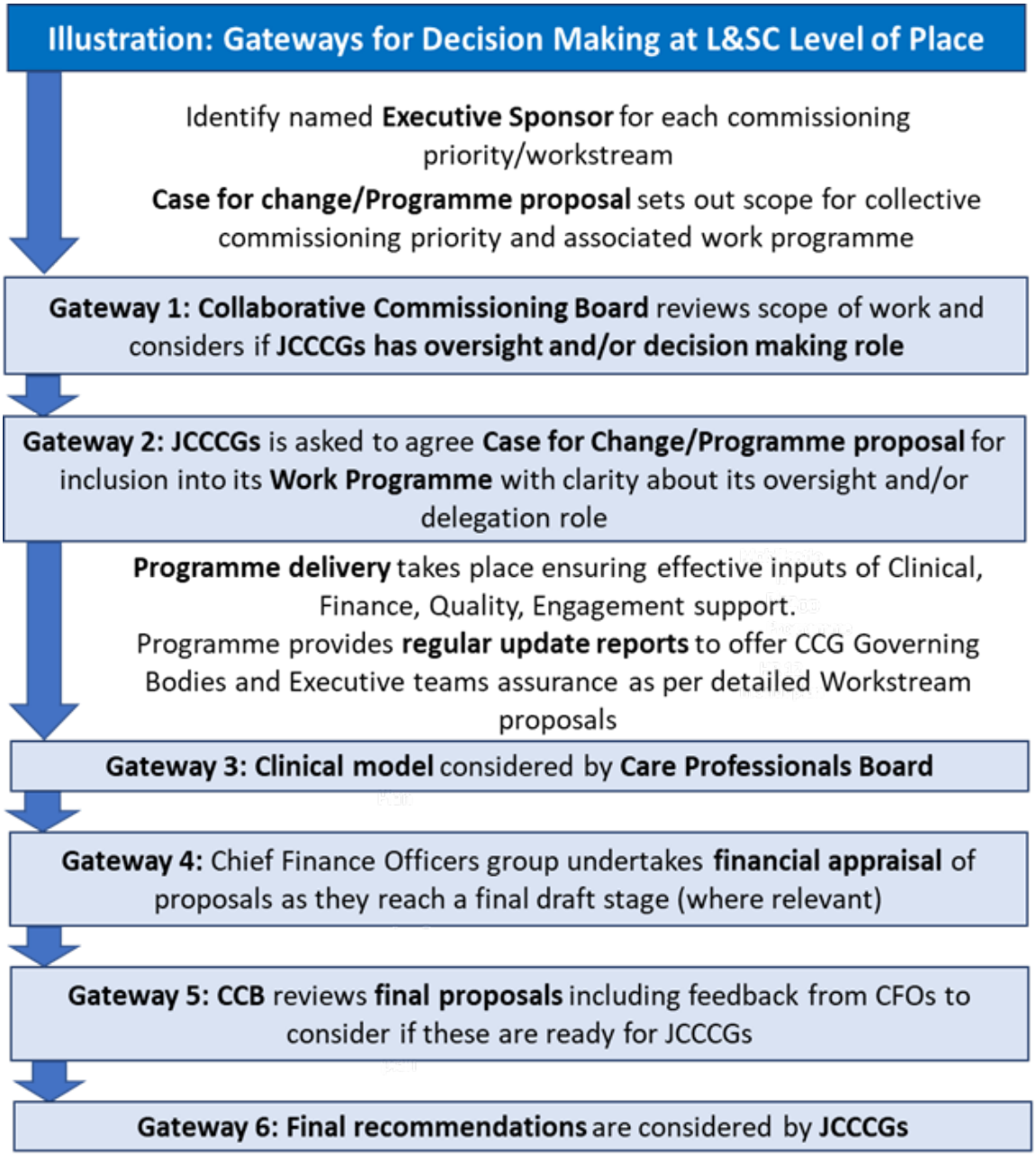
The project team will require specialist input from clinical colleagues, from primary, community and secondary care organisations and also technical (BI, procurement and finance) who will be co-opted to support when necessary.

6. Project Approach

The Ophthalmology Project will report to the monthly Planned Care Workstream Group, drawing on a broad spectrum of best practice and engagement with local clinicians and providers across the footprint.

Then project will utilise Smartsheets as the ICS approved Programme Tool including Project Plan and Risk Register.

The project will follow the decision-making gateways agreed by JCCCGs in April 2019 and set out below:



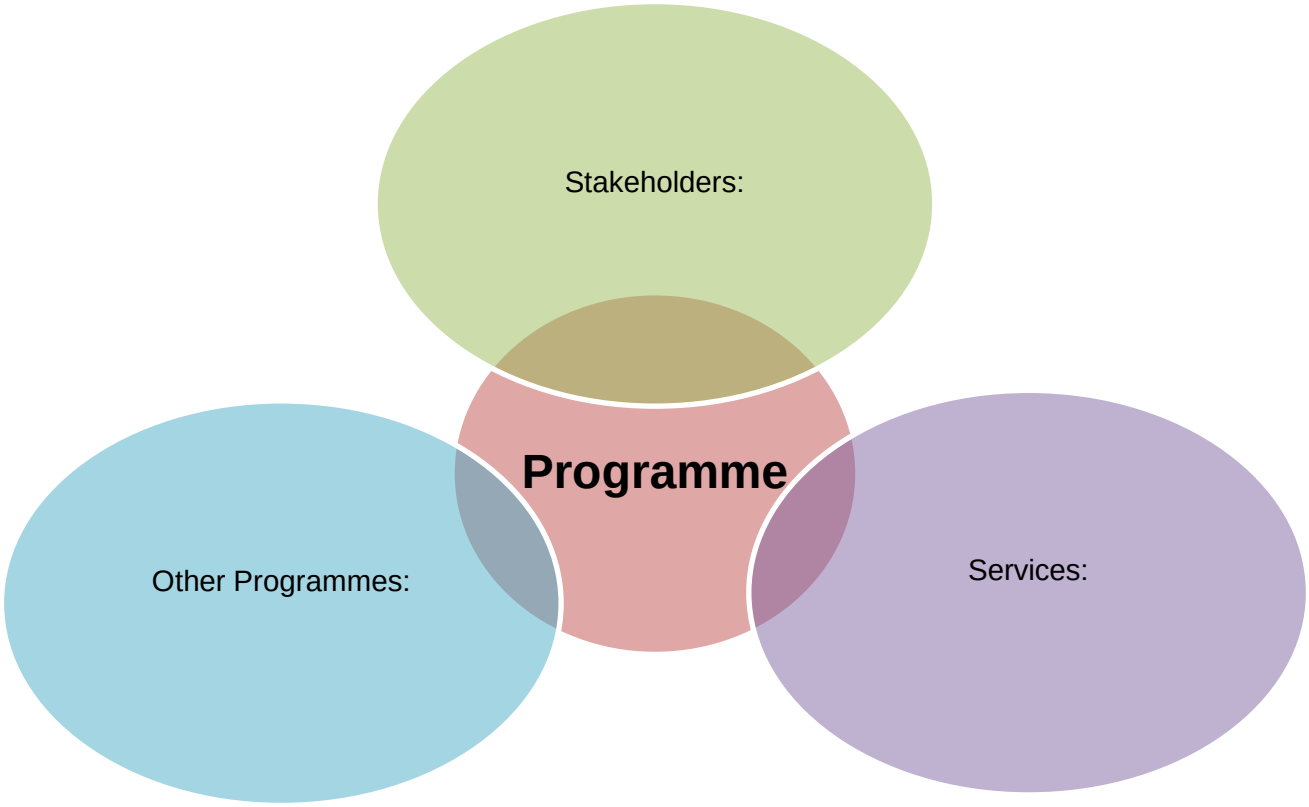
7. Outline Project Plan

Key Tasks	Task Owner	Date for Completion
Identify conditions and services in scope	DP	5.7.19
Determine ophthalmology versus optometry license	AH	31.10.19
Map existing contracts and durations and include in PID as Appendix A & B	BG	31.7.19
Produce DRAFT PID incorporating outline project plan	DP	5.7.19
Socialise PID within CCGs and ICPs – ensuring that CCGs reps on CCB and JCCCGs are comfortable to support the PID – and confirm back to Cathy/Donna	All CCG leads	3.8.19
Gateway 1: Collaborative Commissioning Board reviews scope of work and considers if **JCCCGs has oversight and/or decision-making role**	CG/DP	13.08.19
Gateway 2: JCCCGs is asked to agree **Case for Change/Programme proposal** for inclusion into its **Work Programme** with clarity about its oversight and/or delegation role	CG/DP/AH	05.09.19
Define based on draft from DP: • Standard • Outcome • Measure	CG/DP	2.8.19
Map existing standards, outcomes, measures and best practice in L&SC	BG	2.8.19
Map existing standards, outcomes, measures and best practice nationally	DP	2.8.19
Summarise relevant findings from 4 Eyes work	AH	22.8.19
Identify clinicians and providers for engagement	AH	22.8.19
Engagement session with clinicians and providers to review existing standards, outcomes, measures and best practice	DP/AH	13.9.19
Define standards for L&SC – high, medium and low	DP	30.9.19
Develop DRAFT L&SC standards, outcomes, measures and best practice	DP	30.9.19
Identify PPG ophthalmology reps for engagement session	All CCG Leads	30.8.19
Identify potential opportunities for collaborative pathway redesign and development of delivery models across and between ICP footprints	BG/KR	4.10.19
Engage with patients and patient groups, including clinicians	AH/DP/CG	8.11.19

Appraise potential opportunities for collaborative pathway redesign and development of delivery models across and between ICP footprints against baseline data and agree recommendations for consideration by CPB	BG/KR	8.11.19
Produce final DRAFT L&SC standards, outcomes, measures and best practice reflecting engagement feedback for consideration by CPB	CG	23.11.19
Gateway 3: Clinical model considered by **Care Professionals Board**	CG/DP/AH	TBD
Produce FINAL L&SC standards, outcomes, measures and best practice reflecting any feedback from CPB	CG	13.12.19
Produce FINAL recommendations for collaborative pathway redesign and development of delivery models across and between ICP footprints	CG	13.12.19
Gateway 4: Chief Finance Officers group undertakes **financial appraisal** of proposals as they reach a final draft stage (where relevant)	N/A – financial implications will be picked up as part of ICP lead pathway redesign based on local demand modelling	
Socialise FINAL standards, outcomes, measures, best practice and recommendations with CCGs and ICPs	All CGG leads	4.1.20
Gateway 5: CCB reviews **final proposals** including feedback from CFOs to consider if these are ready for JCCCGs	CG/DP/AH	14.01.20
Gateway 6: Final recommendations are considered by **JCCCGs**	CG/DP/AH	06.02.20
Implementation of agreed standards, outcomes and measures across the ICS footprint.	All CCG leads	From 1.03.20

8. Interdependency Map

The map below highlights the interdependencies that the project has to other areas:



Interdependency	Relationship	Impact/Limitation
Acute & Specialised Programme	Already working on fragile Services Group work Theatre capacity work	Joint approach to tackling provider and commissioner problems using the same project
Out of Hospital Workstream	Outpatients Tier 2 re commissioning/ provision	Joint approach, provides opportunity to match capacity with demand
Optometry commissioned by NHSE	Capacity opportunity within NHSE commissioned services	Ability to optimize workforce and delivery models
4 Eyes	Theatre usage	Findings from 4 Eyes can inform the development of standards
NHS Right Care	Intelligence & resource	Ability to demonstrate movement to National best in class
Digital	Interoperability of systems	Ability to optimise delivery

	Transfer of data	models and pathways
Workforce	Capacity mapping and skill shortages	Ability to optimise delivery models and pathways
Clinical Policies Implementation Group	Ensuring definitions and measures are aligned	Guidance or policies not aligned to standards and outcomes
Communications and Engagement	Media and awareness raising	Ability to link with the wider ICS system and effective clinical patient and clinical engagement delivering consistent messages
Medicines Management	Use of Lucentis vs Avastin	Legal challenge Drug licensing

9. Stakeholders

The RACI matrix below contains the stakeholders and their role within the programme:

Responsible	**Accountable**
• Medicines Management • Clinicians • Providers	• CCGs • JCCCGs • NHSE/I • NHSE Specialised Commissioning • Primary Care • Procurement hubs • CSU procurement
Consulted	**Informed**
• Patients • Patient groups • Third sector providers • VCFS • NHSE/I • Providers – Acute, Optometrists, LOCSU, Private, Independent	• Lobby Groups • Professional groups e.g. Local eye health network, Local optical committee support unit (LOCSU)

10. Communication & Engagement Approach

In order to communicate to and engage with the relevant stakeholders identified, the Healthier Lancashire & South Cumbria Communications & Engagement Plan has been drafted with support and appraisal from the Communications & Engagement Team.

Ophth PID Comms Plan.docx

11. Acceptance and Quality Measures

The project will be measured against production and agreement of the deliverables set out in section 7 above and in line with the outline project plan (section 6).

12. Risk Management Approach

The risk management approach aligns to the ICS PMO framework and the scoring matrix has been used to determine the risks identified at this stage and have been highlighted within the risk log below:

Risk Description	Risk Owner	Mitigating Action	Risk Rating (Utilising the risk matrix within the embedded framework)
Resources/capacity to complete the project	A Harrison	Secure agreement from CCGs via JCCCG to commitment of Planned Care group colleagues in line with outline plan	12
ICPs driving the change to implementation of a consistent set of standards and outcomes versus PCNs developing approaches based on local interest	B Goodman	Communication with ICPs and PCNs about the aims and objectives of the project and the opportunities for local innovation within the context of consistent standards and outcomes	12
Variable contract durations	B Goodman	Mapping of existing contract durations to be included in PID. Recommendations for collaborative commissioning to include options to change contracts through contract variation where this will yield benefits earlier	4
Securing sign up by ICPs, CCGs	A	Progression of the	4

and Care Professionals Board	Harrison	project through the commissioning decision making gateways as agreed with JCCCGs in April 2019. Development of comprehensive communications and engagement plan.	

13. Impact and Assurance

The ICS - Ophthalmology Planned Care Workstream is currently at an early/planning stage. A scoping Stage 1 EIRA has been completed -- at this point no changes to commissioned services are anticipated, however Stage 1 to be revisited and updated as the project develops to reassess potential changes / new impacts.

ics_-_ophthalmology_planned_care_works

14. Change Control

Any changes to the contents of the final PID, including the scope, approach and deliverables will be submitted by the project team, in the form of an Exception Report, to the Planned Care Workstream Group in the first instance and then referred to the Executive Sponsor, Andrew Bennett prior to consideration by Collaborative Commissioning Board and/or JCCCGs as appropriate.

15. Summary Statement

If we are to deliver safe and sustainable ophthalmology services across Lancashire and South Cumbria, clear and consistent standards and outcomes are needed to underpin the redesign of pathways alongside learning from best practice to support the introduction of more innovative approaches to the management of acute and chronic eye disease. There may also be opportunities to deliver economies of scale through collaborative commissioning across and between ICP footprints.

JCCCGs have previously agreed that commissioning activity in relation to ophthalmology services will largely be undertaken on an ICP footprint with work to set standards and outcomes being undertaken collectively on an ICS footprint. This project will produce a consistent set of standards and outcomes for the ophthalmology pathway across Lancashire and South Cumbria which

- Drive improved patient outcomes
- Drive cost effectiveness

- Respond to workforce challenges

These standards will then form the basis for ICPs and PCNs to locally redesign pathways and develop delivery models.

In order for the project to proceed successfully, CCB and JCCCGs are asked to:

1. Confirm agreement for Cathy Gardener, Head of Commissioning, to lead the Ophthalmology project as set out in this PID on behalf of all CCGs, ICPs and PCNs across L&SC.
2. Confirm the release of capacity for project team members as set out in this PID to undertake the tasks required to complete the project,
3. Agree the PID
4. Confirm commitment to re-allocate of project support from the capacity realignment exercise.

Please ensure that all sections are completed, in full, before submitting to the Healthier Lancashire & South Cumbria ICS PMO: mlcsu.lsc-ics.pmo@nhs.net

Healthier Lancashire & South Cumbria

Appendix A – Existing Ophthalmology Contracts and Durations

	Name of Provider	Start Date of Contract or is this NCA?	End Date of Contract or is this NCA?	Total Spend Per Annum	Total Activity	If this is a Tier 2 or other service your CCG has commissioned please state Services in Scope of Contract (e.g. AMD or Cataract etc.)	Key Expected Outcomes & Measures
Pennine	Primary Eye Care Limited (PEL) - EL & BwD	Oct-15	Community contract, due to end March 2020 - In the process of procurement	£757,173	8,630	MECS	Optometry led service, developed to deliver care closer to home, effective triage for adults with urgent or routine conditions as an integrated eye service pathway with Ophthalmology (IES) - (QTR Quality, Performance Meeting)
					347	LVA	
					246	IOP 1st Reading	
					102	IOP 2nd Reading	
					42	Visual Field Repeat	
					2,945	Pre-screening Cataract	
					1,813	Post Op Cat Follow Up	
					79	OHT Monitoring	
					14,204		
	RNIB - (ECLO) EL & BwD	01/04/17	March 2020 - With a view to extend for a further 3 years	£32,744	Local KPI's	Access to specialist assessment health & social care	Enhanced access, non-medical/ social intervention. Provide first stage emotional support at the point of diagnosis (ELCO is embedded within our Integrated Eye Service pathway) - QTR Quality & Performance Report)
	Care UK (EL)	NCA	NCA	£77,240		Cataract/YAG Laser/Glaucoma	Choice agenda/RTT
	Optegra (EL)	01/04/17	31/03/20	£46,605		Cataract/Glaucoma	Choice agenda/RTT
	Care UK (BwD)	NCA	NCA	£7,113		Cataract/YAG Laser/Glaucoma	Choice agenda/RTT
	Optegra (BwD)	01/04/17	31/03/20	£11,066		Cataract/ Glaucoma	Choice agenda/RTT

Central Lancashire	CARE UK	01/04/17	31/03/20	18/19 EACV = £476,850 / Actual = £993,075	2502 Patient Appointments / 582 Referrals / 386 Referrals non Wet AMD / 1250 Patient Injections (Wet AMD)	Community Macular Service inc AMD, DMO & RVO	A single integrated consultant led service managing all new patients with treatable macular conditions - and repatriating existing patients who so wish once the service is established. • 100% of new Wet AMD patients to have their first injection within 14 days of referral 90% within three days and >50% on the next working day
	Community Health & Eye Care	07/04/17	31/03/20	18/19 EACV £538, 211 / Actual = £901,118	16,827 Patient activity	Community Glaucoma Service, Community Cataract Service and Minor Eye Conditions Service	The service aims to reduce the strain on the HES and inconvenience for patients by minimising inappropriate referrals to secondary care and ensuring that all referrals comply with the CCGs criteria.

Fylde Coast	Community Health & Eye Care		14/04/22 (with provision to extend for 2 years)	For 18/19 Blackpool CCG – £344,568 Fylde and Wyre CCG – £343,230 **<u>There are 3 tariff brackets;</u>** New OPA Glaucoma New Glaucoma FU	For 2018/19 2906 First OP 810 Glaucoma New 2088 Glaucoma FU	**Acute conditions** • Field defects / patient reported • Flashes/floaters (photopsia) • Vitreous detachment, vitreous haemorrhage • Retinal lesions / pigmented retinal lesions / abnormal fundus appearance, suspicious naevi • Retinal vein occlusion (RVO) • Raised intraocular pressure • Ocular pain • Systemic disease affecting the eye • Red eye : Differential diagnosis and management as appropriate including but not limited to; Subconjunctival haemorrhage, Conjunctivitis bacterial / vitral / allergic / persistent, Episcleritis, Superficial corneal abrasions • Foreign body and emergency contact lens removal (not by the fitting practitioner) • Pterygium • Pinguecula • Dry eye • Epiphora (watery eye) • Trichiasis (ingrowing eyelashes) • Blepharitis • Differential diagnosis of lumps and bumps in the vicinity of the eye • Lid lesions / chalazion / differential diagnosis of lumps and bumps in the vicinity of the eye • Minor eye conditions	Manage the conditions in the left hand column in a community setting Be a single point of access for all ophthalmology referrals (except the defined exceptions) Offer choice of provider for patients needing referring onto secondary care To be offered a first OPA within 14 days The referral to be triaged within 2 working days Patients diagnosed with WET AMD to be referred within 24 hours to a secondary care provider

						Chronic conditions Glaucoma: Screening for suspected glaucoma or ocular hypertension as per agreed criteria. Management and follow up of these patients in the community. Follow up of low risk of sight loss primary open angle glaucoma, ocular hypertension and suspected ocular hypertension Transfer of low risk of sight loss glaucoma patients from secondary care into the community for ongoing monitoring and management	

NB please note data from enhanced services and third sector providers needs inclusion
NB Morecambe Bay data to follow

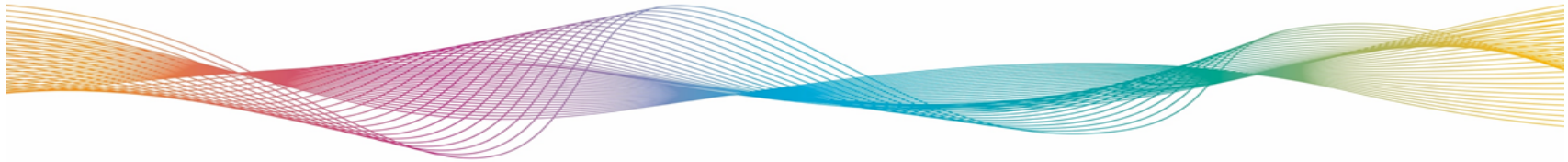
Healthier Lancashire & South Cumbria

Appendix B

NHS Midlands and Lancashire Commissioning Support Unit

Business Intelligence
Analytics Hub

ICS Planned Care workstream Ophthalmology activity across the Healthier Lancashire and South Cumbria ICS



CCG: NHS BLACKBURN WITH DARWEN CCG
NHS BLACKPOOL CCG
NHS CHORLEY AND SOUTH RIBBLE CCG
NHS EAST LANCASHIRE CCG
NHS FYLDE AND WYRE CCG
NHS GREATER PRESTON CCG
NHS MORECAMBE BAY CCG
NHS WEST LANCASHIRE CCG

April 2016 - March 2019

Created : July 15th 2019

Healthier Lancashire and South Cumbria - Ophthalmology hospital spells overview (2016/17 - 2018/19)

Based on all elective and non-elective spells recorded during the 2018/19 financial period under the Ophthalmology and Medical Ophthalmology specialties

This worksheet details all inpatient (planned and unplanned) hosptial provider spells recorded by patients registered with one of the eight CCGs of the Healthier Lancashire and South Cumbria ICS between April 2016 and March 2019 under the Ophthalmology or Medical Ophthalmology specialties. Small numbers (less than six) have been suppressed and secondary suppression has been applied to ensure that such numbers cannot be identified through user calculation.

These tables highlight that the majority of these activity is handled as a day case admission with the Blackpool, East Lancashire Morecambe Bay trusts being the main providers of care.

POD	2016-17	2017-18	2018-19	Total
Day case	24,893	22,802	24,246	71,941
Elective (planned)	797	604	621	2,022
Non-elective (unplanned)	363	426	406	1,195
Non-elective, non-emergency	7	8	7	22
Non-elective short stay	40	27	37	104
Regular Day attender				21
Unknown/unclassified				
Total	**26,110**	**23,874**	**25,323**	**75,307**

Yellow cells highlight cataract spells

Green cells highlight glaucoma

Top 30 spell HRGs split by year - All PODs				
HRG	**2016-17**	**2017-18**	**2018-19**	**Total**
Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 0-1	11,394	9,556	9,254	**30,204**
Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 2-3	2,769	3,104	4,128	**10,001**
Minor, Cataract or Lens Procedures	1,182	1,377	1,522	**4,081**
Intermediate Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	1,481	788	735	**3,004**
Phacoemulsification Cataract Extraction and Lens Implant, with CC Score 4+	429	698	1,392	**2,519**
Procedure Not Carried Out, for Medical or Patient Reasons	645	690	736	**2,071**
Intermediate Oculoplastics Procedures, 19 years and over, with CC Score 0-1	725	649	611	**1,985**
Procedure Not Carried Out, for Other or Unspecified Reasons	507	530	627	**1,664**
Minor Oculoplastics Procedures, 19 years and over	450	395	319	**1,164**
Major Oculoplastics Procedures, 19 years and over, with CC Score 0-1	403	338	323	**1,064**
Intermediate Vitreous Retinal Procedures, 19 years and over, with CC Score 2+	470	165	195	**830**
Very Major Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	297	227	236	**760**
Very Major, Cataract or Lens Procedures, with CC Score 0-1	275	246	207	**728**
Complex Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	230	233	227	**690**
Retinal Tomography, 19 years and over	312	333	2	**647**
Non-Surgical Ophthalmology without Interventions, with CC Score 0-1	223	219	192	**634**
Very Major Oculoplastics Procedures, 19 years and over, with CC Score 0-1	235	177	186	**598**
Major Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	238	188	149	**575**
Very Major, Cataract or Lens Procedures, with CC Score 2+	133	172	229	**534**
Very Major, Glaucoma or Iris Procedures, with CC Score 0-1	154	161	187	**502**
Major Ocular Motility Procedures, between 4 and 18 years	139	142	202	**483**
Complex, Cataract or Lens Procedures, with CC Score 0-1	161	164	123	**448**
Complex, Cornea or Sclera Procedures, with CC Score 0-1	166	139	138	**443**
Complex Oculoplastics Procedures, 19 years and over, with CC Score 0-1	154	144	139	**437**
Intermediate Oculoplastics Procedures, 19 years and over, with CC Score 2+	114	109	168	**391**
Intermediate, Cataract or Lens Procedures, with CC Score 0-1	147	113	123	**383**
Intermediate, Glaucoma or Iris Procedures, with CC Score 0	105	137	127	**369**
Major Ocular Motility Procedures, 19 years and over	111	103	119	**333**
Major, Glaucoma or Iris Procedures, with CC Score 0-1	108	104	115	**327**
Major Oculoplastics Procedures, 19 years and over, with CC Score 2+	102	100	106	**308**
Top 30 HRGs only	**23,859**	**21,501**	**22,817**	**68,177**
Other	**2,251**	**2,373**	**2,506**	**7,130**
Total	**26,110**	**23,874**	**25,323**	**75,307**

Ophthalmology activity across all PODs by provider				
Provider	**2016-17**	**2017-18**	**2018-19**	**Total**
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5,724	5,541	4,795	**16,060**
EAST LANCASHIRE HOSPITALS NHS TRUST	4,501	4,029	4,033	**12,563**
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	3,739	3,669	3,953	**11,361**
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	3,212	2,773	2,891	**8,876**
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	1,792	1,363	1,639	**4,794**
SPAMEDICA	986	1,018	2,104	**4,108**
SPIRE HEALTHCARE	1,176	989	1,383	**3,548**
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1,205	1,129	1,104	**3,438**
BMI HEALTHCARE	1,088	1,004	853	**2,945**
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	618	536	654	**1,808**
Top 10 only	**24,041**	**22,051**	**23,409**	**69,501**
Other	**2,069**	**1,823**	**1,914**	**5,806**
Total	**26,110**	**23,874**	**25,323**	**75,307**

Planned (day case, regular attenders, elective) Ophthalmology acivity across all providers				
Provider	**2016-17**	**2017-18**	**2018-19**	**Total**
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5,652	5,473	4,714	**15,839**
EAST LANCASHIRE HOSPITALS NHS TRUST	4,469	3,993	4,005	**12,467**
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	3,702	3,626	3,917	**11,245**
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	3,183	2,747	2,866	**8,796**
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	1,792	1,363	1,639	**4,794**
SPAMEDICA	986	1,018	2,104	**4,108**
SPIRE HEALTHCARE	1,176	989	1,383	**3,548**
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1,205	1,128	1,102	**3,435**
BMI HEALTHCARE	1,088	1,004	853	**2,945**
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	568	488	603	**1,659**
Top 10 only	**23,821**	**21,829**	**23,186**	**68,836**
Other	**1,869**	**1,584**	**1,681**	**5,148**
Total	**25,690**	**23,413**	**24,867**	**73,984**

Unplanned (Non-elective, non-elective non-emergency, non-elective short stay) Ophthalmology acivity by provider				
Provider	**2016-17**	**2017-18**	**2018-19**	**Total**
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST		114	212	**326**
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	174	113		**287**
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	72	68	81	**221**
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	50	48	51	**149**
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	37	43	36	**116**
EAST LANCASHIRE HOSPITALS NHS TRUST	32	36	28	**96**
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	29	26	23	**78**
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST				**9**
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST				**8**
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST				**7**
Top 10 only	**402**	**455**	**440**	**1,297**
Other	**8**	**6**	**10**	**24**
Total	**410**	**461**	**450**	**1,321**

Healthier Lancashire and South Cumbria - Ophthalmology hosptial spells cost overview (2016/17 - 2018/19)

Based on all elective and none elective spells recorded during the 2018/19 financial period under the Ophthalmology and Medical Ophthalmology specialties

The below tables provide a year by year breakdown activity under the Ophthalmology and Medical Ophthalmology specialties per provider, limited to the top 10 providers (in terms of total cost) and includes a calculated cost per spell field. It should be noted that these tables do not take into account the impact of high costing activity.

Ophthalmology costs by provider, across all PODs

CCG	2016/17			2017/18			2018/19			2016/17 - 2018/19		
	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5,724	£3,626,364	£633.54	5,541	£3,475,165	£627.17	4,795	£3,057,396	£637.62	16,060	£10,158,925	£632.56
EAST LANCASHIRE HOSPITALS NHS TRUST	4,501	£3,518,987	£781.82	4,029	£3,204,946	£795.47	4,033	£3,160,004	£783.54	12,563	£9,883,937	£786.75
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	3,739	£2,966,792	£793.47	3,669	£2,867,301	£781.49	3,953	£3,083,796	£780.12	11,361	£8,917,890	£784.96
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	3,212	£2,171,350	£676.01	2,773	£2,394,610	£863.54	2,891	£2,446,153	£846.13	8,876	£7,012,114	£790.01
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	1,792	£1,339,477	£747.48	1,363	£1,024,776	£751.85	1,639	£1,229,563	£750.19	4,794	£3,593,816	£749.65
SPIRE HEALTHCARE	1,176	£866,300	£736.65	989	£716,925	£724.90	1,383	£1,020,368	£737.79	3,548	£2,603,592	£733.82
SPAMEDICA	986	£476,852	£483.62	1,018	£469,330	£461.03	2,104	£1,336,356	£635.15	4,108	£2,282,538	£555.63
BMI HEALTHCARE	1,088	£778,890	£715.89	1,004	£710,989	£708.16	853	£642,250	£752.93	2,945	£2,132,129	£723.98
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1,205	£714,976	£593.34	1,129	£678,643	£601.10	1,104	£690,479	£625.43	3,438	£2,084,099	£606.20
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	618	£620,424	£1,003.92	536	£542,050	£1,011.29	654	£646,557	£988.62	1,808	£1,809,030	£1,000.57
Top 10 only	**24,041**	**£17,080,412**	**£710.47**	**22,051**	**£16,084,735**	**£729.43**	**23,409**	**£17,312,923**	**£739.58**	**69,501**	**£50,478,071**	**£726.29**
Other	**2,069**	**£1,924,235**	**£930.03**	**1,823**	**£1,870,944**	**£1,026.30**	**1,914**	**£1,983,414**	**£1,036.27**	**5,806**	**£5,778,593**	**£995.28**
Total	**26,110**	**£19,004,647**	**£727.87**	**23,874**	**£17,955,679**	**£752.10**	**25,323**	**£19,296,337**	**£762.01**	**75,307**	**£56,256,664**	**£747.03**

Planned (day case, regular attenders, elective) Ophthalmology costs by provider

CCG	2016/17			2017/18			2018/19			2016/17 - 2018/19		
	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell
EAST LANCASHIRE HOSPITALS NHS TRUST	4,469	£3,476,628	£777.94	3,993	£3,139,037	£786.13	4,005	£3,118,644	£778.69	12,467	£9,734,309	£780.81
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5,652	£3,524,600	£623.60	5,473	£3,288,555	£600.87	4,714	£2,905,927	£616.45	15,839	£9,719,082	£613.62
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	3,702	£2,849,491	£769.72	3,626	£2,775,053	£765.32	3,917	£2,994,635	£764.52	11,245	£8,619,180	£766.49
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	3,183	£2,117,184	£665.15	2,747	£2,328,368	£847.60	2,866	£2,365,047	£825.21	8,796	£6,810,600	£774.28
RAMSAY HEALTHCARE UK OPERATIONS LIMITED	1,792	£1,339,477	£747.48	1,363	£1,024,776	£751.85	1,639	£1,229,563	£750.19	4,794	£3,593,816	£749.65
SPIRE HEALTHCARE	1,176	£866,300	£736.65	989	£716,925	£724.90	1,383	£1,020,368	£737.79	3,548	£2,603,592	£733.82
SPAMEDICA	986	£476,852	£483.62	1,018	£469,330	£461.03	2,104	£1,336,356	£635.15	4,108	£2,282,538	£555.63
BMI HEALTHCARE	1,088	£778,890	£715.89	1,004	£710,989	£708.16	853	£642,250	£752.93	2,945	£2,132,129	£723.98
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1,205	£714,976	£593.34	1,128	£678,170	£601.21	1,102	£689,412	£625.60	3,435	£2,082,559	£606.28
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	568	£557,381	£981.30	488	£478,997	£981.55	603	£581,829	£964.89	1,659	£1,618,206	£975.41
Top 10 only	**23,821**	**£16,701,779**	**£701.14**	**21,829**	**£15,610,200**	**£715.11**	**23,186**	**£16,884,032**	**£728.20**	**68,836**	**£49,196,011**	**£714.68**
Other	**1,879**	**£1,630,961**	**£867.99**	**1,584**	**£1,475,855**	**£931.73**	**1,685**	**£1,611,854**	**£956.59**	**5,148**	**£4,718,670**	**£916.60**
Total	**25,700**	**£18,332,740**	**£713.34**	**23,413**	**£17,086,055**	**£729.77**	**24,871**	**£18,495,886**	**£743.67**	**73,984**	**£53,914,681**	**£728.73**

Unplanned (Non-elective, non-elective non-emergency, non-elective short stay) Ophthalmology costs by CCG

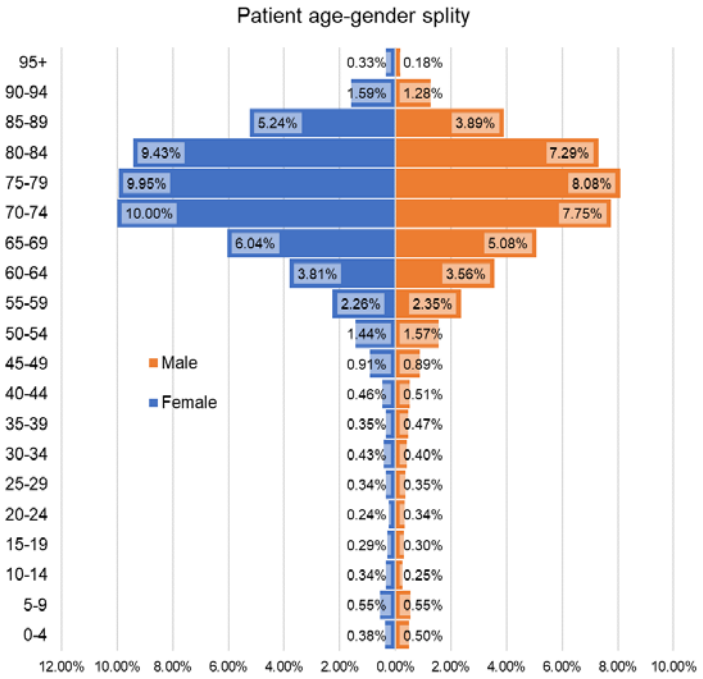
CCG	2016/17			2017/18			2018/19			2016/17 - 2018/19		
	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell	Count of spells	Total cost	Cost per spell
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	[redacted]			114	£181,129	£1,588.85	212	£352,277	£1,661.68	326	£533,406	£1,636.21
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	174	£271,706	£1,561.53	113	£189,957	£1,681.04	[redacted]			287	£461,663	£1,608.58
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	72	£101,764	£1,413.39	68	£186,610	£2,744.26	81	£151,469	£1,869.99	221	£439,843	£1,990.24
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	37	£117,301	£3,170.30	43	£92,248	£2,145.30	36	£89,161	£2,476.70	116	£298,710	£2,575.09
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	29	£54,166	£1,867.79	26	£66,242	£2,547.77	23	£80,241	£3,488.74	78	£200,649	£2,572.42
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	50	£63,043	£1,260.86	48	£63,053	£1,313.60	51	£64,728	£1,269.18	149	£190,824	£1,280.70
EAST LANCASHIRE HOSPITALS NHS TRUST	32	£42,359	£1,323.72	36	£65,909	£1,830.81	28	£41,360	£1,477.14	96	£149,628	£1,558.63
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	[redacted]									9	£21,501	£2,389.00
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST										7	£7,125	£1,017.86
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST										8	£6,353	£794.13
Top 10 only	**402**	**£661,501**	**£1,645.52**	**455**	**£859,754**	**£1,889.57**	**440**	**£788,447**	**£1,791.93**	**1297**	**£2,309,703**	**£1,780.80**
Other	**8**	**£10,406**	**£1,300.75**	**6**	**£9,870**	**£1,645.00**	**10**	**£11,139**	**£1,113.90**	**24**	**£31,415**	**£1,308.96**
Total	**410**	**£671,907**	**£1,638.80**	**461**	**£869,624**	**£1,886.39**	**450**	**£799,586**	**£1,776.86**	**1,321**	**£2,341,118**	**£1,772.23**

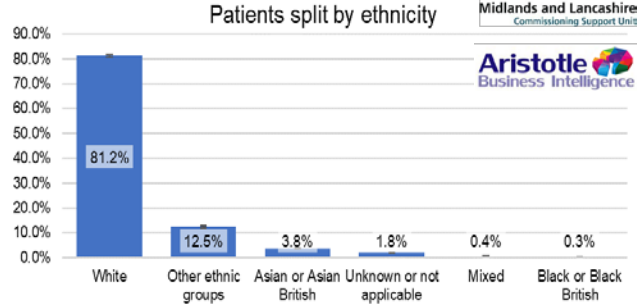
Healthier Lancashire & South Cumbria

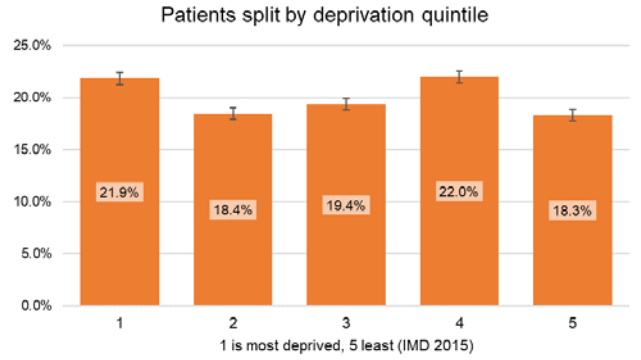
Healthier Lancashire and South Cumbria - One-year (2018/19) Ophthalmology snap shot patient profile

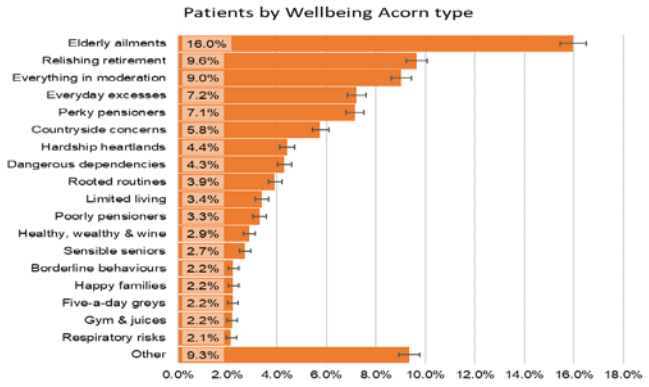
Based on all elective and none elective spells recorded during the 2018/19 financial period under the Ophthalmology and Medical Ophthalmology specialties

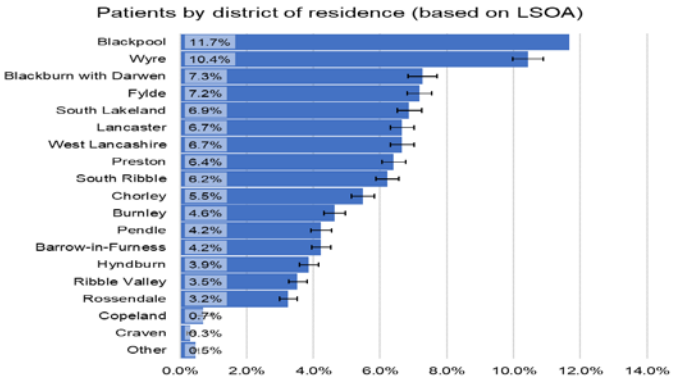
Unless specified, the below tables and charts are based on the last admitted (planned and unplanned) hospital spell recorded by patients registered to one of the eight Lancashire and South Cumbria ICS CCGs during the 2018/19 period under the Ophthalmology or Medical Ophthalmology specialties. Representing a total of 18,698 individual patients (excludes records with no NHS number). Highlighting that patients tend to be aged 65+, White and from the Blackpool and Wyre districts.











The below tables detail the top 10 spell primary diagnosis (ICD-10) and primary procedure codes recorded by above patients in 2018/19. Please note that some double counting will have occurred, in cases were a patient has been admitted for more than primary condition and/or procedure. E.g. A patient who has recorded two spells; one with a primary diagnosis relating to a cataract condition and another for diabetic retinopathy will have been counted twice.

Top 10 spell primary diagnosis	
Females	Males
H251: Senile nuclear cataract	H251: Senile nuclear cataract
H269: Cataract, unspecified	H269: Cataract, unspecified
H259: Senile cataract, unspecified	H259: Senile cataract, unspecified
H264: After-cataract	H264: After-cataract
H258: Other senile cataract	H258: Other senile cataract
H250: Senile incipient cataract	H250: Senile incipient cataract
H353: Degeneration of macula and posterior pole	H330: Retinal detachment with retinal break
H268: Other specified cataract	H409: Glaucoma, unspecified
H409: Glaucoma, unspecified	H020: Entropion and trichiasis of eyelid
H020: Entropion and trichiasis of eyelid	H360: Diabetic retinopathy

Top 10 spell primary procedures	
Females	Males
----: Unknown or not applicable	----: Unknown or not applicable
C121: Excision of lesion of eyelid NEC	C121: Excision of lesion of eyelid NEC
C152: Correction of entropion NEC	C151: Correction of ectropion NEC
C222: Biopsy of lesion of eyelid	C152: Correction of entropion NEC
C601: Trabeculectomy	C601: Trabeculectomy
C733: Capsulotomy of posterior lens capsule	C733: Capsulotomy of posterior lens capsule
C734: Capsulotomy of lens NEC	C751: Insertion of prosthetic replacement for lens NEC
C751: Insertion of prosthetic replacement for lens NEC	C792: Vitrectomy using pars plana approach
C792: Vitrectomy using pars plana approach	C794: Injection into vitreous body NEC
C794: Injection into vitreous body NEC	C825: Panretinal laser photocoagulation to lesion of retina

Title of Paper	Terms of Reference - Joint Committee of Clinical Commissioning Groups		
Date of Meeting	5th September 2019	Agenda Item	9

Lead Author	Jerry Hawker – Accountable Officer Morecambe Bay CCG	
Contributors	Andrew Bennett – ICS Director of Commissioning	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X
Executive Summary	The Terms of Reference of the Lancashire & South Cumbria Joint Committee of Clinical Commissioning Groups (TOR) were last reviewed and updated in November 2017. Under section 14 of the current TOR it is recommended that they are reviewed annually and this paper provides two revised options for the Committee to consider. Both versions of the TOR's have been updated in-line with best practice observed in other joint committee TOR's and take into account new guidance on Conflicts of Interest. The TOR have been aligned to the NHS Long Term Plan, the eight priorities established and agreed as part of the new Lancashire & South Cumbria Integrated Care System (LSC ICS)and specifically the ambition to develop more consolidated commissioning approaches across the ICS. Version 1: Is derived from the existing TOR and incorporates changes outlined above. Criteria related to the decision making authority have been made clearer, but have not been changed. These TOR's do not explicitly link the JCCCG work programme to the level of delegated authority of the committee. Version 2: A new TOR incorporating the changes outlined above. The TOR has been expanded to recognise and strengthen the commissioning responsibilities of the committee and to allow scope for the committee to provide a forum for agreeing future system changes including the development of Integrated Care Partnerships and development of "place based" commissioning arrangements. The scope of decision making authority of the Committee has been directly linked to the work programme. Two levels of decision making have been incorporated in the TOR.	

	All CCG Accountable Officers have been sighted and asked to comment on the draft Terms of Reference. Draft versions have also been presented and discussed at the Collaborative Commissioning Board		
Recommendations	The Joint Committee is asked to consider the two versions of the Terms of Reference and: a) Recommend either Version 1 or Version 2 to be approved by each CCG Governing Body. b) Advise of any further amendments. The lead author (Morecambe Bay Accountable Officer) and ICS Director Committee recommend that Version 2 is endorsed by the Joint Committee and collectively submitted for approval by the CCG Governing Bodies.		
Next Steps	Subject to the recommendations above the terms of reference would be submitted for approval by each Governing Body of the Lancashire & South Cumbria Clinical Commissioning Groups.		
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:	Jerry Hawker		

Healthier Lancashire & South Cumbria

Terms of Reference - Joint Committee of Clinical Commissioning Groups

1. Introduction

1.1 The Terms of Reference of the Lancashire & South Cumbria Joint Committee of Clinical Commissioning Groups (Appendix A) were last reviewed and updated in November 2017. Under section 14 of the current terms of reference (TOR) it is recommended that they are reviewed annually and this paper provides two revised options for the Committee to consider.

1.1 Since the last review of the Terms of Reference a number of important changes/events have taken place that have been considered and where appropriate incorporated into the proposed revised versions. These include:

- The publication of revised guidance on managing Conflicts of Interest in the NHS
- The publication of the NHS Long Term Plan & Implementation framework
- The development of the Lancashire & South Cumbria Integrated Care System (ICS) eight partnership priorities
- The continued development of the Lancashire & South Cumbria CCG's Commissioning framework and the progress to "place based" commissioning.
- The development and approval of the Joint Committee work programme.
- The refresh of the ICS Governance arrangements

1.2 Two versions of the Terms of Reference have been developed for consideration by the Joint Committee. Both versions have been presented to the Collaborative Commission Board for comment and all CCG Accountable Officers have been provided with copies for consideration and recommendations within their organisations.

1.3 In developing the proposed revisions a review of other joint committee terms of reference have been undertaken including those from Merseyside, Greater Manchester, London and Cheshire.

2. Terms of Reference – Version 1 (Appendix B)

2.1 Version 1 of the revised terms of reference has been developed from the existing terms of reference and retains essentially the same format. Key changes can be summarized as follows;

- General updating of terminology in-line with the NHS Long Term Plan.
- Section 1.6 includes increased clarity regarding the statutory responsibly of the committee with respect to the JCCCG work programme.
- Section 3.2 – additional section confirming the process for agreeing the JCCCG annual work programme.
- Section 3.8 replaces section 3.7 and provides a more robust definition of the role of the joint committee expanding its remit in-line with its statutory to cover both transformational change programmes and core commissioning duties including performance and financial management for relevant services delegated to the committee.
- Section 5.2 has been corrected to reflect that the vice chair is a voting member.

- Section 8.1 – the responsibility of CCGs to ensure voting representatives are present has been strengthened.
- Section 14 has been introduced to comply with the 2017 guidance on managing Conflicts of Interest in the NHS.
- Schedule 3 – An example of a JCCCG work programme has been included as part of the terms of reference.

2.2 Version 1 would enable the Joint Committee to continue to discharge its duties in-line with the stated purpose of the committee with the added assurance that the terms of reference comply with the latest NHS Long Term Plan and guidance published by NHS England.

2.3 Version 1 does however require the CCG Governing Bodies and the Joint Committee to be explicitly clear in their understanding of the level of delegation with regard to the work programme. For avoidance of doubt where an area is included in the work programme the terms of reference would allow for full delegated authority including all areas summarized in section 3.8 and all functions included in schedule 1.

3.0 Terms of Reference – Version 2 (Appendix C)

3.1 Version 2 of the revised terms of reference is a more extensive rewrite and is intended to address all the issues/changes identified in section 1.1. In addition version 2 aims to provide additional clarity around the following:

- Improved clarity over the extent of delegated authority based on a methodology currently adopted by a number of Joint Committees in England.
- Aligned to the ICS priorities and the recent review of ICS governance arrangements, provides clarity on the role of the Joint Committee in supporting the continued establishment of the ICS and its governance arrangements; options for progressing towards “place based commissioning” aligned to the NHS Long Term Plan and the development of Integrated Care Partnerships (ICP’s)

3.2 Key changes are summarized as follows:

- General updating of terminology in-line with the NHS Long Term Plan.
- Section 1 provides a broader definition of the purpose of the Joint Committee encompassing its role in collectively supporting and progressing the strategy and priorities of the ICS including transformational change programmes, reducing unwarranted variation in the services and quality available to people across Lancashire & South Cumbria and providing commissioning leadership in developing new ways of working as set-out in the NHS plan.
- Section 4 provides greater clarity on the role and responsibilities of the Joint Committee including; additional clarity and definition regarding levels of delegated authority; increased clarity regarding the statutory responsibly of the committee with respect to the JCCCG work programme and the process by which the plan is agreed by CCG Governing Bodies; and provides a more robust definition of the role of the joint committee expanding its remit in-line with its statutory duties to cover both transformational change programmes and core commissioning duties including

performance and financial management for relevant services delegated to the committee.

- Section 5 provides additional clarity on the decision making process and introduces two levels of delegated authority which would be agreed again each service/subject area identified and agreed within the JCCCG Work programme (schedule 3). The introduction of the two levels of decision making is consistent with best practice in other joint committees and allows clearer definition on where the Joint Committee has full delegated commissioning authority (Level 1) including all functions specified in Schedule 1 and where the Joint Committee acts as a body to exercise collective leadership in supporting recommendations to be made on areas in the work plan where delegated authority for the final decision remains with the eight individual CCG Governing Bodies (Level 2).

- Section 7.2 has been corrected to reflect that the vice chair is a voting member.
- Section 8.1 – the responsibility of CCGs to ensure voting representatives are present has been strengthened.
- Section 14 has been introduced to comply with the 2017 guidance on managing Conflicts of Interest in the NHS.
- Schedule 3 – An example of a JCCCG work programme has been included as part of the terms of reference. The inclusion of level 1 and level 2 delegations has been included in the example for demonstration purposes only and to help the committee in its understanding of the proposed approach. The Committee is asked to note that if Version 2 is approved; a further paper would need to be produced enabling the Joint Committee to recommend to the CCG Governing Bodies setting out levels of decision making authority against the agreed work programme. The final decision would be with each CCG.

4.0 Conclusion

4.1 This report highlights the requirement of the Joint Committee to review the current terms of reference and consider two new versions which have been developed to address the evolution of the Joint Committee taking into account the guidance and requirements as set-out in the NHS Long Term Plan and Implementation Framework together with the priorities developed and agreed by the Lancashire & South Cumbria ICS.

4.2 The proposed terms of reference are intended to support the ambitions agreed by the CCGs to progress the Commissioning Development framework and to ensure decisions are made effectively, transparently and in compliance with the delegations by CCGs to the Joint Committee

5.0 Recommendations

5.1 The Joint Committee is asked to consider the two versions of the Terms of Reference and:

a) Recommend either Version 1 or Version 2 to be approved by each CCG Governing Body.
b) Advise of any further amendments.

Healthier Lancashire & South Cumbria

The lead author (Morecambe Bay Accountable Officer) and ICS Director Committee recommend that Version 2 is endorsed by the Joint Committee and collectively submitted for approval by the CCG Governing Bodies.

Jerry Hawker

Accountable Officer

Morecambe Bay CCG

28th August 2019

JOINT COMMITTEE OF CLINICAL COMMISIONING GROUPS
TERMS OF REFERENCE

Document Control			
Title	Healthier Lancashire and South Cumbria (HLSC): Terms of Reference (TOR): Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Responsible Person	Independent Chair		
Date of Approval	2nd November 2017		
Approved By	Joint Committee of Clinical Commissioning Groups		
Author	STP Corporate Office		
Date Created	18th April 2016		
Date Last Amended	24th October 2017		
Version	6		
Review Date	March 2018		
Publish on Public Website		**Yes** ☑	**No**
The version of the policy posted on the intranet must be a PDF copy of the approved version			
Constitutional Document		**Yes** ☑	**No**
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
4	31.12.16	Updated to standardise all TOR within HLSC
5	17.10.17	Outstanding amendments from Fylde and Wyre CCG incorporated.
6	24.10.17	Update of wording to bring in line with current environment.

1.	**The Purpose of the Joint Committee of the Clinical Commissioning Groups**
1.1	The NHS Act 2006 (as amended) ('**the NHS Act**'), was amended through the introduction of a Legislative Reform Order ('**LRO'**), to allow Clinical Commissioning Groups (CCGs) to form joint committees. This means that two or more CCGs exercising commissioning functions jointly, may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.
1.2	Joint committees are a statutory mechanism, which gives CCGs an additional option for undertaking collective strategic decision making. Whilst NHS England (NHSE) will make decisions on Specialised Commissioning separate from a joint committee, as such decisions cannot be delegated to a CCG or a joint committee of CCGs; they can still make such decisions collaboratively with CCGs.
1.3	Although the Healthier Lancashire and South Cumbria Programme (HLSC) will affect services commissioned by the Specialised Commissioning function of NHSE, it has been decided that decisions on those services will be undertaken on a collaborative basis. This will allow sequential decisions to be undertaken allowing clarity of responsibility, but also recognising the linkage between the two decisions.

1.4	Individual CCGs and NHSE will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.
1.5	The Joint Committee of Clinical Commissioning Groups ('**JCCCGs**') is a joint committee of: • NHS Blackburn with Darwen CCG; • NHS Blackpool CCG; • NHS Chorley & South Ribble CCG; • NHS East Lancashire CCG; • NHS Fylde & Wyre CCG; • NHS Greater Preston CCG; • NHS Morecambe Bay CCG; • NHS West Lancashire CCG.
1.6	The primary purpose of the JCCCGs, is decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme.
1.7	In addition, the JCCCGs will meet collaboratively with NHSE to make integrated decisions in respect of those services within the Programme, which are directly commissioned by NHSE.
1.8	As set out in the Five Year Forward View, STP's are required to accelerate progress to achieve the 'triple aims' of improved population health, quality of care and sustainable finances, in which our programme of work is built around. As such, health leaders across the Healthier Lancashire and South Cumbria area have collectively committed to improve and transform health and care services across the patch, delivering the highest quality of care possible within the resources available. The work of the programme is designed to deliver key clinical standards consistently across the patch, so that all people receive the highest possible care and best outcomes. Among the relevant work streams which the JCCCGs will consider under the programme are: • Acute and Specialised • Urgent & Emergency Care • Mental Health (all ages) • Learning Disabilities • Prevention and Population Health
1.9	HLSC will establish an STP Board, informed by the Care Professionals Board, to oversee the development of agreed clinical quality standards, a feasibility analysis looking at the implications of implementing these standards, a clinical case for change, a financial case for change and new models of care.
1.10	Guiding principles: The Healthier Lancashire and South Cumbria Programme is proposing to adhere to the following principles as a minimum: • People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support. • Delivering a clinically and financially sustainable health and care system

	across HLSC. • Clinically-led, co-design and collaboration across HLSC health & care system, delivering integrated support. • Aligning priorities across local health and care systems and organisations – managing sovereignty and risk. • Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively. • Ensuring Value for Money. Getting it right first time. • Alignment of effort and resource across the system. • Built upon innovation, international evidence and proven best practice. • Subsidiarity with clear framework of mutual accountability.

2.	**Statutory Framework**
2.1	The NHS Act which has been amended by LRO 2014/2436, provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.
2.2	The CCGs named in paragraph 1.5 above, have delegated the functions set out in Schedule 1 to the JCCCGs.

3.	**Role of the JCCCGs**
3.1	The role of the JCCCGs shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme.
3.2	In relation to Acute and Specialised Services - The JCCCG will collaborate with NHSE, on services that they commission, in relation to aspects as yet to be agreed, but leading on the delivery on an agreed HLSC strategy aligned to national priorities.
3.3	In relation to Urgent and Emergency Care (UEC) – The JCCCG will ensure that national standards are delivered and that there is in place, an agreed UEC model, developed against these with all interdependencies mapped and considered.
3.4	Mental Health – The JCCCGs will recognise that this complex programme of work encompasses services for all ages, from Children's and Young People's Mental Health and emotional wellbeing, through to adult and older adult's mental health. Decisions will relate to the development of parity of esteem and delivery of national strategies. This will be transacted through clarity of relevant pathways and understanding what the potential reconfiguration aspects are, to then agree JCCCG decisions and local decisions.
3.5	In relation to Prevention and Population Health – The JCCCG will provide strategic input into the delivery of a Prevention and Population Health Model to the member CCGs across the patch. This will enable the member CCGs to make local decisions, in alignment with the HLSC strategic objectives.

3.6	In relation to Learning Disabilities – The JCCCG will ensure that national standards and expectations outlined in the Transforming Care Programme, are delivered across all ages and that there is in place, an agreed Learning Disability model of care, developed against these with all interdependencies mapped and considered.
3.7	The role described in 3.1 includes, but is not limited to, the following activities: • Determine the options appraisal process; • Determine the method and scope of the engagement and consultation processes; • Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities; • Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process); • Approve relevant consultation plans; • Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process; • Take or arrange for all necessary steps to be taken to enable the CCG's as part of the JCCCG's to comply with its public sector equality duties; • Approve the formal report on the outcome of consultation, that incorporates all of the representations received in response to the consultation document, in order to reach a decision; • Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to the consultation process. This should include consideration of any recommendations made by the STP Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.
3.8	At all times, the Joint Committee, through undertaking the decision making function of each member CCG, will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

4.	**Geographical Coverage**
4.1	The JCCCGs will comprise of those CCGs listed above in paragraph 1.5, covering Lancashire and South Cumbria.
4.2	NHS England Specialised Commissioning will also be involved through a collaborative commissioning arrangement.
4.3	The Joint Committee will have the primary purpose of decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme.

5.	**Membership**
5.1	Membership of the committee will combine both Voting and Non-voting members and will comprise of: -
5.2	Voting members: • The two individuals appointed to represent each of the member CCGs, subject to such voting being in compliance with paragraph 7 below on 'Voting'. (Whilst the JCCCG does not require a clinical majority, the CCG members should ensure it consists of clinicians, lay members and executives).
5.3	Non-voting members: • The Independent Chair of the Joint Committee Non-voting attendees: • The STP Lead; • The STP Medical Director; • A vice chairman to be elected from the membership of the JCCCGs by the members and who will retain their voting rights; • The NHS England Specialised Commissioning Assistant Director will be invited to each meeting, in a non-voting capacity; • A Healthwatch representative nominated by the local Healthwatch groups; • Such representation from the Combined and/or Local Authorities as the JCCCG deems appropriate; • The Lead for the Prevention and Population Health Programme; • The Chair of the Finance and Investment Group
5.4	Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Joint Committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise, so that quoracy can be maintained.
5.5	No person can act in more than one role on the Joint Committee, meaning that each deputy needs to be an additional person from outside the Joint Committee membership.
6.	**Meetings**
6.1	The Joint Committee shall adopt the standing orders of Blackpool CCG, insofar as they relate to the: a) notice of meetings b) handling of meetings c) agendas d) circulation of papers e) conflicts of interest Notice of Meetings and the Business to be transacted (1) Before each meeting of the JCCCG, a clear agenda and supporting documentation, specifying the business proposed to be transacted shall be sent to every member of the JCCCG at least six clear days before the meeting.

	The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website. (2) No business shall be transacted at the meeting, other than that specified on the agenda, or emergency motions allowed under Standing Order 3.8. (3) Before each public meeting of CCG Governing Body meetings, a public notice of the time and place of the next Joint Committee meeting and the public part of the agenda shall be displayed on the CCG's website, at least three clear days before the meeting.

7.	**Voting**
7.1	The Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The voting power of each individual present will be weighted so that each party (CCG) possesses 12.5% of total voting power.
7.2	It is proposed that recommendations can only be approved if there is approval by more than 75%.

8.	**Quorum**
8.1	At least one voting member (or nominated deputy) from each CCG must be present for the meeting to be Quorate.

9.	**Frequency of Meetings**
9.1	Frequency of meetings will usually be monthly, but as and when required, in line with priorities.

10.	**Meetings of the Joint Committee**
10.1	Meetings of the Joint Committee shall be held in public, unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings), whenever publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business, or of the proceedings, or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
10.2	Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability and endeavor to reach a collective view.
10.3	The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.4	The Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Committee.
10.5	Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above, unless separate confidentiality requirements are set out for the Joint Committee, in which event these shall be observed.

11.	**Secretariat Provisions**
11.1	The agenda and supporting papers will be circulated by email, five working days prior to the meeting. The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website.
11.2	Papers may not be tabled without the agreement of the Chair.
11.3	Minutes will be taken and distributed to the members within 14 working days after the meeting.
11.4	Minutes will be published in the public domain, unless there are discussions which need to be recorded confidentially - in which case there will be recorded separately and will not be made public.
11.5	Agenda and papers to be agreed with the Chairman seven working days before the meeting.

12.	**Reporting to CCGs and NHS England**
12.1	The Joint Committee will hold annual engagement events to review aims, objectives, strategy and progress. The Joint Committee will also publish an annual report on progress made against objectives.

13.	**Decisions**
13.1	The Joint Committee will make decisions within the bounds of the scope of the functions delegated.
13.2	The decisions of the Joint Committee shall be binding on all member CCGs, which are: Blackburn with Darwen CCG; Blackpool CCG; Chorley & South Ribble CCG; East Lancashire CCG; Fylde & Wyre CCG; Greater Preston CCG; Morecambe Bay CCG; and West Lancashire CCG.
13.3	All decisions undertaken by the Joint Committee will be published by the Clinical Commissioning Groups.

14	Review of Terms of Reference
14.1	These terms of reference will be formally reviewed by Clinical Commissioning Groups at least annually, taking the date of the first meeting, following the year in which the JCCCG is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

15.	Withdrawal from the Joint Committee
15.1	Should this joint commissioning arrangement prove to be unsatisfactory, the Governing Body of any of the member CCGs or NHS England can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

16. Signatures	
Blackburn with Darwen CCG	**Blackpool CCG**
Chorley & South Ribble CCG	**East Lancashire CCG**
Fylde & Wyre CCG	**Greater Preston CCG**
Morecambe Bay CCG	**West Lancashire CCG**

Schedule 1 - Delegation by CCGs to Joint Committee

A. As required to achieve the purpose of the Joint Committee of CCG's, the following CCG functions will be delegated to the Joint Committee of CCGs ('**the JCCCGs**') by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended). s.14Z3 allows CCGs to make arrangements in respect of the exercise of their functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions.

B. The Lancashire and South Cumbria STP focuses on achieving clinical quality standards in the services listed below provided by the NHS Trusts within the STP. As part of this work, it is necessary to consider interdependencies between these services and any other services that are affected. The relevant services are:

a. All elements of the programme, including the Case for Change, evaluation criteria, options, communications plan and such like.

b. Such other services not set out above, which the CCG members of the JCCCGs determine should be included in the programme of work.

C. Each member CCG shall also delegate the following functions to the JCCCGs, so that it can achieve the purpose set out in (A) above:

a. Acting with a view to securing continuous improvement to the quality of commissioned services in so far as these services are included within the scope of the programme. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.

b. Promoting innovation, in so far as this affects the services included within the scope of the programme, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

c. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act').

d. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:
    - Support from GP commissioners;
    - Strengthened public and patient engagement;
    - Clarity on the clinical evidence base;
    - Consistency with current and prospective patient choice.

e. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

f. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

    13C and 14P - Duty to promote the NHS Constitution

    13D and 14Q - Duty to exercise functions effectively, efficiently and economically

    13E and 14R – Duty as to improvement in quality of services

    13G and 14T - Duty as to reducing inequalities

    13H and 14U – Duty to promote involvement of each patient

    13I and 14V - Duty as to patient choice

    13J and 14W – Duty to obtain appropriate advice

    13K and 14X – Duty to promote innovation

    13L and 14Y – Duty in respect of research

    13M and 14Z - Duty as to promoting education and training

    13N and 14Z1- Duty as to promoting integration

    13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs

    13O - Duty to have regard to impact in certain areas

    13P - Duty as respects variations in provision of health services

    14O – Registers of Interests and management of conflicts of interest

    14S – Duty in relation to quality of primary medical services

g. The JCCCGs must also have regard to the financial duties imposed on CCGs under the NHS Act 2006 and as set out in:
    - 223G – Means of meeting expenditure of CCGs out of public funds
    - 223H – Financial duties of CCGs: expenditure
    - 223I - Financial duties of CCGs: use of resources
    - 223J - Financial duties of CCGs: additional controls of resource use

h. Further, the JCCCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).

i. The expectation is that CCGs will ensure that clear governance arrangements are put in place, so that they can assure themselves that the exercise by the JCCCGs of their functions is compliant with statute.

j. The JCCCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated regulations.

k. To continue to work in partnership with key partners e.g. the Local Authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.

l. The Joint Committee will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups and NHS England under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

D. The role of the JCCCGs, shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme. This includes, but is not limited to, the following activities:

- Determine the options appraisal process;
- Determine the method and scope of the engagement and consultation processes;
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities;
- Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process);
- Approve relevant consultation plans;
- Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process;
- Take or arrange for all necessary steps to be taken to enable the CCG to comply with its public sector equality duties;
- Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision;
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to

the consultation process. This should include consideration of any recommendations made by the STP Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.

At all times, the Joint Committee, through undertaking the decision making function of each member CCG will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

Schedule 2 - List of Members from each Constituent CCG

JOINT COMMITTEE OF CLINICAL COMMISIONING GROUPS
TERMS OF REFERENCE – VERSION 1

Document Control			
Title	Healthier Lancashire and South Cumbria (HLSC): Terms of Reference (TOR): Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Responsible Person	Independent Chair		
Date of Approval	2nd November 2017		
Approved By	Joint Committee of Clinical Commissioning Groups		
Author	CCG Accountable Officers & ICS Director of Commissioning		
Date Created	28/08/2019		
Date Last Amended	24th October 2017		
Version	7		
Review Date	October 2020		
Publish on Public Website		**Yes** ☑	**No**
The version of the policy posted on the intranet must be a PDF copy of the approved version			
Constitutional Document		**Yes** ☑	**No**
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
4	31.12.16	Updated to standardise all TOR within HLSC
5	17.10.17	Outstanding amendments from Fylde and Wyre CCG incorporated.
6	24.10.17	Update of wording to bring in line with current environment.
7	29/04/2019	Update of wording to bring in line with current environment and clarify decision making and the annual work programme.

1.	**The Purpose of the Joint Committee of the Clinical Commissioning Groups**
1.1	The NHS Act 2006 (as amended) ('**the NHS Act**'), was amended through the introduction of a Legislative Reform Order ('**LRO'**), to allow Clinical Commissioning Groups (CCGs) to form joint committees. This means that two or more CCGs exercising commissioning functions jointly, may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.
1.2	Joint committees are a statutory mechanism, which gives CCGs an additional option for undertaking collective strategic decision making. Whilst NHS England (NHSE) will make decisions on Specialised Commissioning separate from a joint committee, as such decisions cannot be delegated to a CCG or a joint committee of CCGs; they can still make such decisions collaboratively with CCGs.
1.3	Although the Healthier Lancashire and South Cumbria Programme (HLSC) will affect services commissioned by the Specialised Commissioning function of NHSE, it has been decided that decisions on those services will be undertaken on a collaborative basis. This will allow sequential decisions to be undertaken allowing clarity of responsibility, but also recognising the linkage between the two decisions.

1.4	Individual CCGs and NHSE will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.
1.5	The Joint Committee of Clinical Commissioning Groups ('**JCCCGs**') is a joint committee of: • NHS Blackburn with Darwen CCG; • NHS Blackpool CCG; • NHS Chorley & South Ribble CCG; • NHS East Lancashire CCG; • NHS Fylde & Wyre CCG; • NHS Greater Preston CCG; • NHS Morecambe Bay CCG; • NHS West Lancashire CCG.
1.6	The primary purpose of the Joint Committee is decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the agreed work programme. A specimen copy of a work programme is included in Schedule 3 Decisions will be taken by members of the joint committee in accordance with delegated authority from each CCG in-line with its Constitution, Scheme of Reservation & Delegation and the functions set-out in Schedule 1.
1.7	In addition, the JCCCGs will meet collaboratively with NHSE to make integrated decisions in respect of those services within the Programme, which are directly commissioned by NHSE.
1.8	As set out in the NHS Long Term Plan, ICS's and STP's are required to accelerate progress to achieve the 'triple aims' of improved population health, quality of care and sustainable finances, in which our programme of work is built around. As such, health leaders across the Healthier Lancashire and South Cumbria area have collectively committed to improve and transform health and care services across the patch, delivering the highest quality of care possible within the resources available. The work of the programme is designed to deliver key clinical standards consistently across the patch, so that all people receive the highest possible care and best outcomes. Among the relevant work streams which the JCCCGs will consider under the programme are: • Acute and Specialised • Urgent & Emergency Care • Mental Health (all ages) • Learning Disabilities • Prevention and Population Health
1.9	HLSC has established an ICS Board, informed by the Care Professionals Board, to oversee the development of agreed clinical quality standards, a feasibility analysis looking at the implications of implementing these standards, a clinical case for change, a financial case for change and new models of care.

1.10	Guiding principles: The Healthier Lancashire and South Cumbria Programme is proposing to adhere to the following principles as a minimum: • People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support. • Delivering a clinically and financially sustainable health and care system across HLSC. • Clinically-led, co-design and collaboration across HLSC health & care system, delivering integrated support. • Aligning priorities across local health and care systems and organisations – managing sovereignty and risk. • Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively. • Ensuring Value for Money. Getting it right first time. • Alignment of effort and resource across the system. • Built upon innovation, international evidence and proven best practice. • Subsidiarity with clear framework of mutual accountability.

2.	**Statutory Framework**
2.1	The NHS Act which has been amended by LRO 2014/2436 provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.
2.2	The CCGs named in paragraph 1.5 above, have delegated the functions set out in Schedule 1 to the JCCCGs.

3.	**Role of the JCCCGs**
3.1	The role of the JCCCGs shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the agreed work programme.
3.2	The JCCCG work programme (specimen in Schedule 3) will be agreed annually and approved by the Governing Body of each member CCG. The work programme may include, but is not limited by, those areas defined in section 3.3 to 3.9.
3.3	In relation to Acute and Specialised Services - The JCCCG will collaborate with NHSE, on services that they commission, in relation to aspects as yet to be agreed, but leading on the delivery of an agreed HLSC strategy aligned to national priorities.
3.4	In relation to Urgent and Emergency Care (UEC) – The JCCCG will ensure that national standards are delivered and that there is in place, an agreed UEC model, developed against these with all interdependencies mapped and considered.
3.5	Mental Health – The JCCCGs will recognise that this complex programme of work encompasses services for all ages, from Children's and Young People's Mental Health and emotional wellbeing, through to adult and older adult's mental health. Decisions will relate to the development of parity of esteem and delivery of national strategies. This will

	be transacted through clarity of relevant pathways and understanding what the potential reconfiguration aspects are, to then agree JCCCG decisions and local decisions.
3.6	In relation to Prevention and Population Health – The JCCCG will provide strategic input into the delivery of a Prevention and Population Health Model to the member CCGs across the patch. This will enable the member CCGs to make local decisions, in alignment with the HLSC strategic objectives.
3.7	In relation to Learning Disabilities – The JCCCG will ensure that national standards and expectations outlined in the Transforming Care Programme, are delivered across all ages and that there is in place, an agreed Learning Disability model of care, developed against these with all interdependencies mapped and considered.
3.8	The role described in 3.1 includes, but is not limited to the following activities which are aligned to those set-out in Appendix 1. • Acting to secure continuous improvement in the quality of commissioned services, including outcomes for patients, safety and patient experience. • Duty to promote the NHS Constitution • Due regard to the finance duties imposed on CCGs under the NHS Act 2006 including ensuring the means of meeting expenditure out of public funds. • Duty to ensure that process and decisions comply with the NHS Guidance on Planning, assuring and delivering service change for patients (including but not limited to Case for changes, service models and decision making business cases) • Statutory duties with respect to public engagement and consultation (including Local Authorities and associated committees) • Complying with public sector equality duty
3.9	At all times, the Joint Committee, through undertaking the decision making function of each member CCG, will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

4.	**Geographical Coverage**
4.1	The JCCCGs will comprise of those CCGs listed above in paragraph 1.5, covering Lancashire and South Cumbria.
4.2	NHS England Specialised Commissioning will also be involved through a collaborative commissioning arrangement.
4.3	The Joint Committee will have the primary purpose of decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme.

5.	**Membership**
5.1	Membership of the committee will combine both Voting and Non-voting members and will comprise of: -
5.2	Voting members:

	• The two individuals appointed to represent each of the member CCGs, subject to such voting being in compliance with paragraph 7 below on 'Voting'. (Whilst the JCCCG does not require a clinical majority, the CCG members should ensure it consists of clinicians, lay members and executives). • A vice chairman to be elected from the membership of the JCCCGs by the members and who will retain their voting rights;
5.3	Non-voting members: • The Independent Chair of the Joint Committee Non-voting attendees: • The ICS Lead; • The ICS Medical Director; • The NHS England Specialised Commissioning Assistant Director will be invited to each meeting, in a non-voting capacity; • A Healthwatch representative nominated by the local Healthwatch groups; • Such representation from the Combined and/or Local Authorities as the JCCCG deems appropriate; • The Lead for the Prevention and Population Health Programme; • The Chair of the Finance and Investment Group
5.4	Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Joint Committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise, so that quoracy can be maintained.
5.5	No person can act in more than one role on the Joint Committee, meaning that each deputy needs to be an additional person from outside the Joint Committee membership.
6.	**Meetings**
6.1	The Joint Committee shall adopt the standing orders of Blackpool CCG, insofar as they relate to the: a) notice of meetings b) handling of meetings c) agendas d) circulation of papers e) conflicts of interest Notice of Meetings and the Business to be transacted (1) Before each meeting of the JCCCG, a clear agenda and supporting documentation, specifying the business proposed to be transacted shall be sent to every member of the JCCCG at least - five working days before the meeting. The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website. (2) No business shall be transacted at the meeting, other than that specified on the agenda, or emergency motions allowed under Standing Order 3.8.

	(3) Before each public meeting of CCG Governing Body meetings, a public notice of the time and place of the next Joint Committee meeting and the public part of the agenda shall be displayed on the CCG's website, at least three clear days before the meeting.

7.	**Voting**
7.1	The Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The voting power of each individual present will be weighted so that each party (CCG) possesses 12.5% of total voting power.
7.2	It is proposed that recommendations can only be approved if there is approval by more than 75%.

8.	**Quorum**
8.1	At least one voting member (or nominated deputy) from each CCG must be present for the meeting to be Quorate. It is the responsibility of each CCG to ensure that they have at least one voting member present at all Committee meetings. In the exceptional circumstances that a CCG cannot field a representative, the CCG must communicate this information to the independent chair in advance of the meeting.

9.	**Frequency of Meetings**
9.1	Frequency of meetings will usually be monthly, but as and when required, in line with priorities.

10.	**Meetings of the Joint Committee**
10.1	Meetings of the Joint Committee shall be held in public, unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings), whenever publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business, or of the proceedings, or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
10.2	Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability and endeavor to reach a collective view.
10.3	The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.4	The Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Committee.
10.5	Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above, unless separate confidentiality requirements are set out for the Joint Committee, in which event these shall be observed.

11.	**Secretariat Provisions**
11.1	The agenda and supporting papers will be circulated by email, five working days prior to the meeting. The agenda and papers will be published on each member CCG website and the Healthier Lancashire and South Cumbria website.
11.2	Papers may not be tabled without the agreement of the Chair.
11.3	Minutes will be taken and distributed to the members within 14 working days after the meeting.
11.4	Minutes will be published in the public domain, unless there are discussions which need to be recorded confidentially - in which case there will be recorded separately and will not be made public.
11.5	Agenda and papers to be agreed with the Chairman seven working days before the meeting.

12.	**Reporting to CCGs and NHS England**
12.1	The Joint Committee will hold annual engagement events to review aims, objectives, strategy and progress. The Joint Committee will also publish an annual report on progress made against objectives.

13.	**Decisions**
13.1	The Joint Committee will make decisions within the bounds of the scope of the functions delegated.
13.2	The decisions of the Joint Committee shall be binding on all member CCGs, which are: Blackburn with Darwen CCG; Blackpool CCG; Chorley & South Ribble CCG; East Lancashire CCG; Fylde & Wyre CCG; Greater Preston CCG; Morecambe Bay CCG; and West Lancashire CCG.
13.3	All decisions undertaken by the Joint Committee will be reported to the Governing Body of each member CCG and published by the Clinical Commissioning Groups.

14.	**Conflicts of Interest**
14.1	The Committee shall hold and publish a register of interests. Each member and attendee

	of the committee will be under a duty to declare any such interests. Any interest related to an Agenda item should be brought to the attention of the Chair in advance of the meeting or notified as soon as the interest arises and recorded in the minutes. Any changes to these interests should be notified to the Chair.
14.2	All members of the Committee and participants in its meetings shall comply with, and are bound by, the requirements in the relevant CCG's Constitutions, Policies, the Standards of Business Conduct for NHS staff and NHS Code of Conduct.

15	**Review of Terms of Reference**
15.1	These terms of reference will be formally reviewed by Clinical Commissioning Groups at least annually, taking the date of the first meeting, following the year in which the JCCCG is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

16.	**Withdrawal from the Joint Committee**
16.1	Should this joint commissioning arrangement prove to be unsatisfactory, the Governing Body of any of the member CCGs or NHS England can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

17.	**Signatures**
Blackburn with Darwen CCG	**Blackpool CCG**
Chorley & South Ribble CCG	**East Lancashire CCG**
Fylde & Wyre CCG	**Greater Preston CCG**
Morecambe Bay CCG	**West Lancashire CCG**

Schedule 1 - Delegation by CCGs to Joint Committee

A. As required to achieve the purpose of the Joint Committee of CCG's, the following CCG functions will be delegated to the Joint Committee of CCGs ('**the JCCCGs**') by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended). s.14Z3 allows CCGs to make arrangements in respect of the exercise of their functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions.

B. The Lancashire and South Cumbria STP/ICS focuses on achieving clinical quality standards in the services listed below provided by the NHS Trusts within the STP/ICS. As part of this work, it is necessary to consider interdependencies between these services and any other services that are affected. The relevant services are:

a. All elements of the programme, including the Case for Change, evaluation criteria, options, communications plan and such like.

b. Such other services not set out above, which the CCG members of the JCCCGs determine should be included in the programme of work.

C. Each member CCG shall also delegate the following functions to the JCCCGs, so that it can achieve the purpose set out in (A) above:

a. Acting with a view to securing continuous improvement to the quality of commissioned services in so far as these services are included within the scope of the programme. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.

b. Promoting innovation, in so far as this affects the services included within the scope of the programme, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

c. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act').

d. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:

- Support from GP commissioners;
- Strengthened public and patient engagement;
- Clarity on the clinical evidence base;
- Consistency with current and prospective patient choice.

e. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

f. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

13C and 14P - Duty to promote the NHS Constitution

13D and 14Q - Duty to exercise functions effectively, efficiently and economically

13E and 14R – Duty as to improvement in quality of services

13G and 14T - Duty as to reducing inequalities

13H and 14U – Duty to promote involvement of each patient

13I and 14V - Duty as to patient choice

13J and 14W – Duty to obtain appropriate advice

13K and 14X – Duty to promote innovation

13L and 14Y – Duty in respect of research

13M and 14Z - Duty as to promoting education and training

13N and 14Z1- Duty as to promoting integration

13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs

13O - Duty to have regard to impact in certain areas

13P - Duty as respects variations in provision of health services

14O – Registers of Interests and management of conflicts of interest

14S – Duty in relation to quality of primary medical services

g. The JCCCGs must also have regard to the financial duties imposed on CCGs under the NHS Act 2006 and as set out in:

- 223G – Means of meeting expenditure of CCGs out of public funds
- 223H – Financial duties of CCGs: expenditure
- 223I - Financial duties of CCGs: use of resources
- 223J - Financial duties of CCGs: additional controls of resource use

h. Further, the JCCCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).

i. The expectation is that CCGs will ensure that clear governance arrangements are put in place, so that they can assure themselves that the exercise by the JCCCGs of their functions is compliant with statute.

j. The JCCCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated regulations.

k. To continue to work in partnership with key partners e.g. the Local Authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.

l. The Joint Committee will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups and NHS England under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

D. The role of the JCCCGs, shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the agreed work programme. This includes, but is not limited to, the following activities:

- Determine the options appraisal process;
- Determine the method and scope of the engagement and consultation processes;
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities;
- Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process);
- Approve relevant consultation plans;
- Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process;
- Take or arrange for all necessary steps to be taken to enable the CCG to comply with its public sector equality duties;
- Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision;
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to

the consultation process. This should include consideration of any recommendations made by the ICS Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.

At all times, the Joint Committee, through undertaking the decision making function of each member CCG will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

Schedule 2 - List of Members from each Constituent CCG

Clinical Commissioning Group	Representative
Blackburn with Darwen CCG	
Blackpool CCG	
Chorley & South Ribble CCG	
East Lancashire CCG	
Fylde & Wyre CCG	
Greater Preston CCG	
Morecambe Bay CCG	
West Lancashire CCG	

Schedule 3 – Specimen work programme

Service/Subject	Executive Sponsor	Delegation
Urgent Care	David Bonson	Approve updated Urgent and Emergency Care strategy for Lancashire and South Cumbria which will be developed in response to the national strategy.
SEND	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to deliver the 2019-2020 Lancashire SEND partnership improvement plan with specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental diagnostic pathway; speech and language and occupation therapy service reviews; consistency in multiagency school readiness pathway
Mental Health	Andrew Bennett	Agree action plan for commissioners which may arise from the external review of the urgent care mental health system in Lancashire being undertaken by Northumberland Tyne and Wear NHS Foundation Trust
Individual Patient Activity (IPA)	Jerry Hawker	Agree a single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICPs and neighbourhoods. Agree a single governance, business intelligence and delegated financial framework with accountability to the ICS and JCCCGs
Cancer	Denis Gizzi	Agree recommendations for commissioners which arise from Cancer transformation programme
Cancer/Workforce	Denis Gizzi	Agree the Outline Business Case for Oncology Advanced Clinical Practitioners
Specialist weight management services	Clare Thomason	Approve a case for change for multi-agency action in relation to obesity and specialist weight management
Stroke	Andrew Bennett	Agree options for the configuration of Hyper Acute and Acute stroke services Review and approve outline business case. Decide on requirement and readiness to consult. Approve full business case Review outcomes of consultation Consider and approve commissioning approach and approve delivery plan
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs Agree updated medicines management policies developed collectively for all CCGs
Vascular	Talib Yaseen	Agree operating model for vascular services across Lancashire and South Cumbria.
Commissioning	Andrew	Agree recommended operating models and

development	Bennett	implementation plans arising from Commissioning Development Framework programme
Children and Young People's Mental Health	TBA	Approve clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve transition and implementation plan for clinical model
Children and Maternity	Arif Rajpura	Approve case for change for paediatric services
Primary Care	Amanda Doyle	Approval of ICS Strategy for Primary Care
Planned Care	Andrew Harrison	Agree prioritised list of pathways and timeline for development of outcome based consistent clinical pathways across Lancashire & South Cumbria
Learning Disability	Andrew Bennett	Agree clinical model of non-secure, specialist inpatient provision for Learning Disabilities and Autism within the Lancashire and South Cumbria footprint
Integrated Commissioning (on LCC footprint)	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to build a common platform for integrated commissioning at an ICP level: Initiation to proof of concept phase:- scope principles, commitment and approaches, for the integration agenda building on BCF; test two areas for "in view" budget management leading to transformation for intermediate care and mental health section 117.

JOINT COMMITTEE OF CLINICAL COMMISIONING GROUPS
TERMS OF REFERENCE – VERSION 2

Document Control			
Title	Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs) – Terms of Reference		
Responsible Person	Independent Chair		
Date of Approval			
Approved By	Joint Committee of Clinical Commissioning Groups		
Author	JC CCG Accountable Officers		
Date Created	11th July 2019		
Date Last Amended	24th October 2017		
Version	7		
Review Date	October 2020		
Publish on Public Website		**Yes** ☑	**No**
The version of the policy posted on the intranet must be a PDF copy of the approved version			
Constitutional Document		**Yes** ☑	**No**
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
4	31.12.16	Updated to standardise all TOR within HLSC
5	17.10.17	Outstanding amendments from Fylde and Wyre CCG incorporated.
6	24.10.17	Update of wording to bring in line with current environment.
7	28/08/2019	Update to bring in-line with current environment

1.	The Purpose of the Joint Committee of the Clinical Commissioning Groups
1.1	The purpose of the Joint Committee is to bring together the leadership of the eight Lancashire & South Cumbria Clinical Commissioning Groups (JCCCG) who have collectively committed to improve and transform health and care services across the patch, delivering the highest quality of care possible within the resources available. The work of the Joint Committee is designed to deliver on the ambitions, commitments and priorities set-out in the NHS Long Term Plan and the Lancashire & South Cumbria ICS Strategy. The leadership of the eight Lancashire & South Cumbria commissioning groups (CCGs) will through the Joint Committee aim to: a. reduce unwarranted variation in the range and quality of services available to people living in different boroughs in Lancashire & South Cumbria by improving outcomes in areas that are below average and driving up outcomes overall; b. ensure key clinical standards are consistently met across the patch, so that all people receive the highest possible care and best outcomes. c. provide a joined-up approach to the commissioning of acute, community and mental health services, enabling the CCGs to work effectively with major health and care providers to ultimately improve quality of outcomes for patients; d. Work collectively to ensure progress towards and ultimately delivery of financial sustainability (agreed control totals) at both ICP and ICS levels. e. provide leadership in developing new ways of working as set-out in the NHS Plan including; a. supporting the continuing establishment of the Lancashire & South Cumbria ICS , b. options for moving towards "place based commissioning" c. development of integrated care partnerships
1.2	The primary purpose of the Joint Committee is to take collective commissioning decisions about services provided to the Lancashire & South Cumbria population.
1.3	Decisions will be taken by members of the joint committee in accordance with delegated authority from each CCG in-line with its Constitution, Scheme of Reservation & Delegation and the functions set-out in Schedule 1.
1.4	Guiding principles: The Lancashire and South Cumbria Joint Committee will adhere to the following principles already adopted by the Healthy Lancashire & South Cumbria Programme: • People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support. • Delivering a clinically and financially sustainable health and care system across HLSC. • Clinically-led, co-design and collaboration across HLSC health & care system, delivering integrated support. • Aligning priorities across local health and care systems and organisations – managing sovereignty and risk.

	• Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively. • Ensuring Value for Money. Getting it right first time. • Alignment of effort and resource across the system. • Built upon innovation, international evidence and proven best practice. • Subsidiarity with clear framework of mutual accountability.
1.5	The Joint Committee of CCGs will meet collaboratively with NHSE to make decisions in respect of those services within the Programme, which are directly commissioned by NHSE.

2.	**Geographic Coverage**
2.1	The Joint Committee shall comprise the eight Clinical Commissioning Groups who collectively cover the geographic footprint of the Lancashire & South Cumbria Integrated Care System (ICS)
2.2	The Joint Committee of Clinical Commissioning Groups ('**JCCCGs**') is a joint committee of: • NHS Blackburn with Darwen CCG; • NHS Blackpool CCG; • NHS Chorley & South Ribble CCG; • NHS East Lancashire CCG; • NHS Fylde & Wyre CCG; • NHS Greater Preston CCG; • NHS Morecambe Bay CCG; • NHS West Lancashire CCG.
2.3	Specialised services commissioned by NHS England for the population of Lancashire & South Cumbria whilst outside the delegated authority of the Committee will be involved through a collaborative commissioning arrangement.
2.4	Services commissioned by Local Authorities for the population of Lancashire & South Cumbria whilst outside the delegated authority of the Committee will be involved through, wherever appropriate, a collaborative commissioning arrangement.

3.	**Accountability & Responsibility - Statutory Framework**
3.1	The NHS Act 2006 (as amended) was amended through the introduction of a Legislative Reform Order (LRO 2014/2436) to form joint committees. This means that two or more CCG's exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 of the NHS Act. Joint Committees are statutory mechanisms which enable CCG's to undertake collective decision making.
3.2	The CCGs named in paragraph 1.5 above, have delegated the functions set out in Schedule 1 to the Joint Committee for commissioning services and functions as set-out and agreed within the Committee's annual work programme.
3.3	Joint committees are a statutory mechanism, which gives CCGs an additional option for undertaking collective strategic decision making. Whilst NHS England (NHSE) will make decisions on Commissioning Specialised services separate from the Joint Committee, it has been decided that decisions on those services will be undertaken on a collaborative basis. This will allow sequential decisions to be undertaken allowing clarity of responsibility, but also recognising the linkage between the two decisions.

3.4	Individual CCGs and NHSE will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

4.	**Role of the Joint Committee of CCGs**
4.1	The overarching role of the Joint Committee is to take collective commissioning decisions about services provided for the Lancashire & South Cumbria population. Decisions will be taken by members of the Joint Committee in accordance with delegated authority from each CCG. Members will represent the whole Lancashire & South Cumbria population and make decisions in the interests of all patients.
4.2	Decisions will support the strategy, aims and objectives of the Lancashire & South Cumbria ICS and will contribute to the sustainability and transformation of local health and social care systems. The Joint Committee will at all times, act in accordance with all relevant laws and guidance applicable to the CCGs.
4.3	The role of the committee will be to exercise the collective functions of the Clinical Commissioning Groups with respect to: a) Delegated decision making authority (level 1) on commissioning services across Lancashire & South Cumbria as agreed within the Committees Annual work programme and each member CCG Scheme of Reservation & Delegation. b) Making collective recommendations (level 2) to each member CCG Governing Body on commissioning services across Lancashire & South Cumbria which fall outside either the Annual work programme or member CCG Schemes of Reservation & Delegation. c) Making collective recommendations (level 2) to each member CCG Governing Body on developing new ways of working as set-out in the NHS Plan including; a. supporting the continuing establishment of the Lancashire & South Cumbria ICS b. future options for the configuration of Clinical Commissioning Groups c. development of integrated care partnerships
4.4	The Joint Committee will develop an annual work programme (Example in Schedule 3) which will be agreed and approved by the Governing Body of each member CCG. It will be the responsibility of executive leads and the JCCCG to ensure clarity over the scope of decision making associated with the work plan (Level 1 or Level 2)
4.5	The role described in 4.3 includes, but is not limited to the following activities which are aligned to those set-out in Appendix 1. • Acting to secure continuous improvement in the quality of commissioned services, including outcomes for patients, safety and patient experience. • Duty to promote the NHS Constitution • Due regard to the finance duties imposed on CCGs under the NHS Act 2006 including ensuring the means of meeting expenditure out of public funds. • Duty to ensure that process and decisions comply with the NHS Guidance on Planning, assuring and delivering service change for patients (including but not

	limited to Case for changes, service models and decision making business cases) • Statutory duties with respect to public engagement and consultation (including Local Authorities and associated committees) • Complying with public sector equality duty

5.	**Decision Making**
5.1	The primary purpose of the Joint Committee is to take collective commissioning decisions about services provided to the Lancashire & South Cumbria population.
5.2	Joint Committee members will make decisions in the best interests of the whole Lancashire & South Cumbria population, rather than the population of the Governing Body they are drawn from.
5.3	At all times, the Joint Committee, through undertaking the decision making function of each member CCG, will act in accordance with the terms of their Constitutions , Scheme of Reservation & Delegation and the functions set-out in Schedule 1.
5.4	The decision of the Committee will be binding on all member CCGs
5.5	**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.*
5.6	Any item or paper presented to the JCCCG which has not been previously agreed as part of the work programme will only be considered under Level 2 delegation.

6.	**Voting**
6.1	The Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The voting power of each individual present will be weighted so that each party (CCG) possesses 12.5% of total voting power.
6.2	It is proposed that recommendations can only be approved if there is approval by more than 75% of the voting membership.

7.	**Membership**
7.1	Membership of the committee will combine both Voting and Non-voting members and will comprise of: -
7.2	Voting members: • The two individuals appointed to represent each of the member CCGs, subject to such voting being in compliance with paragraph 7 below on 'Voting'. (Whilst the JCCCG does not require a clinical majority, the CCG members should ensure it consists of clinicians, lay members and executives).

7.3	Non-voting members: • The Independent Chair of the Joint Committee • A vice chairman to be elected from the membership of the JCCCGs by the members and who will retain their CCG voting rights; Non-voting attendees: • The Lancashire & South Cumbria ICS Lead; • The Lancashire & South Cumbria ICS Medical Director; • NHS England Representatives • A Healthwatch representative nominated by the local Healthwatch groups; • Such representation from the Combined and/or Local Authorities as the JCCCG deems appropriate; • Other such representation as the JCCCG deems appropriate;
7.4	Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Joint Committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise, so that quoracy can be maintained.
7.5	No person can act in more than one role on the Joint Committee, meaning that each deputy needs to be an additional person from outside the Joint Committee membership.

6.	**Meetings**
6.1	The Joint Committee shall adopt the standing orders of Blackpool CCG, insofar as they relate to the: a) notice of meetings b) handling of meetings c) agendas d) circulation of papers e) conflicts of interest Notice of Meetings and the Business to be transacted (1) Before each meeting of the JCCCG, a clear agenda and supporting documentation, specifying the business proposed to be transacted shall be sent to every member of the JCCCG at least six clear days before the meeting. The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website. (2) No business shall be transacted at the meeting, other than that specified on the agenda, or emergency motions allowed under Standing Order 3.8. (3) Before each public meeting of CCG Governing Body meetings, a public notice of the time and place of the next Joint Committee meeting and the public part of the agenda shall be displayed on the CCG's website, at least three clear days before the meeting.

8.	Quorum
8.1	At least one voting member (or nominated deputy) from each CCG must be present for the meeting to be Quorate. It is the responsibility of each CCG to ensure that they have at least one voting member present at all Committee meetings. In the exceptional circumstances that a CCG cannot field a representative, the CCG must communicate this information to the independent chair in advance of the meeting.

9.	Frequency of Meetings
9.1	Frequency of meetings will usually be monthly, but as and when required, in line with priorities.

10.	Meetings of the Joint Committee
10.1	Meetings of the Joint Committee shall be held in public, unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings), whenever publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business, or of the proceedings, or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
10.2	Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability and endeavor to reach a collective view.
10.3	The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
10.4	The Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Committee.
10.5	Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above, unless separate confidentiality requirements are set out for the Joint Committee, in which event these shall be observed.

11.	Secretariat Provisions
11.1	The agenda and supporting papers will be circulated by email, five working days prior to the meeting. The agenda and papers will be published on each member CCG website and the Healthier Lancashire and South Cumbria website.
11.2	Papers may not be tabled without the agreement of the Chair.
11.3	Minutes will be taken and distributed to the members within 14 working days after the meeting.

11.4	Minutes will be published in the public domain, unless there are discussions which need to be recorded confidentially - in which case there will be recorded separately and will not be made public.
11.5	Agenda and papers to be agreed with the Chairman seven working days before the meeting.

12.	**Reporting to CCGs and NHS England**
12.1	The Joint Committee will hold annual engagement events to review aims, objectives, strategy and progress. The Joint Committee will also publish an annual report on progress made against objectives.

13.	**Decisions**
13.1	The Joint Committee will make decisions within the bounds of the scope of the functions delegated.
13.2	The decisions of the Joint Committee shall be binding on all member CCGs, which are: Blackburn with Darwen CCG; Blackpool CCG; Chorley & South Ribble CCG; East Lancashire CCG; Fylde & Wyre CCG; Greater Preston CCG; Morecambe Bay CCG; and West Lancashire CCG.
13.3	All decisions undertaken by the Joint Committee will be published by the Clinical Commissioning Groups.

14.	**Conflicts of Interest**
14.1	The Committee shall hold and publish a register of interests. Each member and attendee of the committee will be under a duty to declare any such interests. Any interest related to an Agenda item should be brought to the attention of the Chair in advance of the meeting or notified as soon as the interest arises and recorded in the minutes. Any changes to these interests should be notified to the Chair.
14.2	All members of the Committee and participants in its meetings shall comply with, and are bound by, the requirements in the relevant CCG's Constitutions, Policies, the Standards of Business Conduct for NHS staff and NHS Code of Conduct.

15	**Review of Terms of Reference**
15.1	These terms of reference will be formally reviewed by Clinical Commissioning Groups at least annually, taking the date of the first meeting, following the year in which the JCCCG is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

16.	Withdrawal from the Joint Committee
16.1	Should this joint commissioning arrangement prove to be unsatisfactory, the Governing Body of any of the member CCGs or NHS England can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

17. Signatures	
Blackburn with Darwen CCG	**Blackpool CCG**
Chorley & South Ribble CCG	**East Lancashire CCG**
Fylde & Wyre CCG	**Greater Preston CCG**
Morecambe Bay CCG	**West Lancashire CCG**

Schedule 1 - Delegation by CCGs to Joint Committee

A. As required to achieve the purpose of the Joint Committee of CCG's, the following CCG functions will be delegated to the Joint Committee of CCGs ('**the JCCCGs**') by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended). s.14Z3 allows CCGs to make arrangements in respect of the exercise of their functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions.

B. The Lancashire and South Cumbria STP focuses on achieving clinical quality standards in the services listed below provided by the NHS Trusts within the STP. As part of this work, it is necessary to consider interdependencies between these services and any other services that are affected. The relevant services are:

a. All elements of the programme, including the Case for Change, evaluation criteria, options, communications plan and such like.

b. Such other services not set out above, which the CCG members of the JCCCGs determine should be included in the programme of work.

C. Each member CCG shall also delegate the following functions to the JCCCGs, so that it can achieve the purpose set out in (A) above:

a. Acting with a view to securing continuous improvement to the quality of commissioned services in so far as these services are included within the scope of the programme. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.

b. Promoting innovation, in so far as this affects the services included within the scope of the programme, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

c. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act').

d. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:

- Support from GP commissioners;
- Strengthened public and patient engagement;
- Clarity on the clinical evidence base;
- Consistency with current and prospective patient choice.

e. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

f. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

13C and 14P - Duty to promote the NHS Constitution

13D and 14Q - Duty to exercise functions effectively, efficiently and economically

13E and 14R – Duty as to improvement in quality of services

13G and 14T - Duty as to reducing inequalities

13H and 14U – Duty to promote involvement of each patient

13I and 14V - Duty as to patient choice

13J and 14W – Duty to obtain appropriate advice

13K and 14X – Duty to promote innovation

13L and 14Y – Duty in respect of research

13M and 14Z - Duty as to promoting education and training

13N and 14Z1- Duty as to promoting integration

13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs

13O - Duty to have regard to impact in certain areas

13P - Duty as respects variations in provision of health services

14O – Registers of Interests and management of conflicts of interest

14S – Duty in relation to quality of primary medical services

g. The JCCCGs must also have regard to the financial duties imposed on CCGs under the NHS Act 2006 and as set out in:

- 223G – Means of meeting expenditure of CCGs out of public funds
- 223H – Financial duties of CCGs: expenditure
- 223I - Financial duties of CCGs: use of resources
- 223J - Financial duties of CCGs: additional controls of resource use

h. Further, the JCCCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).

i. The expectation is that CCGs will ensure that clear governance arrangements are put in place, so that they can assure themselves that the exercise by the JCCCGs of their functions is compliant with statute.

j. The JCCCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated regulations.

k. To continue to work in partnership with key partners e.g. the Local Authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.

l. The Joint Committee will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups and NHS England under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

D. The role of the JCCCGs shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme. This includes, but is not limited to, the following activities:

- Determine the options appraisal process;
- Determine the method and scope of the engagement and consultation processes;
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities;
- Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process);
- Approve relevant consultation plans;
- Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process;
- Take or arrange for all necessary steps to be taken to enable the CCG to comply with its public sector equality duties;
- Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision;
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to

the consultation process. This should include consideration of any recommendations made by the STP Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.

At all times, the Joint Committee, through undertaking the decision making function of each member CCG will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

Schedule 2 - List of Members from each Constituent CCG

Clinical Commissioning Group	Representative
Blackburn with Darwen CCG	
Blackpool CCG	
Chorley & South Ribble CCG	
East Lancashire CCG	
Fylde & Wyre CCG	
Greater Preston CCG	
Morecambe Bay CCG	
West Lancashire CCG	

Schedule 3: <u>EXAMPLE</u> OF A WORK PROGRAMME AND DELEGATION LEVELS

Service/ Subject	Executive Sponsor	Description	Key Output	Level of Decision making
Urgent Care	David Bonson	Approve updated Urgent and Emergency Care strategy for Lancashire and South Cumbria which will be developed in response to the national strategy.	Strategy Document	Level 1
SEND	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to deliver the 2019-2020 Lancashire SEND partnership improvement plan with specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental diagnostic pathway; speech and language and occupation therapy service reviews; consistency in multiagency school readiness pathway		Level 2
Mental Health	Andrew Bennett	Agree action plan for commissioners which may arise from the external review of the urgent care mental health system in Lancashire being undertaken by Northumberland Tyne and Wear NHS Foundation Trust	Action Plan	Level 1
Individual Patient Activity (IPA)	Jerry Hawker	Agree a single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICPs and neighbourhoods. Agree a single governance, business intelligence and delegated financial framework with accountability to the ICS and JCCCGs	Proposed Commissioning Model	Level 1 Level 2
Cancer	Denis Gizzi	Agree recommendations for commissioners which arise from Cancer transformation programme	Set of Recommendations	Level 1
Cancer/ Workforce	Denis Gizzi	Agree the Outline Business Case for Oncology Advanced Clinical Practitioners	Outline Business Case	Level 2
Specialist weight management services	Clare Thomason	Approve a case for change for multi-agency action in relation to obesity and specialist weight management	Case for Change	Level 1
Stroke	Andrew Bennett	Agree options for the configuration of Hyper Acute and Acute stroke services	Case for Change	Level 1

		Review and approve outline business case. Decide on requirement and readiness to consult. Approve full business case Review outcomes of consultation Consider and approve commissioning approach and approve delivery plan	Outline Business Case Full Business Case	Level 1 Level 2
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs Agree updated medicines management policies developed collectively for all CCGs	Policy Documents	Level 1
Vascular	Talib Yaseen	Agree operating model for vascular services across Lancashire and South Cumbria.	Case for Change Service (operating) model	Level 1
Commissioning development	Andrew Bennett	Agree recommended operating models and implementation plans arising from Commissioning Development Framework programme	Commissioning Framework	Level 1
Children and Young People's Mental Health	TBA	Approve clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve transition and implementation plan for clinical model	Clinical Model and implementation plan	Level 1
Children and Maternity	Arif Rajpura	Approve case for change for paediatric services	Case For Change	Level1
Primary Care	Amanda Doyle	Approval of ICS Strategy for Primary Care	ICS Strategy	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
Learning Disability	Andrew Bennett	Agree clinical model of non-secure, specialist inpatient provision for Learning Disabilities and Autism within the Lancashire and South Cumbria footprint	Clinical Model	Level 1
Integrated Commissioning (on LCC footprint)	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to build a common platform for integrated commissioning at an ICP level: Initiation to proof of concept phase:- scope principles, commitment and approaches, for the integration agenda building on BCF; test two areas for "in view" budget management leading to	Integrated Commissioning platform	Level 2

		transformation for intermediate care and mental health section 117.		

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.*